

MRH-90 Taipan Helicopter Incident
Submission to the Legal and Constitutional Affairs References Committee

I am the mother of Warrant Officer 2 Joseph Phillip Laycock, one of four aircrew killed in the crash of Bushman 83 in the Whitsundays on 28 July 2023.

I cannot use the term “accident” to describe what happened on the evening of 28 July 2023 when Bushman 83 crashed into the ocean. The term “accident” implies the incident was unforeseen. However, after considering the Defence Flight Safety Bureau’s (DFSFB) report into the incident, listening to 56 days of evidence at the Inspector General’s (IGADF) inquiry, and being notified of the recommendations from Comcare to the CDPP regarding breaches of the Cth WHS Act, there appears nothing accidental about the crash of Bushman 83. I applaud the action of the Committee, therefore, to have matters regarding the Bushman 83 incident re-visited and considered for inquiry and report.

My inability to access to the IGADF Inquiry report, which earlier this week was delayed in its delivery to the families for the fourth time, makes it impossible (and extremely frustrating) to make a comprehensive and well-informed submission to the Committee. Furthermore, the inability of Comcare to outline the details of its recommendations for prosecution for breaches of the WHS Act, and the refusal of the Office of the Commonwealth Director of Public Prosecutions (CDPP) to communicate its reasons for rejecting the Comcare recommendations, render this submission something of a toothless tiger. It relies on the narrow remit of the Defence Flight Safety Bureau’s (DFSFB) Report and my personal recollections of the evidence presented at the IGADF inquiry.

Airworthiness Assessments of the MRH-90 Platform and Associated Equipment

Hardware

The DFSB report describes the MRH-90 as a “conventional helicopter designed to transport troops and cargo by day and/or night” (p.3). It’s a description that does little to describe the special operations environments in which 6th Avn operates. In particular, it fails to describe the conditions on 28 July that involved Bushman 83 flying at approximately 200 feet above the water, at speed, at night in degraded conditions with a lack of visual horizon, in close formation with approximately two rotor diameters between craft, and in a holding pattern of tight turns.

The DFSB report notes that, at the time of the incident, “there was no evidence of technical failure of the aircraft or major systems” (p. 5). It noted, however, increased pilot workload that would have been created by the “visually restricted environment” (p.6) of the cockpit in the MRH-90 that restricted visibility of Bushman 82 and 81 in the formation.

Importantly, regarding airworthiness, the DFSB report notes, “the MRH-90 and Army Aviation systems as a whole were clearly under significant strain” (p.10) in the maintenance and operational areas. It notes further, that, within the organisation, “the elevated level of risk to airworthiness and flight safety were generally well recognised, documented and accepted” (p. 10).

At the IGADF inquiry we heard “acquisition evidence” that described a politically-driven procurement of the MRH-90 platform based on tests conducted in, and by, overseas countries in environmental conditions unlike those experienced in Australia and for purposes very different from those of the special operations of 6th Avn. The inquiry also heard, repeatedly, about the frequent interruption to discussions

and decisions regarding the acquisition of hardware and software systems caused by the Army's frequent posting of personnel. Phrases such as "It was before my time" and "I'd moved on by then" populated the evidence of decision-makers. As an observer, it appeared that no-one was prepared to take responsibility for allowing an aircraft that was unfit for special operations purposes to be acquired and operated for some 16 years in an environment that obviously placed pressure and additional workloads on those who maintained and flew the MRH-90.

The lack of "ownership" of the decision-making of the MRH-90 platform is clearly apparent in the placement in 2011, only four years after its entry into service, of the MRH-90 project on the Department of Defence's "Projects of Concern." Alarming, in June 2021 the MRH-90 project remained the only major project still on that list, and in December of that year, the Minister for Defence Peter Dutton, deemed the aircraft inefficient, expensive and unreliable, asserting "they haven't lived up to expectation."

In summary, The MRH-90 involved in the crash on 28 July 2023 was unfit for purpose and had been known to be so for years prior to the incident. It was also known and accepted that deficiencies in the MRH-90 platform presented an elevated risk to its airworthiness.

Software

The DFSB could not make a determination on the role played in the incident on July 28 by the upgraded TopOwl navigation software (version 5.10) used by the pilot and co-pilot of Bushman 83. However, the DFSB did note the agreement between the Army Aviation Test and Evaluation Section (ATSE) and the Aviation Branch Standards Section regarding "deficiencies relating to attitude presentation" (p.7) in the upgrade. That said, the two parties could not agree on the severity of the hazard and the upgrade was released into service with specific requirements for further evaluation, which was not completed. Furthermore, a litany of evidence at the IGADF Inquiry from past and present members of 6th Avn and from expert witnesses who tested the system upgrade, highlighted known deficiencies in TopOwl (5.0) that added another layer of complexity to the airworthiness of the system.

In summary, the pilots of Bushman 83 were flying in complex and challenging conditions using equipment that was widely known to be deficient and hazardous.

Army Aviation Compliance With the Defence Aviation Safety Regulations

"Elevated risk" describes a situation where the possibility of a negative outcome is raised above normal expectations for the situation at hand; thus, requiring closer than usual monitoring or specific safety measures to ensure the safety of those involved. And while a level of risk in the context of the special operations carried out by the 6th Avn Regiment is not unexpected and considered "part of the job," the fact that the risk was elevated by resource and systems failure and accepted as such for over a decade, is unacceptable and warrants further investigation.

In particular, the DFSB report notes that, the Commander Aviation Command—and Military Air Operator-Accountable Manager (MAO-AM)—"clearly accepted, documented and communicated that MRH-90 operations presented a MEDIUM level of risk to safety to personnel despite significant and disproportionate efforts to minimise risk across the MRH-90 enterprise" (p.10). Evidence given at the IGADF inquiry suggested that a medium level of risk was "likely" to result in a "controlled flight into terrain." Moreover, emotional testimony from an expert witness who was involved in the testing of the

upgraded version of TOPOWL, described a risk so great that “someone was going to die” and those responsible for its implementation should be charged with industrial manslaughter.

The DFSB report provides a substantial body of other findings that point to deficiencies in Army Aviation’s duty of care to ensure the safety of its personnel and which are considered factors contributing to the crash of Bushman 83. These deficiencies were also highlighted in the IGADF inquiry and relate to the management of fatigue, inconsistencies in pilot training, and inconsistent and inadequate attention to risk management procedures at all levels.

In summary, the crash of Bushman 83 was an incident waiting to happen and was not unexpected. Tragically, it did happen on 28 July, killing my son Joseph Laycock, Danniell Lyon, Alexander Naggs and Maxwell Nugent.

Findings of the Comcare Investigation Into the Incident

It is beyond my comprehension, especially in the absence of details underlying the decision of the CDPP, as to why the Comcare recommendations will not be acted upon. Having read the DFSB report and listened to evidence in the IGADF inquiry, I have no doubt that there is sufficient evidence to support the prosecution of offences under the *Commonwealth Work Health and Safety Act (2011)*. Comcare’s recommendations regarding fatigue management, provision of unsafe equipment, inadequate risk assessment, and negligence regarding known risks are serious matters that, in the public interest, should be tested in court. I believe that the recommendations by Comcare for prosecution were not made lightly but based on strong and sound evidence collected and considered by senior counsel.

Any Other Investigations Into the Incident

As noted earlier, I am forced to write this submission in the absence of the report from the IGADF inquiry, which began some two years ago. While I appreciate the care and concern of the inquiry to ensure “all bases were covered” regarding its terms of reference, the delay in receiving the report is both frustrating and stressful. It is almost 12 months since the inquiry finished and since then, there have been extensions granted and delays in providing the findings of the inquiry to the families of the fallen. The fact that the draft report was circulated for comment at the end of 2025 to invested parties, seems to me, rightly or wrongly, like a chance for those who have been implicated to elaborate on their evidence outside the bounds of the public spotlight and beyond the bounds of an oath. This is yet another reason for the Senate Committee to investigate the matter further.

The Appropriateness of the Decision not to Prosecute Any Matters Arising From the Incident

In any “normal” workplace, an employer that fails in its duty of care to enact appropriate measures to ensure the safety of its employees would be brought before the courts. And while the special operations environment is not “normal” by everyday standards, the Defence Force still has a duty of care and an obligation to do everything possible in its unique work context to ensure the wellbeing of personnel.

The DFSB report findings, evidence from the IGADF inquiry, and the recommendations from Comcare indicate various levels of negligence regarding work, health and safety requirements in Army Aviation and cannot be overlooked. At the very least, the CDPP’s reasons for rejecting the Comcare recommendations to prosecute should be made public to provide transparency in its decision. At best, however, is for the CDPP to allow the matter to be brought before the courts so that the Bushman 83

families, friends, colleagues and the public can witness the justice system at work and maintain faith in both the decision-making and integrity of governments and the judicial system. Let the people decide!

Related Matters

According to the report of the DFSB, the most likely cause of the crash of Bushman 83 on the night of 28 July 2023 was the loss of spatial awareness by both the pilot and co-pilot. The crash, therefore, might simply be described as “pilot error,” but an expert witness at the IGADF inquiry better described the cause as a systemic failure in aircraft systems and those managing them rather an error of those whose hands were on the controls at the time. Both DFSB and Inquiry evidence points to a gamut of acknowledged and preventable deficiencies in systems, risk management, and organisational decision-making that, had they been addressed, would have allowed the crew of Bushman 83 to come home that night. Instead, their families are broken, and, along with friends and colleagues of Max, Dann, Alex and Phil, grieve not only for what has been lost but for a future they will never have.

While nothing will bring the boys of Bushman 83 back, some comfort might be gained for all those affected by knowing all avenues to understand the cause of the Bushman 83 incident have been explored and responsibility for the incident is made transparent and acted upon. My hope is that this will help prevent another mother, father, spouse, sibling, or child live a life incomplete.

While progress in this area has already been made, I am frustrated and angry knowing that the Comcare recommendations will not be acted upon. Therefore, I implore the Legal and Constitutional Affairs References Committee to pursue its own multi-partisan inquiry into the crash of Bushman 83.

Dr Dianne Patricia Laycock
30^h April 2026