RESERVED DECISION OF CORONER FOR TAUMARUNUI, GIVEN THIS 2nd DAY OF MARCH 2001

IN RESPECT OF THE INQUEST INTO THE DEATHS OF THE LATE MR NEVILLE HAIG MCDONALD THE LATE MRS HEATHER ANNE WILLIAMS AND THE LATE MISS HAYLEY NICOLE WILLIAMS

Background to the Inquest Process

These three Inquests were heard jointly at Taumarunui as they arose from the same tragic incident namely an Aircraft crash which occurred near Taumarunui at approximately 8.30 am on Tuesday the 11th day of May 1999. As a result of the crash, the Pilot and Owner of the Aircraft (a Piper Cherokee P28A) Neville Haig McDonald of Renwick near Blenheim, aged 81 years died as also did his two passengers, Heather Anne Williams and her daughter Hayley Nicole Williams, both of Tauranga.

As is usual in respect of air craft accidents (at least so far as the Court is aware) once preliminaries were complete the Coronial process was put to one side to await the publication of the Aircraft Accident Report. This was received from the Civil Aviation Authority of New Zealand (CCA) on 20th December 1999. It is clearly not possible for the Coronial Process in respect of an aircraft accident to be undertaken adequately without awaiting the Aircraft Accident Report. Thus the Coronial Process was not able to advance in any real sense until the New Year 2000.

Prior to the actual Hearing portion of the Inquest (which was held at the Taumarunui Court House) it became clear from the results of the post mortem that the Deceased Pilot, Mr McDonald, had large concentrations of Quinine (in his liver) at the time of his death. It appeared that this might well be an issue at the Hearing for that reason I requested a

preliminary report from Dr Peter Black, Senior Lecturer, Clinical Pharmacology, University of Auckland. This report was received on the 2nd of June 2000. I later caused a representative polling of Designated Medical Assessors (DMA's) and Aviation Medical Examiners (AME's) to be undertaken. A further paper by AGC Balfour entitled "The Bark of Jesuits Bite" dated July 1989 (having been published in an American Publication "A Journal of Space and Environment Medicine") was made available to me by the Civil Aviation Authority (CAA). This paper detailed the effects of Quinine on American Subject Pilots.

The Formal Inquest Hearing was commenced at the Taumarunui Court House on Monday 19th June and occupied three days. Unfortunately matters could not be finalised then. A further two day Hearing occurred at the Taumarunui Court House on Tuesday 29th August and Wednesday 30th August 2000. An issue then arose in respect of transcripts of the evidence of one of the Witnesses (Dr Scrivener). That issue will be commented upon in more detail later in this Decision. Initially it delayed the preparation of a Draft Decision.

It became clear as the Hearing progressed that there were issues that might cause me to comment adversely upon the actions of various persons and/or organisations where these appeared to have a bearing upon the deaths. Section 15 (2) a and b of the Coroner's Act 1988 requires a Coroner who is considering making adverse comment to indicate an intention to do so. To notify nominated people of the proposed comment and provide an opportunity to be heard in respect thereof. There are various ways that a Coroner may fulfil the obligations of Section 15 (2a and b). In respect of matters of unusual importance it has become the practise of at least some Coroners and to prepare a full draft decision and to make this available to persons (or their representatives) and organisations in respect of whom adverse comment may be directed. The advantage of such a process is that persons or organisations have absolute knowledge of what is proposed and an opportunity to respond to it. The disadvantage clearly is that the issuing of such a draft decision is time consuming. On this basis the November 9th draft decision was prepared and was circulated on 28th November 2000. A time frame for responses to the draft decision was set at 5 pm Friday 21st January but later extended to 5 pm Friday 2nd February. The draft decision served notice upon the Estate of the Late Mr McDonald, the Estate of the Late Mrs and Ms Williams, The Civil Aviation Authority and Doctors Hedley and Scrivener (later Ms Roil) that adverse comment was likely in respect of

their involvement in events leading up to the deaths. The responses by way of submissions were received from or on behalf of all these parties to the proposed comments. This decision will in due course deal with the issues raised in such responses.

Background to the Aircraft Crash

Mr McDonald was the holder of a Private Pilot's License. He had a casual acquaintance with the two women passengers stemming from a mutual contact (a distant relative of his) in the Bay of Plenty. Mr McDonald was a Retired Royal New Zealand Air Force Officer (Engineering Branch), a Wing Commander. He was a keen Amateur Aviator who sort every opportunity to fly. He was carrying his two passengers without reward. The Court had taken the view that there would have been some sort of reward offered although falling short of a commercial situation - for example a payment made for the purchase of aviation fuel. Mr McDonald's relative Mrs Boyd however gave evidence of Mr McDonald's generous nature and she said that she thought this was unlikely. Nothing much turns on it in any event. There was evidence given that it was CAA policy that fuel payment arrangements did not breach the restrictions of a private pilot's license.

Mr McDonald had already flown the two women from Tauranga to Blenheim and the crash occurred some days later on the return flight from Blenheim to Tauranga. The evidence was that the two women probably chose to fly with Mr McDonald, firstly to economise and secondly out of the sense of adventure in respect of flying in a small aircraft. Of course it may have been simply more convenient for them to do so as it is doubtful whether there are any direct flights between Tauranga and Blenheim. The flight with Mr McDonald was direct.

When matters proceeded to Inquest Hearing at the Taumarunui Coroner's Court the evidence of Forensic Dentist, Dr Koorey, and Pathologist, Dr Hasan, was accepted in a Formal sense having been provided to the Court at an earlier date. With one exception this evidence was non-controversial and went to identity (of the Deceased) and the medical cause of death.

At the Hearing the evidence of Police Sgt Craig and Mr and Mrs Belling went to scene setting. The evidence of Inspector of Air Accidents, Mr Walker and Mr MacFarlane (CAA),

Dr Callaghan (Principal Medical Officer, CAA) went to the tendering of the Air Accident Report. The evidence of Dr Hedley and Dr Scrivener went to the actual Medical Assessments Examination and Assessment of the Deceased pilot in respect of his application to renew his license. The evidence of Mrs Boyd, the Deceased pilot's relative, and to Mrs Johnson his friend gave an insight into the personality of the Late Mr McDonald. A vast bundle of documents was produced by Mr Walker on behalf of CAA containing a copy of the Air Accident report and Mr McDonald's medical file.

Scene Setting Evidence

The aircraft crashed in the Kirikau Valley about 20 kilometres distance from Taumarunui. A Mr Belling was first on the scene but his wife, Mrs Belling, was the only person who actually observed the aircraft immediately before the crash. Mrs Belling is an Indian Woman and it was clear that her command and understanding of English was limited. Mr Belling is also an Indian but someone born and raised in New Zealand with a perfect command of English. He attempted to assist from time to time by explaining from the body of the Court what he believed Mrs Belling had seen (whilst she was giving her evidence). It was pointed out to him that the Court needed to obtain her evidence rather than his unofficial interpretation of it. There was a suggestion that the aircraft may have been flying at a very low level perhaps under the level of a power cable strung across the Valley. It has been stressed in submissions to the Court on behalf of the Deceased pilot and on behalf of Doctors Hedley and Scrivener that this was a possible cause of the crash. The Court does not accept those submissions. Although Mrs Belling gave her evidence with some difficulty the Court persevered with her, in particular in respect of the height of the aircraft. At one point a form of sign language was used with a pencil representing the power cable. It was crystal clear that Mrs Belling's evidence was that she saw the plane above not below the power cable. Mr Belling interjected from the body of the Court in an informal way to the effect that she had told him something different but that is not evidence.

Mrs Belling saw the aircraft flying low but not below the level of the cable. She saw the aircraft flying down the river. Relatively speaking the flow of the river is from North-East to South-West, therefore when she saw the aircraft it was basically flying directly away from its

recognised flight path, that is away from Taumarunui and Tauranga, not towards those destinations. She saw the aircraft do a 180° turn and come back up the river. The fact that she saw the aircraft flying above the power cable creates a very clear picture that the crash was not a failed manoeuvre to avoid a power cable. She did not see the actual crash. There is no clear evidence as to what the final cause of the crash was. However she heard the engine revving just prior to the crash as if the aircraft was endeavouring to gain height. It has been suggested in submissions on behalf of Dr Scrivener and Hedley that this suggests a manoeuvre to avoid the power cable. With respect again the Court does not agree. All that suggests to the Court is that immediately before impact with the ground the Deceased pilot tried desperately to regain height. There is nothing at all unusual about that. It certainly does not suggest a manoeuvre to avoid a power cable. Rather it suggests a manoeuvre to avoid contact with the ground. The scene setting evidence described a situation wherein the death of the three Deceased's occurred as a result of the impact of a low flying aircraft into a sloping hillside. Left without more the implication is that the pilot was either disorientated or lost and was trying to ascertain his position. That is reinforced because he was involved in some sort of circling manoeuvre and was clearly unsure of his position relative to the ground that he was flying too low in the circumstances. One would have thought that it would have been relatively easy for the pilot to ascertain that he was flying above the Wanganui River and that all he had to do to at least position himself above Taumarunui which was one of his markers, was to fly directly upstream, thus inevitably arriving at Taumarunui even if by a somewhat and indirect route. Once at Taumarunui above his marker he could have continued on to Tauranga.

The Post-mortem Evidence

The post-mortem evidence was obtained to determine the medical cause of deaths and together with the evidence of the Forensic Dentist, to establish conclusively identity. With one exception it is unremarkable. The exception was the detection of (in the words of the Pathologist) a near fatal level of Quinine in the liver of the Deceased pilot, Mr McDonald. This finding was totally unexpected and quite remarkable. Its significance was to colour the evidence and the conduct of the Inquest from that point and will be the subject of lengthy comment in this decision.

The Recording of the Evidence

Pursuant to Section 26(9) of the Coroner's Act 1988 the evidence of each Witness at the Inquest must be put into writing, read over by or to the Witness and signed by the Witness and the Coroner. The purpose of this Section of the Act is clearly to establish and preserve a written record of the Inquest. However it creates some practical problems especially for the Court at Taumarunui which does not have the benefit of a professional Court stenographer. The process of recording takes time, and inaccuracies of a typing variety inevitably occur in the recording of the evidence. That is in no way an adverse comment on the typing services available in Taumarunui. It is simply a recognition that a part-time recording service has its limitations. The Court in respect of this Inquest was further hampered due to the desirability of releasing Witnesses promptly at the end of the Hearings so that Witnesses could connect with transport out of Taumarunui which is of course an isolated rural location. When Dr Scrivener's evidence was recorded it was clear that there would be insufficient time available for him to peruse and sign it in the environments of the Court which is the usual practise. It is clear that had he been required to do so he would have missed his connecting aircraft flight to the South Island. He would have been delayed in Taumarunui for probably up to twenty four hours. That was seen as completely unreasonable and with the agreement of Counsel present (although this was unnecessary) Dr Scrivener was permitted to leave the Court on the basis that the evidence would be forwarded to him via the New Zealand Police for signing and prompt return. In the event the Court understands that the evidence was presented to Dr Scrivener by the Police and he signed and returned it to them. The evidence did not initially arrive in Taumarunui. This caused delay in the drafting of the interim and the final decision in that at first I chose to attempt to have the evidence located - without success. I had determined to complete the decision and to provide detailed reasons why I considered that the "loss of the transcripts was not fatal" to this process. However that has proved unnecessary as during the preparation of the final decision. The transcripts "arrived" - via the Taumarunui Police (on 23rd February 2001). In any event the Court had a copy. The Court notes that Dr Scrivener has heavily amended his cross examination brief before signing, but only in respect of typing "inaccuracies

The CAA Evidence

Three Witnesses gave evidence on behalf of CAA. Mr Walker, the Accident Investigator, Mr MacDonald, the Licensing Manager, and Dr Callaghan, the Principal Medical Officer. Their evidence was lengthy and technical. Matters of particular significance were:

1. There was no evidence of mechanical failure.

2. The suggested likely cause (Mr Walker) - "a stall as a result of a sudden dropped manoeuvre possibly due to incapacity coupled with stress as a result of possible loss of positional awareness".
3. The number of aged pilots. Apparently there were three around the same age as the Late Mr McDonald but he was the only one with an Unrestricted License.

4. What is known as the "One Percent Rule". This rule is the subject of comment in the District Court Judgement CAA of the Prestland. This is a decision of the Dunedin District Court given by His Honour, Judge Harding. He was of course formerly the Hamilton District Coroner. Put simply the One Percent Rule is a rule requiring pilots to be free of risk factors rendering them likely to become suddenly unable to perform flying duties safely. A one percent risk of incapacity from a cardio-vascular event is considered the threshold of acceptable. A pilot having greater than a one percent of cardio-vascular risk assessment is required by the rule to have a special medical examination by the Principal Medical Officer or a Senior Medical Officer of CAA. This opposed to the normal assessment by a DMA following an actual examination by a AME. It is clear from the evidence and from Prestland's case that an older male of the age of the Late Mr McDonald must in fact fail the One Percent cardio vascular test. The One Percent Rule does not state that such candidates for a Pilot's License cannot obtain a medical "Pass" but rather they must have a special examination and assessment at CAA level.

A strict interpretation of the One Percent Rule in respect of the Late Mr McDonald would obviously have created a situation where he was required to have a special medical

assessment undertaken by the Principal Medical Officer or a Medical Officer at CAA. It must be noted clearly that this is not the same as saying that Mr McDonald would not have been granted medical clearance. He might well have been. However without in anyway detracting from the competency of Dr Hedley or Dr Scrivener it is possible that such a special assessment (indeed it is probable that such a special assessment) would have been somewhat more searching if carried out to create compliance with the One Percent Rule. It is possible that Mr McDonald would not have overcome the hurdle. Alternatively he might partially have overcome it. He might have retained a License but one endorsed to prohibit the carrying of passengers. Why then was the One Percent Rule not enforced? The evidence seems to be that CAA does not strictly enforce the Rule in so far as AME's or DMA's are concerned. Further that the Rule is not strictly enforced even when its own special medical assessments are made. It is difficult for the Court to understand why this situation has arisen. There was reference to a "fear of backlash" from the Medical Profession and/or Older Pilots and also the difficulty of interpretation relevant to the Prestland Case. The best that can be said for the rule is that it is confused and uncertain. The Coroner's Court at Taumarunui is hardly the place to attempt ground breaking Legal Principles. On the other hand nor is the District Court in Dunedin. The District Court decision refers particularly to the prosecution of the Pilot without an appropriate medical certificate. This is a very different thing to an assessment of whether the failure to issue a certificate because of the workings of the One Percent Rule is ultra-vires (beyond the authority) of CAA. The Rule has been formulated in the interests of Pilot and Public Safety. It seems absurd to say there is a rule but that it will not be implemented because of fear of Pilot or Medical or Legal backlash. Either there is a rule or there is not a rule. There can be no middle ground. In the Court's view CAA has three options.

1. To abandon the One Percent Rule. This in the Court's view would be to use the Colloquial "a cop out".
2. To impose rigorously the One Percent Rule. To take the flak, Legal or otherwise that eventuates from that. The flak at least in the Legal sense ultimately would be determined by interpretation of the Court somewhat higher than the Taumarunui Coroner's Court or the Dunedin District Court.

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3. To lobby Parliament to establish beyond doubt the statutory ability to impose the One Percent Rule. This may be the appropriate course. Parliament has a duty to make Aviation as safe as it reasonably can.

Medical Evidence Generally

The Medical evidence before the Court and also the evidence of Mrs Boyd and Mrs Johnson (which in a sense can be linked to it) is most significant and tragic. It could not have been easy for the Medical Witnesses, Dr Hedley and Dr Scrivener to give their evidence. There must have been times when they thought to themselves *"if only"* and *"what if"*. That they gave their evidence in a candid fashion, *"warts and all"* as it were, without seeking to justify their own position is a credit to themselves and to their profession and did not go unnoticed by the Court. The *"if onlys"* and *"what ifs"* will remain. However events have superseded such thoughts. In dealing with the Medical Evidence it is important to realise that the Court is now looking at events with the benefit of hindsight. In hindsight anyone can tell what has gone wrong and anyone can suggest what should have occurred to prevent it going wrong. The Court must be careful to be realistic. On the one hand not to impose an impossible burden on the Doctors and on the other hand not to excuse matters which really should have been detected or addressed by them. The Doctors owe a Duty of Care but they do not owe a Duty of Guarantee. The Duty of Care is also clearly to CAA rather than to the Pilot candidate presenting for examination.

The Evidence of Dr Hedley

The Court deals firstly with the evidence of **Dr Hedley** who was the DME who examined Mr McDonald at Blenheim. Dr Hedley had some previous association with Mr McDonald and had undertaken a number of previous examinations. He had developed a rapport with Mr McDonald and described his dealings as cordial until the end of the final examination when he conceded that upon awarding Mr McDonald a "failing grade" the relationship deteriorated. He described Mr McDonald as "a gentleman" although he conceded that he had heard rumours around the community that others did not always find him so. That is unimportant

except perhaps to go to his state of mind at the close of the final examination. It is clear that Mr McDonald was less than frank with Dr Hedley. He did not disclose either blood pressure problems or the taking of quinine, although it was quite clear that he should have. His relationship with Dr Hedley had always been cordial but perhaps this was because things had always gone his way. At the time of the final examination on the 26th of January 1999 he was assessed to have blood pressure problems and was given a "failing grade" in the examination because of this. Dr Hedley also took the precaution of recording an endorsement *"No flying for one month."* This was recorded by him in his own handwriting on the general medical examination Report (page 2) dated 26th January 1999. It is quite clear that the intention was that Mr McDonald should not fly for one month because of concerns in respect of his blood pressure. It seems that this was an Unofficial Stand Down (although Mr McDonald may not have realised that it was only Unofficial). Dr Hedley could have issued an Official Notice of Unfitness to CAA. This would have had the effect of preventing Mr McDonald obtaining a medical certificate without a special medical examination. Notice of Unfitness is referred to in the CAA Medical Manual Volume 3, Chapter 3. Clearly that is what should have occurred.

The other matter which stands out from Dr Hedley's evidence is that he allowed Mr McDonald to take a copy of the general medical examination report away with him presumably so that he could make his own arrangements with an AME. Dr Hedley's Counsel has submitted that this is in fact a practise which occurs reasonably frequently and is not subject to any specific embargo from CAA. If this is the situation then I am very surprised. It seems to me that to allow such a situation to occur defies every rule of common sense. It creates an environment "tailor made" for a form to be tampered with as it was here. When Mr McDonald left Dr Hedley's consulting rooms on that final occasion, the parting was less than cordial. Clearly he regarded Dr Hedley as "the villain" who had stood him down from flying. Dr Hedley should not have allowed him to take the forms away with him. Especially not given Mr McDonald's state of mind which was not lost upon Dr Hedley. There may be no specific embargo on this practise and indeed it may be relatively common. If it is then hopefully this decision will serve to change that practice which in the Courts view is dangerous in the extreme. If there is no specific embargo however there is certainly a general embargo to be found in CAA Medical Manual Volume 1, Chapter 3, Checklist for discontinued examination. 3.12.4. Send the reports yourself to the AME. Don't just give

them to the Applicant to deliver or to fail to deliver. A guideline not exactly on point but the message is clear enough. Question 19 (of the General Medical Examination Report) was left incomplete on all other copies of the form but contained a reference to Quinine medicine by the time the copy which Mr McDonald took from Dr Hedley's rooms reached the AME. The only possible explanation for this is that Mr McDonald "tampered" with the form after taking it himself (with Dr Hedley's consent) from Dr Hedley's rooms. To put it bluntly the word "Quinine" was added by Mr McDonald to the one copy (of the form) in his possession - after his examination with Dr Hedley. All this would have been prevented if Dr Hedley had retained the form and had sent it himself to the AME. It is not clear why Mr McDonald chose to tamper with the form. He did not disclose the taking of Quinine to Dr Hedley and one would have thought logically given that factor he would simply not disclose it either to the AME. However the fact that later he made this disclosure (by tampering with the form) created an environment wherein the AME (Dr Scrivener) took the view that Dr Hedley had been aware of the Quinine and did not consider it a problem. That does not absolve Dr Scrivener from responsibility or justify his response to the reference to Quinine. However it does make it somewhat more understandable.

At the conclusion of the medical examination Dr Hedley should have been placed on alert that all was not well. He was aware that Mr McDonald did not take kindly to being failed and passed unfit to fly. He was aware that Mr McDonald appeared to blame him personally for this rather than taking the realistic view that it was his (Mr McDonald's) health that was responsible. In that situation it was entirely probable that Mr McDonald would try to obtain a second more favourable opinion (if it can be put that way) from an AMA and not beyond the bounds of possibility that his having of the form in his actual possession would be used to his advantage. The form should have been despatched by Dr Hedley to an AMA of Mr McDonald's nomination. Had that occurred to the opportunity to tamper with the form would not have arisen. Perhaps more to the point it would have given Dr Hedley an opportunity to have some contact and communication with the AMA to alert the AMA to the blood pressure problem and possibly also the personality problem.

The Evidence of Dr Scrivener

Dr Scrivener, the Aviation Medical Assessor, had the task of assessing the Examination Report of Dr Hedley and Mr McDonald's medical condition generally "on the papers" as it were. It was not necessary for him to conduct a further physical examination of Mr McDonald although presumably he could have insisted upon that had he wanted to. He could and did insist upon some blood pressure readings. His contact with Mr McDonald was by telephone and letter. He never in fact met Mr McDonald. He had had no previous contact with Mr McDonald and was dealing with him from a considerable distance, namely Blenheim to Canterbury. This type of initial contact might itself cause some "alarm bells" to ring. Four matters stand out.

1. The fact that Mr McDonald presented with his copy of the General Medical Examination Report himself rather than Dr Scrivener obtaining this from the Practitioner who had undertaken the examination.

2. Mention of quinine and an indication that this was taken to relieve muscle cramps.

3. The Failed Medical on the basis of blood pressure.

4. Mr McDonald's advanced age - 80 years.

As a matter of logic one wonders why a person suffering from cramps to such an extent that quinine was prescribed to relieve them could be passed Fit to Fly. What would have occurred in the cramped confines of a small aircraft's cockpit if the excruciating cramps described by one of the other Witnesses were experienced whilst Mr McDonald were flying. Perhaps that did occur. That in itself probably should have been sufficient to ensure that medical certificates were not issued. Mr McDonald thought that the taking of quinine for cramps or otherwise had some significance - otherwise why was it excluded on his previous medical forms. The only other explanation is that he thought the matter so insignificant as to be unworthy of mention. Hardly likely considering the "excruciating cramps". The form is quite clear, it was not for Mr McDonald to decide what medications he would include. It is quite

clear that the taking of quinine even in relatively small doses can have a very significant effect on a Pilot's orientation - in particular can cause disorientation. That may have been what had occurred on the fatal flight. Dr Scrivener however did not consider that, or if he did, did not regard it as significant.

Dr Scrivener made inquiries relating to the blood pressure situation. These were somewhat limited and did not result in the correct information being obtained. In particular he received entirely erroneous and untruthful information from Mr McDonald when he was advised that Mr McDonald had never been on medication for blood pressure problems. Dr Scrivener made an inquiry of the Medical Section of CAA but was satisfied with an answer given him by a Clerical Worker rather than someone with Medical training. He did not speak personally to Mr McDonald's General Practitioner or to Dr Hedley, the doctor who had failed Mr McDonald at the Aviation Medical. Given Mr McDonald's advanced age these seem incredible oversights. Had he done so - he may well have come to a different conclusion. Dr Scrivener took the view that he was walking a "tightrope" between his duty to CAA and his duty to the pilot candidate. With respect to him he need not walk that "tightrope". Indeed he must not walk it. His only duty must be, and I consider at Law is, to CAA. He is assessing the pilot's medical condition on behalf of CAA to supply an Assessment to CAA. That is where and only where his duty lies. This is perhaps a unique departure from the normal medical duty of care to a patient. If AMA's or DME's attempt to superimpose this extra duty (ie to the patient) then inevitably they find themselves walking the "tightrope" as described by Dr Scrivener. They cannot afford to do this. The examination and/or the assessment they are undertaking (for CAA) must "stand alone". Any treatment options for a patient must come later and be entirely separate.

<u>The Conduct of the Pilot</u> (Mr McDonald)

Mr McDonald was a retired Royal New Zealand Air Force Engineering Officer who had apparently had attained the rank of Wing Commander and held a responsible position at the Woodburn Base near Blenheim. He was obviously long retired. At the date of the final medical assessments in early 1999 he was 80 years of age and the date of the crash he had just turned 81 years of age. He was then one of only three pilots still flying over the age of 80

years and the only one licensed to carry passengers. He was described as a proud, stubborn man. Someone used to getting his own way. Mr James, who was Counsel for Dr Hedley and Dr Scrivener at the Inquest Hearing rather kindly described him when questioning various Witnesses as the *"Biggles"* of Blenheim. Counsel for the Late Mr McDonald has suggested that it is inappropriate in a Decision of this type to refer to the Deceased as *"Biggles"*. In particular, that comment like that (which may be somewhat lighthearted) has no place in solemn Judicial Coronial Findings. With respect to Counsel I disagree. A Coroner's Court is at the best of times a sad and solemn place. However on rare occasions there can be humour. This in the Court's view reduces tension and stress without "degrading" the proceedings in any way. Hopefully none of the three Deceased were people without humour, hopefully none would object to an occasional lighthearted comment in the context of proceedings otherwise sad and solemn. *"Biggles"* was of course a legendary although fictitious early aviator of the First World War Era created by the novelist Captain WE Johns. His exploits had great appeal to young people in the 1950's and 1960's. It appeared that Mr James had himself read some of the *"Biggles"* novels and has always regarded *"Biggles"* as something of a hero. . It does not do *"Biggles"* much credit to be associated with Mr McDonald. *"Biggles"* was certainly a proud Aviator and a risk taker to some degree but he took risks out of necessity and they were calculated risks. Mr McDonald was also a proud Aviator but there was no necessity for him to take the risks that he took and they were not calculated. He risked his own life but what is worse he risked the lives of others and ultimately he and others paid the price. To some extent Mr McDonald was a person who had beaten the odds. He had got to an advanced age and had remained *"hail, hearty"* and generally healthy. He took pride in living the life of a much younger man and this included his flying activities. His pride was justified. However the time had been reached when he should have acknowledged that time was no longer on his side. Mr McDonald did not appear to be able or willing to do this. At worst he appeared to be prepared to manipulate people and the System in order to retain his Private Pilot's Licence. If it had been suggested to him that his activities turned him into little more than a criminal forger he would no doubt have been horrified but yet that is exactly what he seems to have become by "doctoring" the General Medical Examination Report dated 26th January 1999 after it had been "signed off" by Dr Hedley. He supplied false information to Dr Scrivener when he indicated that he had never received any treatment for blood pressure problems. It seems clear that this was supplied in an attempt to influence Dr Scrivener's assessment and

one wonders how far removed that was from the criminal offence of obtaining by a false pretence. As a Retired Military Officer and a gentleman (as the saying goes) he was not meant also to fit into the category of *"Liar"*. Counsel for the Late Mr McDonald has submitted to the Court these comments about the character of Mr McDonald are "unduly harsh." The Court fully appreciates that the comments are harsh and they are made with considerable regret. However the Court cannot avoid its duty to comment in strong terms where strong terms are necessary. Counsel for the Late Mr McDonald has suggested that the effects of the quinine upon Mr McDonald caused not only a physical disorientation but a mental disorientation to the effect that he began to behave irrationally thus explaining the conduct in respect of which the Court is particularly critical. With respect to his Counsel the Court disagrees. There is nothing in the information before the Court to suggest that quinine has anything other than a physical disorientating effect. In particular the Court requested a report from Dr Black and also took notice of the article "The Bark of Jesuit's Bite". Neither the report or the article suggest the possibility of any mental degeneration or disorientation. Counsel for Dr Hedley and Dr Scrivener refers the Court in submissions to the "Warburton Article. Amongst a large bundle of material the Court can locate no such article although it is referred to as a reference source by Dr Black (in his report).

That Mr McDonald less than two weeks after being Unofficially grounded by Dr Hedley for approximately four weeks (and prior to Dr Scrivener's reassessment) should not only pilot an aircraft himself but take up as a passenger one of his own relative's almost defies belief. This is little more than an implied expression that *"the Doctors are wrong and I am right" or "I simply don't care"*. He did not disclose to Mrs Boyd, his passenger, what his current status was. It could not have been that he had forgotten. It could only have been that once again he took the view that he knew best and it was unnecessary to (or perhaps best not to) make the disclosure. Mrs Boyd had a right to know and as she indicated in her evidence she would not have flown had she known that she was flying with Mr McDonald - during the exact period when had been directed not to fly by Dr Hedley. This evidence which was given towards the end of the Hearing and was quite staggering.

The time had come for Mr McDonald to cease flying. He should have been aware of that. He was not senile. He had age against him. He had blood pressure against him. He had a

propensity to suffer excruciating cramps against him. It seems that he was determined to keep flying for as long as he possibly could at any cost. It is clear that Mr McDonald viewed his Pilot's Licence as a right rather than a privilege. A right to be closely guarded and protected at any cost.

Mrs Heather Williams and Miss Hayley Williams

The Court turns now to the position of the two Deceased Women, Ms Hayley William and Mrs Heather Williams. Primarily they had a right to expect that they would be safe in flying with Mr McDonald. He was a licensed Pilot and as such subject to all the checks and balances imposed of the CAA. They were entitled to expect that those checks and balances would actually work. They were also entitled to expect that Mr McDonald himself would view his obligations and responsibilities seriously and would not place their lives (or his own) in jeopardy. Regrettably they were sadly let down especially by Mr McDonald. Nevertheless they too must bear some responsibility. They were prepared to fly a long distance between Blenheim and Tauranga, a fair distance of this across open water in a single engine aircraft with a Pilot holding only a Private Pilot's Licence, a part timer (as it were) and who in addition was 81 years of age.

What if they had been offered a choice between two Commercial Airlines. Airline "A" offering all the usual services and standards expected of such airlines. Airline "B" offering cheaper fares for "no frills" - single engine aircraft, no service, non-commercially qualified (part-time) pilots (only one pilot per aircraft) - all over 80 years of age - which airline would they have chosen? The answer would be obvious. Yet the two ladies were prepared to fly in exactly these circumstances in a non-commercial situation. It is difficult to understand why. Perhaps it was a sense of adventure. Perhaps it was "cost saving". Perhaps it was the opportunity to fly direct between Tauranga and Blenheim. We will never be certain of the reason - but it does not seem to make much logical sense. It seems to be a decision made for a disaster. If ever there is a potential for an air accident, the combination presented by Mr

McDonald must have been it. Some of the factors were of course unknown to the two ladies and could not reasonably have been known. Others were known however and it is difficult to understand why the "risk" was taken.

As a result of the Court circularising the Draft Decision Mr Williams (who so ably represented the Estates of his Late Wife and Daughter) made sound and reasoned submissions. The heart of the submissions were an endeavour to explain why he believed the two ladies had flown with Mr McDonald. I must disregard that part of his submissions. Mr Williams has represented his family in a most able manner but he is not a Lawyer. Submissions can never be a "back door" method of getting unsworn evidence before the Court. The opportunity to make submissions is the opportunity to comment upon the evidence in an endeavour to persuade the Court to a particular way of thinking. Before the Hearing commenced the Court made it clear to Mr Williams that if he intended to represent his Deceased family members in person he would not be able to give evidence (this on the principle that the Counsel cannot give evidence in his cause). He was given a clear choice either to give evidence and retain Counsel or to an effect be Counsel and not give evidence. He chose the latter.

CIVIL AVIATION AUTHORITY

The Authority has set in place a system of licensing and a system of medical checks and balances. Here it seeks to shelter behind the deceit and manipulation of Mr McDonald and the combined oversights of Dr Hedley and Dr Scrivener. To a large extent this sheltering is justified but not completely. There are two factors that arise from the evidence that cause real concern.

The first is that when Dr Scrivener enquired of Mrs Roil, the Clerical Worker at the Authority, if anything unusual was known about this man (meaning the McDonald) she took it upon herself to respond. The Prime error was clearly Dr Scrivener's. He is a professional and should not have asked this question of a non-professional. On the other hand the non-

professional (Mrs Roil) was and I understand still is an employee of CAA. She acted with its implied authority. There should have been and hopefully now are clear protocols that all professional medical questions are to be referred to a Medical Officer for answer. It should not fall upon non-medical personnel to attempt to answer such enquiries. To do so is again a recipe for disaster. If an inquiry is directed to non-medical personnel that is not in itself a reason to answer. It is a reason to refer the question on to the appropriate qualified person.

It has been suggested by Counsel for Mrs Roil that she should not be named in this Decision. The Court has considered that submission very carefully. The Court has the utmost sympathy for Mrs Roil. A request was made of her by Dr Scrivener and she responded to it. She should not have done but this may have been more indicative of a lack of training by the CAA and/or a natural impulse to assist Dr Scrivener. There is no suggestion whatsoever that Ms Roil acted with any improper motive. She simply provided the information she was requested to provide "as a matter of routine". However she should not have done so. She should have referred the request to someone with medical training to answer. Unfortunately for the Court to provide Ms Roil with what would amount in effect to name suppression would create an environment where all of the other parties who are named and who are commented upon in some cases much more adversely could with some justification expect the same consideration. Generally speaking the interests of justice are not well served by suppressing information from the public.

The other factor of concern in respect of the CAA is the implementation of the 1% rule. The CAA does have such a rule and if it had been applied in respect of Mr McDonald he would not have been able to obtain a medical clearance without a special Medical Examination conducted by the Authority's Medical Staff. The implementation of the rule seems hazy at best. It is a *"Clayton's Rule"*. It is a rule but it does not seem to be enforced. Either the rule should be enforced as a rule, or it should be abandoned. There can be no middle ground. Medical Examiners should not be offered the opportunity to have a discretion in the implementation of the 1% rule. They have a duty to the CAA and must comply with that duty. The consequences (or "flak" flowing from the 1% rule) are not their concern. These are matters for CAA and CAA alone. If the CAA is unsure about the enforcibility of the 1% rule then it must do something to clarify the position.

Outside Influences

It sometimes happens that during the course of a Coronial Inquiry persons approach the Coroner usually in an informal way in an attempt to offer the Coroner "helpful advice" or information. These persons usually do so with good motives and good intentions. That has occurred here in respect of an inquiry from the Medical Aviation Society and at least one independent Pilot. Unfortunately although such approaches are usually well meaning they have no place in the general scheme of the Coronial Inquiry and should be ignored as they have been. If the Coroner wants to seek information then the Coroner will do so.

Unfortunately in this Inquest something more sinister also occurred which perhaps would be better placed in the pages of a John Grisham novel. In early October 2000 a confidential briefing paper in respect of this Air Accident apparently passed between CAA and the Minister of Transport. A copy of that paper was faxed to this Court from a person or persons unknown presumably in an unsuccessful attempt to influence the Court. It might be supposed that it was an attempt to influence the Court to support some particular CAA type agenda. However equally it could be an attempt to (upon the "double bluff" principle) influence the Court to support an anti CAA type agenda (based on a Judicial reaction against receiving copy of the leaked material). Whatever the intention it has failed. No notice whatsoever of the fax's content has been taken by the Court. The Court can however indicate that it is particularly unimpressed with what it sees as an attempt to improperly influence it. If the originator of the fax was known issues of Contempt of Court would arise.

Submissions from Counsel

The Court has received and able submissions from all Counsels and Mr Williams and is obliged for the assistance given by the same. The submissions have been carefully considered by and large have been referred to in this Decision and where the Court considers it

appropriate the Interim Decision has been modified or amended to take account of such submissions.

The Lessons

1. The Prime cause of this tragedy was clearly Mr McDonald's pattern of deceit which enabled him to obtain a medical clearance which would otherwise in all probability not have been available. That is the single overwhelming factor. However there are other factors which contributed to a greater or lesser extent to the tragedy.
2. The willingness of Mrs and Ms Williams to embark upon a flight with an elderly Pilot who they really knew little if anything about.
3. Lack of ability to or willingness (by CAA) to enforce the 1% rule.
4. The release (by Dr Hedley) of the medical forms to Mr McDonald.
5. Dr Hedley's failure to put the "Stand down" on an official basis.
6. Dr Hedley's failure to detect that one of the questions on his form remained unanswered.
7. Dr Scrivener's acceptance of a "direct" referral from the applicant.
8. Dr Scrivener's failure to consider the possible effects of quinine and/or muscle cramps.
9. Dr Scrivener's failure to liaise with Dr Hedley and Dr Armstrong (Mr McDonald's GP).
10. Dr Scrivener's 'superficial' inquiries regarding blood pressure.
11. Dr Scrivener's erroneous consideration that he owed some sort of duty to Mr McDonald as well as CAA. The "walking a tight rope" comment.

Thus some adverse comment is levied at Mrs and Miss Williams, CAA and Drs Hedley and Scrivener. Most adverse comment however is directed at Mr McDonald. Had Mr McDonald survived the crash one wonders what might have been the implications for him in respect of the Criminal Law.

At the time of the crash apart from the fact that Mr McDonald was aged 81 years and that the crash was an obvious tragedy it did not seem otherwise initially remarkable. What triggered initial alerts was the finding of high levels of quinine in Mr McDonald's liver. Later the

Court caused a random survey to be made amongst AMA's and DMA's throughout New Zealand to determine what was known about the effects of quinine. The survey revealed that many were either totally or relatively ignorant about its effects until reading the literature provided (by the Court itself) in the Survey. The Court finds this in itself somewhat remarkable.

Recommendations

Finally it remains to consider any recommendations which may reasonably follow from the matters inquired into. Mr McDonald's conduct has come under close scrutiny and has been the subject of considerable adverse comment. It is pointless to suggest a recommendation in respect of that conduct. The recommendation could only be that people in Mr McDonald's position should not act in such a way and that is simply to state the obvious. Similarly a recommendation that the Late Mrs and Miss Williams should perhaps have been more prudent in selecting their mode of transportation would again state the obvious. Thus the recommendations must fall in other areas.

Any recommendations in respect of the conduct of Examiners and Assessors would also probably simply be to state the obvious. There were things that were not done adequately and that could have been improved upon. For the most part Dr Hedley and Dr Scrivener recognised that. It is expressly recorded here that their evidence was given in a candid open fashion and the Court has the view that they are good people doing their best but to some extent made mistakes and errors of judgement. It did not help that they were being manipulated by a determined Mr McDonald.

Recommendations as follows:

1. CAA must clarify the issue of the 1% rule. If it is to be a rule then it must be strictly enforced. Assessors and Examiners must receive a very clear message that it is not open for interpretation in any way. Assessors and Examiners must receive a clear message from the CAA that there is to be no walking of a *"tight rope"* as it were between CAA and the Pilot Applicant. The Examiner and the Assessor's duty is clearly to CAA.

2. CAA develop "a rule", that Pilot's licences should be age limited with the age perhaps being 70 years or something of the like. Aged pilots will not like that but public safety is a greater issue. A Pilot's Licence is a privilege not a right. It is also not a necessity. It does not have about it anything approaching the social implications or ramifications of the loss of a Motor Driver's Licence. An age cut off barrier would go some of the way to solving many of the problems encountered by the Doctors here.

3. If a "blanket" age restriction is not imposed then

(a) all pilots over a certain age (say 70 years) be subject to referral for special medical assessment.

(b) all such "aged" pilots be prohibited from carrying passengers.

4. A comprehensive circular be prepared by CAA, circularised to its AMA's and DME's to the potential effects of quinine upon pilots. Appropriate withholding period should be suggested. The CAA should further circularise this information to all commercial carriers and aero clubs throughout New Zealand.

5. That DME's and AMA's be circularised by CAA to the effect that a candidate for medical examination must not be permitted to take any of the medical forms away to deliver him/herself to the next level without checking it out personally.

6. That CAA advice DME's and AMA's that there must be no informal stand downs from flying as the case here. If the medical is of such concern as to cause the Practitioner to create an "informal stand down" the stand down is to be formalised.

7. A spot comparison on a random basis by the Medical Division of CAA between the latest forms completed by a Candidate pilot for medical assessment and the immediate previous forms in an endeavour to detect (again on a random basis) any such differences in the way questions have been answered. <u>The forms should not simply be filed away</u>.

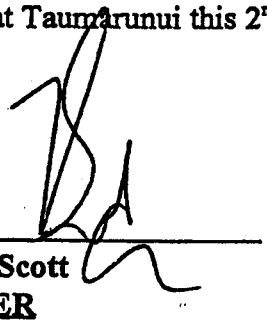
CONCLUSION

It remains for the Court to complete the Inquest by recording the medical causes of death. Also to express sincere sympathy to families of the Deceased. The Court's sympathies go to the family of the Late Mr McDonald. That his conduct was unacceptable makes their tragedy no less real. Indeed in many ways it perhaps makes it greater. The Court's sympathies go out to the family of the Late Mrs and Miss Williams, especially as they were mother and daughter. They may have been a little foolhardy in accepting a flight with Mr McDonald but they did not expect to pay the ultimate price. The input, the tenacity and the conduct of Mr Williams, the husband and the father of the Deceased, throughout this whole inquiry is recognised and appreciated. He gained the respect of all he encountered during the course of the Inquest and his two deceased family members were well served by him.

The Court records the three deceased died at Tawata, Kirikau Valley, near Taumarunui on the 11th day of May 1999 as a result of an air craft crash. The air craft which was piloted by the deceased, Mr McDonald, was seen to be flying low. It was seen to be flying in the opposite direction from its flight path and then to turn 180 degrees to approximate its flight path. It then disappeared from view and the crash occurred. It could have been several reasons for the crash. The elderly pilot may have suffered a stroke or heart attack or may have suffered leg cramps. He may have become disorientated because of the effects of quinine. There may have been other causes. The Court has no way of determining this accurately. The most likely and probable cause in the Court's view is that the Pilot, McDonald, became disorientated because of the effects of quinine. This disorientation lead to the erratic flying and impact with the ground which caused the aircraft to ignite. There was no determined mechanical or technical failure. The three deceased, Mr Neville Haig McDonald, Heather Anne Williams and Hayley Nicole Williams, all died as a result of this crash. Mr McDonald from traumatic injuries, Mrs Williams from traumatic injuries and Ms Williams from incineration.

The deaths of the Late Mr McDonald, Mrs and Ms Williams have now fallen under the very closest of scrutiny. It is clear that with one exception parties whose conduct came under scrutiny acted with the best of intent and with the best motives. Each one of their errors and omissions was relatively small in itself but the combined affect especially when linked to the conduct of the one person who cannot be said to have acted at all times in good faith was to set the scene for the tragedy.

DATED at Taumarunui this 2nd day of March 2001.



Timothy Scott
CORONER