CORONERS COURT OF NEW SOUTH WALES

Inquest:	Inquest into Death of Grant Kuhnemann Inquest into Death of Gregory Miller Inquest into the disappearance and suspected death of Jocelyn Villanueva Inquest into the disappearance and suspected death of David John Kerr Inquest into the disappearance and suspected death of Jamie Ogden
Hearing dates:	12 and 13 April 2022
Date of findings:	13 April 2022
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate Carolyn Huntsman, Deputy State Coroner
Catchwords:	CORONIAL LAW – missing persons; helicopter crash, pilot error - spatial disorientation; weather conditions
File number:	19/302794 19/302765 19/293372 19/293566 19/293477
Representation:	Coronial advocate assisting the coroner, Sergeant Christina Xanthos

Findings:

Findings in relation to the deceased, Gregory Miller, under section 81(1) of the Act:

Identity: Gregory Miller

Date: 6 September 2019

Place: Anna Bay, New South Wales, 2316

Cause of death: multiple injuries (sustained in helicopter crash)

Manner of death: misadventure

Findings in relation to the deceased, Grant Kuhnemann, under section 81(1) of the Act:

Identity: Grant Kuhnemann

Date: 6 September 2019

Place: Anna Bay, New South Wales, 2316

Cause of death: multiple injuries (sustained in helicopter crash)

Manner of death: misadventure

Findings in relation to the missing person, Jocelyn Villanueva:

The Missing Person Jocelyn Villanueva, is deceased.

The findings in relation to the deceased, Jocelyn Villanueva, under section 81(1) of the Act are:

Identity: Jocelyn Villanueva

Date: 6 September 2019

Place: Anna Bay, New South Wales, 2316

Cause of death: multiple injuries (sustained in helicopter crash)

Manner of death: Misadventure

Findings in relation to the missing person, David John Kerr:

The Missing Person, David John Kerr, is deceased.

The findings in relation to the deceased, David John Kerr, under section 81(1) of the Act are:

Identity: David John Kerr

Date: 6 September 2019

Place: Anna Bay, New South Wales, 2316

Cause of death: multiple injuries (sustained in helicopter crash)

Manner of death: Misadventure

Findings in relation to the missing person, Jamie Ogden:

The Missing Person Jamie Ogden, is deceased.

The findings in relation to the deceased, Jamie Ogden, under section 81(1) of the Act are:

Identity: Jamie Ogden

Date: 6 September 2019

Place: Anna Bay, New South Wales, 2316

Cause of death: multiple injuries (sustained in helicopter crash)

Manner of death: Misadventure

Recommendations Nil

Non-publication orders: A non-publication order was made in relation to certain images forming part of the police brief of evidence tendered in the inquest

FINDINGS

Introduction

1 This is an inquest into the deaths of two people, and suspected deaths of a further three people, who were on a private flight aboard a Bell Helicopter Company UH-1H helicopter, registration VH-UVC (UVC), on 6th September 2019. The helicopter departed Archerfield Airport, Queensland, heading for Bankstown, NSW. Following a re-fuelling stop at Coffs Harbour, the pilot contacted Williamtown Air Traffic Control (ATC) before heading towards Anna Bay, where Williamtown ATC saw UVC make a left turn to the south, depart the coastal route and head offshore on a direct track to Bankstown Airport. Approximately 90 seconds later, the helicopter was seen to rapidly descend and disappear from radar. Attempts to contact the pilot were unsuccessful and local search and rescue authorities were notified.

2 A search commenced and continued over several days until the wreckage was located approximately 5km south-west of Anna Bay on 25th September 2019. The remains of two of the five passengers were located.

3 A police and coronial investigation was managed by NSW Police Marine Command under Strike Force Felton. At the same time, the Australian Transport Safety Bureau (ATSB) conducted their own independent investigation.

4 Of the five passengers on the helicopter on that tragic day, the remains of two deceased persons were located in the helicopter wreckage after the crash, however three passengers remained missing. Identification investigations established that the deceased were Grant Kuhnemann and Gregory James Miller. The other three persons aboard the helicopter - Jocelyn Villanueva, David John Kerr and Jamie John Ogden – were missing.

Coroner's role

5 The purpose of the inquest in relation to Grant Kuhnemann and Gregory Miller is to make the findings required under s81 of the Coroners Act as to identity of each deceased, and the date and place of the person's death, the cause of death, and manner (or circumstances) of the person's death.

6 The police and coronial investigation conducted to date, indicates that Jocelyn Villanueva, David John Kerr and Jamie John Ogden are suspected to be dead, and the suspected cause (from the helicopter crash) is an unnatural cause of death, hence the Coroner has jurisdiction.

7 The Act provides that the Coroner is to investigate and make findings about suspicious or unnatural deaths. The required findings include the identity of the person who has died, the date and place of the person's death, the cause of death, and manner (or circumstances) of the person's death. Coroners may also make recommendations in relation to any matter connected with the person's death if appropriate to do so.

8 Where a person is missing, the Coroner must make a determination based on the evidence provided, whether or not to declare the missing person deceased. Declaring a missing person deceased is a serious matter, and there should be clear and concise evidence supporting this declaration.

9 The purpose of this inquest is therefore also to determine whether the missing persons, Jocelyn Villanueva, David John Kerr and Jamie John Ogden are deceased, and, if I am satisfied of this, then determinations will be made as to the required findings under s81 of the Coroner's Act: as to the identity of the person who has died, the date and place of their death, and the cause and manner of the death.

10 Whilst there has been an ATSB inquiry and a police investigation, the Coroner is bound by neither of these – the Coroner is assisted by such investigations, which provide evidence that assists the coronial inquiry. The Coroner's role is to independently assess all evidence with the object of answering the questions which the Coroner is required to answer under the Coroners Act 2009.

The Inquest

11 The inquest was held over two days in Newcastle, New South Wales. A number of family members and friends of the deceased persons and missing persons attended the inquest in person or by video link. A number of statements were made to the inquest by, or on behalf of, family members. Many families expressed their appreciation towards those who conducted the search efforts after the crash, and also to the officer in charge of the police investigation, Detective Sergeant O'Keefe.

The evidence

12 There was a detailed police and coronial investigation in this matter, and a significant brief of evidence was compiled for the Coroner. The brief contained various records, witness statements including statements by expert witnesses. Forensic material was also obtained, including autopsy reports

from a forensic pathologist. I will not list all the evidence in these reasons for decision but will summarise the main items. I note that the statement of Detective Sergeant Michael O'Keefe, officer in charge of the investigation, comprehensively summarised a large part of the evidence contained in the police brief.

13 Witnesses statements included those provided by :

- family members of the deceased persons and missing persons;

- statements by witnesses who were present at Archerfield airport before the helicopter took off on its journey;

- witnesses present at Coffs Harbour airport when the helicopter landed and refuelled; these witnesses included Mr Hearps, an experienced helicopter pilot, who owned the same sort of helicopter as the UVC; and Mr Evans who was at Coffs Harbour airport because he was working that day as a pilot for the Royal Flying Doctors, he also took a video of the helicopter which was given to police;

- a statement from Mr Stephen Ardred, aircraft maintenance engineer, who conducted a visual inspection of the structure of the UVC, its oil and fluid levels and the general condition of all rotating components, on 6 September 2019 before it left Archerfield airport;

- a statement from Mr Johns who was involved with the hangar at Bankstown which was to store the UVC. He has several years experience flying helicopters and 10 years as a helicopter flight instructor. He had known Greg Miller since 2014. They were in sporadic contact after Miller completed his training. Mr Johns shared a number of text messages with Greg Miller on 6 September 2019 which were provided to police. He was also monitoring the flight on an app called flight radar 24. He received a text message at 18.04 which stated "coming through Williamtown South", he was later in contact

with Williamtown Tower. Importantly, during the text messages between Mr Johns and Greg Miller, at 17.06, Johns asked Miller if he was night visual rules qualified to which Miller replied “David is”;

- statement by James Swan, air traffic controller, Williamtown - transcripts of communications with the UVC were attached to the statement;

- statements by independent witnesses who saw and/or heard the helicopter in the vicinity of Anna Bay just prior to its disappearance/impact with the water;

- statements of police crime scene officers;

- statement by a witness for Lifeflight, and fuelling facility;

- witnesses involved with the search and rescue operation, including Sergeant Clint Brown of Sydney Water Police, and Sergeant Lisle of the New South Wales police diving unit;

- information from the previous owner of the UVC from whom Kerr purchased;

- records/statements from those involved in the shipping/freight delivery of the UVC to David Kerr after he purchased it;

- a witness statement from Mr Cullen who had tested the helicopter after its rebuild, and was a flight instructor who had certified David Kerr.

- statements were also obtained from those who prepared the helicopter for airworthiness/carried out the rebuild after it was transported from USA, including Mr Whitehead and Mr Beck. The statement of Mr Whitehead is very detailed.

- Expert evidence obtained included from Dr Brad Tucker, astronomer/astrophysicist and cosmologist at the Australian National University. Dr Tucker provided evidence as to the light and visibility conditions, the timing of sunset, evening civil twilight, and evening nautical twilight and evening astronomical Twilight.

- Bureau Of Meteorology Aviation Meteorological Information and forecasts for the day in question at Archerfield, Coffs Harbour, Port Macquarie, Newcastle and Bankstown; in addition to Graphical Area Forecast and Grid Point Wind and Temperature Charts and Aerodrome Weather Reports. (BoM records);

- an expert statement/explanatory statement in relation to the weather conditions (BoM records) supplied and prepared by Mr Haigh, Senior Aviation Meteorologist;

- as part of the coronial investigation, CASA records were obtained in relation to the UVC;

- the police obtained a number of pieces of video and photo evidence as provided by witnesses, often recorded on mobile phones - one such witness, Mr Tony Evans, had videoed on his phone the helicopter taking off from Coffs Harbour airport and supplied this to police.

- The brief included medical records for David Kerr and a statement also from his treating psychiatrist - medical records and statements of doctors treating David Kerr were obtained by police investigators. The statements were supplied to Professor Andrews and he conducted a review of those documents and medical records. Professor Andrews noted that David Kerr had not disclosed to his Designated Aviation Medical Examiner (DAME) all of the doctors that he was seeing or all the medications he had been prescribed. The evidence indicated that David Kerr had not told Prof Andrews, who was David Kerr's

Designated Aviation Medical Examiner (DAME), all diagnosis made and doctors who were treating him.

- The police brief of evidence also included the report by the Australian Transport Safety Bureau (ATSB) “Loss Of Control And Collision with Water Involving Bell UH – 1H Helicopter, VH – UVC”. This was the report of the ATSB aviation investigation dated 23 June 2021. The report was detailed and examined, amongst other matters, the wreckage of the helicopter which was located, and all records relating to its flight path and interactions with a traffic control. Sources of information considered during the investigation and report by ATSB included Air Services Australia, Aerion, the Bureau of Meteorology, Civil Aviation Safety Authority; Flight Radar 24; maintenance organisation for VH – UVC; medical and air traffic control specialists, New South Wales police service, and a number of witnesses.

14 The coronial documents included the autopsy report and documents relating to identification of the deceased persons.

15 In addition to the detailed police brief of evidence and coronial documents, the evidence at the inquest included the oral evidence of the Officer in Charge of the Police Investigation, Detective Sergeant Michael O’Keefe. Amongst other matters, Detective Sergeant O’Keefe explained his role as officer in charge of the police investigation, and the interaction of the police investigation with the ATSB investigation. As officer in charge of the police investigation Detective Sergeant O’Keefe was present from the beginning of the investigation, being on site on 6 September 2019, and remained actively in charge of the investigation, and communicating with the families of those missing and deceased persons, up until the date of the inquest.

16 In relation to the interaction between the police investigation and the investigation of ATSB, Detective Sergeant O’Keefe explained that they were separate and parallel investigations given that there are separate reasons for each investigation. In Detective Sergeant O’Keefe’s view, the focus of the

ATSB investigation is a safety focus whereas the focus of the police investigation is to charge a person if an offence has been committed, and to assist the Coroner in the coronial investigation into the manner and cause of death and identity of those deceased. Detective Sergeant O'Keefe gave evidence that he understands the ATSB can recommend changes to CASA. He accepted the finding of the ATSB that there was no mechanical fault in the helicopter which contributed to the crash. He stated that the search and rescue teams, based on what he observed at the time, tried very hard to recover the helicopter, and to rescue/recover the bodies of all who had been aboard the helicopter. He also observed that the police investigation into the rebuild of the UVC took a lengthy period and was very detailed and comprehensive and that his colleague, Detective Veness, had thoroughly investigated this issue.

Backgrounds of the Deceased Persons and Missing Persons Subject of this Inquest

David Kerr: Missing person and the pilot and owner of the VH-UVC

17 David Kerr was born on 12th June 1972 in Goulburn, NSW to Lorraine Miller and Douglas Godfrey. David Kerr's parents were unmarried and separated when David Kerr was very young. Lorraine later married John David Kerr and had a daughter, Elizabeth, six years younger than David Kerr. David Kerr was brought up by his stepfather and was not told about his biological father until later in his childhood. David Kerr reconnected with his biological father, in his thirties.

18 Lorraine and John's marriage deteriorated, and Lorraine moved to Queensland with Elizabeth. David Kerr left home and joined the navy when he was 18. It is unclear how long his service in the navy was, but after leaving the navy, he joined the Queensland police service for approximately three years before moving into real estate. David Kerr's first partner, Sonia, passed away in 1996 from cancer. David Kerr had great difficulty in overcoming this loss. However, David Kerr met his future wife, Ms Cameron, after selling her first home. They later married and had two children, Emma, and Daniel.

19 David Kerr was successful in real estate, eventually opening his own business, Summit Real Estate in Oxley. It was during this time he started to learn how to fly. David Kerr always had a love of flying and from the success of his business, he was able to purchase his first helicopter, a Robinson R-44 Bell, and learned how to fly on it. He also hired out the machine to other pilots which earned him additional income and helped to pay for his private pilot's licence before getting his Class 1 Commercial Licence in 2015. It was during this time he realised he could make a career from this endeavour.

20 David Kerr eventually left the real estate business to pursue flying full time. He sold the Robinson R-44 and purchased and built a Jet Ranger. Using the Jet Ranger, he set up his business, Brisbane Helicopters, which catered to providing recreational and sightseeing flights for tourists. He later bought a share into a Bell 47 before selling that to purchase and begin restoration on the UVC costing him $357,491.13 AUD. The UVC was kept at Archerfield Airport where restoring the machine became his primary focus that would ultimately lead to the demise of his marriage.

21 On 9th December 2018, Ms Cameron and the children moved out of the family home after a fight that required police intervention. It was reported to police that the marriage had slowly been deteriorating - David Kerr's pursuit of rebuilding the UVC impacted greatly on the family's finances and his personality. It was reported to police that David Kerr's moods became unpredictable resulting in David Kerr seeing a GP and being prescribed medication. It was also disclosed during the investigation that David Kerr had periods where he would "self-medicate" by using illegal substances, primarily cocaine, however this had reportedly ceased some six months prior to 2019.

22 The process to obtain a pilot's licence includes undergoing a medical examination with CASA. On obtaining his commercial licence, David Kerr was subjected to annual examinations with Professor Andrews, a Designated Aviation Medical Examiner (DAME). Prior to any examination, a pilot is required to disclose personal medical information using an online CASA questionnaire which is then reviewed by the DAME. The DAME then performs

an age-based examination, and the results are sent to CASA for a determination as to whether the licence can be issued. The questionnaire David Kerr completed required him to disclose whether he had any medical problems or had been dispensed medication, either prescribed or over the counter. Furthermore, he was required to disclose if he had been diagnosed with mental health or using illicit substances. The importance of this is that it allows CASA to assess the seriousness of the illness and assess the medication/treatment being received, so as to consider whether grounding until recovery is necessary. Professor Andrews found on review of PBS Summary which had been obtained during the investigation, that David Kerr failed to disclose the following: 2017 - 4 prescriptions of Paracetamol Plus Codeine tablets over 7 days (Codeine is considered to be incompatible with flying duties); Amoxycillin plus Clavulanic Acid (these are antibiotics); 2 prescriptions of Meloxicam in 2018 (this is an anti-inflammatory medication for muscle pain) however Professor Andrews noted this was not a medication incompatible with flying duties; and 2019 - prescribed Naltrexone (Revia).

23 The Naltrexone was prescribed on 19th February 2019, two months before David Kerr's last medical examination with the DAME on 22nd April 2019. Naltrexone is prescribed to assist withdrawal and abstinence from many addictive substances, including alcohol and some illicit drugs. This drug had been prescribed by psychiatrist, Dr Andrzejewski, this indicates that David Kerr had been seeking psychiatric care. This should have been reported to the DAME/CASA and David Kerr failed to do so. Professor Andrews confirmed that this information would have required immediate grounding and that as DAME Professor Andrews would have communicated with CASA for advice and management from an aviation perspective.

24 David Kerr was referred to Dr Andrzejewski by his GP, Dr Ng, on 12th December 2018 - this referral also came days after the breakdown of his marriage, and he was reportedly emotionally distressed at the time of the separation.

25 David Kerr continued seeing Dr. Andrzejewski during 2019 – however there was a gap in his attendance from March 2019 to September 2019. At his last appointment on 3rd September 2019, David Kerr was prescribed Diazepam (Valium), this was to help with sleep; this is 3 days before the crash, however it is unknown if he had commenced taking it.

26 Dr Andrzejewski reported that at the March 2019 appointment, Mr Kerr reported feeling much better and settled in life – he was planning a holiday in Galapagos with a friend. At the September 2019 appointment he appeared to have come to terms with the separation from his wife and he had plans for the future and was not suicidal.

27 As of 6th September 2019, David Kerr was prescribed, and may have been taking, Valdoxan, Diazepam, Naltrexone and Olanzapine. The records indicate that olanzapine was prescribed on an as required basis. The regular medication that it appears he took, according to the statement of Dr Andrzejewski, was valdoxan (an anti-depressant) which he reported as helpful. He reported to Dr Andrzejewski in September 2019 that he was continuing to use Valdoxan and olanzapine as needed, and naltrexone. Dr Andrzejewski stated that she had treated him from January 2019 to September 2019 for Major Depressive Disorder, adding treatment for Alcohol dependence.

28 Professor Andrews expressed the opinion, on review of all the medical information, that if David Kerr was forced to act in an emergency whilst flying, his natural mindset was that he would be likely to take a risk to push through the crisis. He also found that David Kerr failed to disclose his treatment as required and also failed to answer some questions correctly.

29 David Kerr was the holder of licence number 806280 with category ratings for a Commercial, Private and Recreational Pilot Licence. He was rated for VFR but was not rated to fly at night. As of 6th September 2019, David Kerr was rated for Single Engine Helicopters where the next review was due in October 2020. His medical certificate was current and did not expire until April 2020.

His logbook indicated a total of 1,440.5 hours total flying experience where 103 hours were on the UVC. In the 90 days before the crash, David Kerr had accrued 9 hours with 1.8 hours on the UVC. None of the hours logged were during the night. Subsequent investigations also found that David Kerr had enrolled to commence flight training with Mauna Loa Helicopters in Hawaii to undergo their external load training course. He was due to begin this course on 10th October 2019.

30 Police obtained many statements from persons who knew David Kerr where descriptions are provided as a both a friend and pilot.

> 'Dave always had something on the go and was always running late. Never enough hours in a day and seemed very busy be it flying or otherwise…As a pilot, Dave was a smooth and confident pilot. He was thorough with his pre-flight checks and was able to handle the aircraft well, demonstrated good airmanship. He also demonstrated good communication skills both in the cockpit and with ATC (air traffic control) in controlled airspace.'

> 'David was a lovely guy and appeared to be someone who would always want to help people out, I know a lot of people you speak with will vouch for that, however, while working with David, he was always in a rush or late for something. Everything was a little unorganised….'

Gregory James Miller: Deceased and suspected co-pilot of VH-UVC on 6 September 2019

31 Gregory James Greg Miller was born on 24th January 1980 on the Redcliffe Peninsula, Queensland. His parents separated when he was young and his mother re-married Colin Coote when Greg Miller was 9 years of age. Not long after, Elizabeth, Greg Miller's younger sister was born. Growing up, Greg Miller was very close to his family, in particular with his sister and older cousins.

32 Greg Miller was educated at De La Salle College and in his senior years he went to St Joseph's Nudgee Boys College where he excelled at basketball, cricket, and golf. In his spare time, he spent it at the Army disposal stores in the area where he would speak to people about the army. In March 1998, Greg Miller enlisted in the Australian Army and was allocated to the Royal Australian Engineers where he became a Warrant Officer/Squadron Sergeant

Major of the Special Operations Engineering Regiment. He had been deployed to East Timor in 2000, the Solomon Islands in 2004 and did 4 rotations to Afghanistan from 2006 to 2016 earning him many medals and commendations. He was qualified as a Deep-Sea Diver, Parachutist, Bomb Disposal Expert, and Instructor at the School of Military Engineering.

33 During his time in Darwin, he met Jocelyn Jocelyn Villanueva. They remained in Darwin for approximately 11 years whilst Greg Miller continued his deployments. In 2008 and after a rotation in Afghanistan, Greg Miller and Jocelyn Villanueva moved to Sydney where Greg Miller was stationed at Holsworthy Army Base. As of 6th September 2019, Greg Miller had been in the Army for 21 years.

34 Greg Miller always had a passion for Ford Mustangs and this passion grew where over the years, where he bought and sold between 10 and 20 cars including a Shelby Cobra from the USA. Many of his dealings were through Australian Muscle Car Sales (AMCS) Pty Ltd. It was reported to police that the funds had been obtained through a Self-Managed Super Fund (SMSF) established by Jocelyn Villanueva in August 2016; and that Jocelyn Villanueva established the SMSF through Macquarie Cash Management and transferred a portion of her Qantas Superannuation to this account. She was the sole trustee of the SMSF. The funds from this account were reportedly used to buy and sell vintage vehicles with Greg Miller.

35 Greg Miller also had an interest in helicopters, even as a child where he owned model helicopters and was ‘enthralled’ by them. This fascination only grew during his time in the Army. After returning from Afghanistan, he expressed his desire to become a helicopter pilot and began lessons at Bankstown Airport. Reportedly, after Jocelyn Villanueva was made redundant from Qantas, the money was given to Greg Miller to help finance his lessons. He was granted his flight crew licence on 30th July 2014.

36 Greg Miller’s interest in helicopters continued to grow and by mid-2019 he expressed his interest to get out of the car business and buy into a helicopter

business. He would speak about a business that was going to be run by an 'ex-military friend of his out of Bankstown doing joy flights.' It was not long afterwards that the arrangement with David Kerr was entered into regarding the purchase of UVC. To purchase his share, Greg Miller sold one his 1971 XY GT Falcon Nugget Gold for $222,500.

Jocelyn Villanueva: Missing person and passenger 1

37 Jocelyn Villanueva was born on Good Friday, 4th April 1969, to parents Lamberta and Jose Villanueva in the Philippines. She was named after her father and was to be the third and last child, but two more siblings were welcomed into the household, giving the Villanuevas five daughters. In 1972, after the first four daughters were born, the family relocated to Australia and by February 1973, the family were settled in Darwin, Northern Territory where Jose took up a teaching position and their youngest daughter was born. After becoming homeless following Cyclone Tracy in 1974, the Villanueva's returned to Sydney for a short time before returning to Darwin and re-building their home. By 1975, the Villanueva's became Australian citizens.

38 Jocelyn Villanueva spent her childhood with her family exploring Australia on road trips. With her father being a teacher, he would stop at each attraction and educate his daughters about the history of Australia. The Villanueva daughters would spend the days watching cricket and nights lying on blankets outside watching the stars. It is likely that this is where her love of Star Wars may have come from where her family say, Jocelyn Villanueva lived her life according to "The Force."

39 Jocelyn Villanueva was affectionately known as 'Jos'. She was described as being fiercely strong and independent. If she wanted something, she would research and set out to achieve her goals. Jocelyn Villanueva had always wanted to work for Qantas and in her late teens, she handed in her resume to Qantas and was soon offered employment. She demonstrated a very strong and dedicated work ethic.

40 Jocelyn Villanueva met her first husband when she was 16 years old. They remained together for 17 years, only marrying in the last 2 years. Unfortunately, the marriage did not last but she soon met Greg Miller and they soon became a couple. When they arrived in Sydney, Jocelyn Villanueva continued her employment with Qantas that included managing a portfolio of 4 international European airlines. In May 2014, she accepted a redundancy package and left Qantas. Subsequently, she completed a Certificate IV in Government (Personnel-Security) Australian Forensic Services course and became a self-employed sub-contractor by conducting and assessing security vetting of Commonwealth employees. This led to a permanent position with ASIC.

41 Jocelyn Villanueva was reported to be very supportive of Greg and his love of cars and flying. From the sale of properties and money from her redundancy package, she was able to finance the purchase of vintage cars Greg Miller loved, as well as pay for his flying lessons and finally the purchase of the UVC.

42 At the time of her disappearance, Jocelyn Villanueva was living with Greg Miller at Picnic Point with their beloved huskies, Teska and Storm.

Jamie Ogden: Missing person and passenger 2

43 Jamie John Jamie Ogden was born on 2nd April 1971 in Maryborough Queensland to parents Graham and Dorothy Ogden. He had one brother, Darren. Jamie Ogden grew up in Maryborough and enjoyed playing sport, especially rugby league. He represented Australia for rugby league and toured England when they won the World Cup.

44 After school, he joined the Queensland Police Service as a cadet in 1990. He excelled throughout his police career receiving several awards and also was named the youngest person to reach the rank of Senior Constable. It was during his policing career that he met his friends David Kerr and Grant Kuhnemann. He left the service in 2006 to pursue his passion for financial planning. By this time, he was a single father with two children, Stephanie

(who he affectionally called “Chopper”) and Benjamin. All he wanted was to have the time available to be with his children.

45 Jamie Ogden bought a farm in Maryborough, near Hervey Bay, so that he could retire and live off the land. As there was a hangar in Hervey Bay, David Kerr would often fly Jamie Ogden between Brisbane and Hervey Bay. Jamie Ogden’s daughter even recalls a time when David Kerr landed his helicopter on Jamie Ogden’s farm.

46 Jamie Ogden is described by his family as a special kind of person who always put others first and could always put a smile on your face.

Grant Kuhnemann: Deceased and passenger 3

47 Grant David Grant Kuhnemann was born on 20th April 1970 in Brisbane to parents Alfred and Christine. Twenty-two months later, David Kuhnemann was born, and the family resided happily in East Brisbane before moving and settling at the Gold Coast in 1973. The family spent their days at Tallebudgera Creek swimming, fishing, and walking on Palm Beach. Grant Kuhnemann had always enjoyed spending his time outdoors.

48 Grant Kuhnemann went to Palm Beach Currumbin State High School where he excelled at swimming attending a Laurie Lawrence swim camp. He was good enough to be considered for the Olympics and he also showed great ability at athletics and basketball. Not only was he a natural athlete, he was also very popular within the social circles having many friends at school and naming him Vice Captain in his final year.

49 In 1987, Grant Kuhnemann joined the Queensland Police Service and was the youngest cadet graduating in the 1988 class. He began his policing career at Broadbeach Precinct and soon became a detective in 1993. He retired from the police service in 1997 and moved on to a retail sales business position. Grant Kuhnemann travelled for this job where he moved to New Zealand for a brief time as a casino surveillance officer. He had returned to Queensland by 2000 working at the Gold Coast casino.

50 Grant Kuhnemann soon met associates within the investment property industry, propelling him to start his own company, National Property Centre. He thrived in his business, selling and networking with developers over the next 16 years and his brother even began working with him.

51 Grant Kuhnemann married and divorced, however he had two children as a result of that marriage, Kate, and Jordan. Grant Kuhnemann put his children first above everything else. He was described as a “hands-on” father; not only did he work and run his own business, but he cooked, cleaned and was always present at his children’s school functions and sporting events. He made sure to always tell his kids he loved them and made “home feel like home.” Grant Kuhnemann passed this affection on to his two grandchildren.

VH-UVC – a UH-1H “Bell” Helicopter

52 The UVC is a former US Military Helicopter originally built in 1966. It was retired to a training college in the USA after several years of assisting the US military and coast guard. In 2017, it was purchased by David Kerr from Mr Don Morse of Washington State, USA. Tamarack Helicopters in Montana were retained to oversee the dismantling of the helicopter and prepare the shipment in two separate Contex containers for transportation to Australia costing David Kerr $43,486.60 USD.

53 David Kerr rebuilt the helicopter with the assistance of Paul Whitehead from Jetpoint Aviation Queensland and Matt Beck of Beck Helicopters New Zealand. Their instructions from David Kerr were to ‘put the machine back on the register and to get it flying again.’ The rebuild commenced in July/August 2018 and took place at David Kerr’s hangar at Archerfield Airport. The rebuild was documented using photographs and videos. It is submitted by investigators that the rebuild of UVC was a ‘quality job’ and in compliance with all statutory requirements. There is no evidence to suggest the construction of the UVC played a role in the fatal outcome.

54 By 2nd October 2018, the helicopter had been placed on the Register of Australian Aircraft under David Kerr’s business, Brisbane Helicopters Pty Ltd

as a “Warbird.” The certificate of registration was issued on 17th October and specially certified for airworthiness with 13 conditions. The conditions included that the aircraft could only be operated in accordance with the operating limitations contained within the approved Army Model UH-1H Helicopter Operator’s Manual and ‘by day under Visual Flight Rules (VFR) unless the aircraft is appropriately equipped for night and/or IFR.’ At the time of registration and as at 6th September 2019, none of the required equipment to allow the machine to fly at night had been installed.

55 Following the machine’s registration, regular maintenance was required using a schedule of maintenance known as the ICAP (Interagency Committee for Aviation Policy). Using the ICAP planning guide, a schedule of maintenance with a Preventative Maintenance Inspection ensured inspections occurred every 10 hours/14 days, 50-hour, 100-hour, and 150-hours with special and conditional inspections. After maintenance is completed, the machine is subject to test flight procedures by an experienced pilot to ensure it’s airworthy. David Kerr hired a pilot, Mick CULLEN, from a registered training organisation called “Aeropower”. Mr. Cullen completed all the test flying on the machine and then provided David Kerr with training.

56 To pilot a helicopter at night, a pilot is required to have at least 10 hours of aeronautical experience at night including at least three hours of dual flight, one hour of solo night circuits and at least three hours of dual instrument time in a helicopter. In addition to these requirements, a helicopter operating under night VFR must be equipped with an altitude indicator (artificial horizon), along with a heading indicator (directional gyroscope), a vertical speed indicator and a means of indicating whether the power supply to the gyroscope instrument is working satisfactorily. Considerable detail about the requirements for night flying is provided in the statement of the witness, Mark Pearce, who has significant experience as helicopter pilot for 22 years and also as a CEO if HAAMC (Head of Aircraft Airworthiness & Maintenance Control) amongst other roles. Mr Pearce described David Kerr as a confident pilot who was thorough with pre-flight checks. Mr Pearce was also of the understanding that David Kerr was not accredited for night flying.

57 David Kerr had 6.5 hours of flying time with Mr. Cullen on the UVC along with several days of ground training. Mr. Cullen told investigators that he did not consider David Kerr to be inexperienced and knew he had over a thousand hours on different machines in the capacity of his own business. However, Mr. Cullen did confirm that he did no night flying with David Kerr and as far as he knew, David Kerr was not trained to fly in the dark.

58 David Kerr had operated the UVC in a business capacity after registration. However, the financial burden of rebuilding the UVC forced David Kerr to consider selling it. Greg Miller and Jocelyn Villanueva expressed their interest where an agreement between David Kerr and Greg Miller was communicated, according to associates.

59 On 31st August 2019, Greg Miller reportedly sold his 1971 XY GT Falcon Nugget Gold and a deposit of $200,000 was transferred to David Kerr's bank account. It was also agreed that the UVC would be re-housed at 'The Helicopter Collective', Hangar 581 located at Bankstown Airport.

60 On 6th September 2019, the UVC left Archerfield Airport, Queensland to travel to Bankstown Airport with David Kerr, Greg Miller, and Jocelyn Villanueva. David Kerr's friends, Grant Kuhnemann and Jamie Ogden had been invited for recreational purposes only.

What happened on 6th September 2019?

61 On 4th September 2019, David Kerr requested, through Christopher Jarrott the owner of Heliedge Aviation, to park the UVC at their hangar at Lot 657 of Archerfield Airport until 6th September. David Kerr also asked that a staff member perform a 14-day inspection (ICAP PMI). Mr. Jarrott organised Steven Ardred, an aircraft maintenance engineer employed at Heliedge to assist.

62 About 07:00 on 6th September 2019, Mr. Ardred arrived at hangar 657. He prepared to perform the maintenance inspection on the UVC that included a visual inspection of its structure, oil and fluid levels and general condition of all

rotating components. Other than some dust and grass in the engine pan, there were no issues identified with the aircraft and was subsequently certified for release.

63 LifeFlight Australia oversees the operational side of Rescue Helicopter and are based at five bases including Archerfield Airport. They lease a facility at the airport at Lot 676. Also, at Lot 676, IOR run a 40,000-litre fuelling facility with aviation fuel. Despite the fuel installation being owned and operated by IOR, vehicle access to the area is provided by LifeFlight staff as the predominant users of the fuel installation. However, IOR will provide access to other people who operate in the area who have accounts with them to access the fuel. David Kerr is one of those people where a verbal agreement had been established giving him a fuel card with the provision he repaid the debt the following day. At about 09:40, David Kerr contacted LifeFlight engineering staff by telephone requesting access Lot 676 to access the fuel. David Kerr also requested drums to carry his fuel.

64 About 10:40, David Kerr arrived at Lot 676 and was allowed access by LifeFlight staff member, Mal Campbell. At 11:03, David Kerr obtained 1033 litres of fuel using his own two 44-gallon drums and an IBC provided by LifeFlight. The IBCs are used to defuel aircraft; therefore, they are stored in an empty and clean state. The IBC given to David Kerr was labelled “Waste Fuel”, “Not for Aircraft Use” and bear the LifeFlight logo. David Kerr left the site returning the key to LifeFlight reception at about 11:30.

65 David Kerr arrived at Archerfield at 11:42 and began fuelling the helicopter. It remains unclear who assisted in this process, however David Kerr and Greg Miller were involved. During the refuelling, they were seen transferring the fuel into a 44-gallon drug, but the nozzle would not go into the drum. As a result, David Kerr left to get a hose end that would fit. It was estimated that he was gone for about 1 to 1.5 hours. During this time, Greg Miller was seen to become frustrated and was ‘pacing.’ He expressed concern about the delay in departure to ensure they arrived at Bankstown whilst there was still daylight. He said, “We might have to do this tomorrow”. About 13:30, David

Kerr returned to the hangar and began to load the helicopter and Greg Miller called Bankstown Airport and advised them of their time of arrival. The witnesses who were present and assisted police in their investigation, all expressed that the take-off time had been significantly delayed.

66 The seating arrangements upon departure was David Kerr in the front right pilot seat; Greg Miller on the left front seat; Jocelyn Villanueva on the left of the middle seat on her own (directly behind Greg Miller); and Grant Kuhnemann and Jamie Ogden occupied the third row of seats. Niza Villanueva, Jocelyn's sister, was present at Archerfield Airport to see the helicopter off on the trip – her statement is detailed and provides descriptions of the delay in the helicopter departing, the seating arrangements of the passengers on take off. She also took a number of photos and videos on her mobile phone which were provided to police investigators – these records also provide evidence of the time of take off, and other aspects of the journey. She also exchanged text messages with Joceyln during the flight – there was a group text with Niza and Jocelyn and other family members - and these records also form part of the police brief of evidence. A similar statement was provided to police by Eufracia Villanueva who also attended Archerfield Airport, and also by Lamberta Villanueva (mother of Jocelyn).

67 Air traffic was quiet on 6th September 2019 at Archerfield Airport. The tower supervisor identified that it was a cloudless day but there was a south-westerly wind that stopped a lot of aircraft wanting to fly. There was also dust and smoke in the air.

68 About 14:25, the helicopter started up and took off approximately 8 minutes after at 14:33. Video footage and photographs taken by persons on the ground shows that the port side rear sliding door of the UVC was open and the starboard side was closed. It is noted that the evidence also indicates that the doors were also in this position as it took off from Coffs Harbour airport. Chapter 5 in the Operations Manual for Army Model for UH-1HV Helicopters issued by the US Headquarters, Department of the Army states that, 'The helicopter can be flown up to an IAS (Indicated Air Speed) of 50 knots with

one door open and one door closed.' The flight data and records indicate that the 50 knot limit was exceeded for much of the flight. The same Operations Manual indicates that the UVC can travel at its maximum speed of 112 knots with both side doors locked, or both side doors open. The reduced speed limit applies to one door being opened and one door being closed. It is unknown whether the whole flight was taken with one door open and one door closed.

69 Between 15:10 and 16:00, the UVC landed at Coffs Harbour Airport, NSW to refuel using their own on-board fuel using a 400-litre plastic Poly diesel tank and pump assembly. This was witnessed by Carl Hearps, another helicopter pilot, and Company Director for NSW Helicopters in Hawkesbury. Mr. Hearps recognised the UVC being advertised for sale approximately five months earlier. Whilst the refuelling was taking place, David Kerr and Mr. Hearps met and walked over to the aircraft. The tank ran dry during the refuelling process and a 200-litre drum, also filled with fuel, was brought out from the aircraft and the refuelling continued by using a portable pump. Not long after, the battery on the portable pump went flat. David Kerr borrowed a portable battery pack from Mr. Hearps where the pump was recharged and refuelling continued. Mr. Hearps assisted police by stating that a full tank for a Huey engine would carry 791 litres of fuel and burn approximately 340 to 350 litres of fuel per hour. Mr. Hearps also noticed, once the passengers re-boarded the aircraft, none of them were wearing vests. Despite not being a mandatory requirement, it was recommended if an aircraft flies over the ocean.

70 Captain Evans, another pilot who was at Coffs Harbour on 6th September confirmed speaking to David Kerr about the weather telling him, "there is a big front coming in from down south and it has hit a bit early" he says that he also said to the pilot "there was a big storm cloud to the west of Coffs Harbour and …..there has been a wind change in the last 20 minutes or so since I landed." He says he had this conversation with the pilot while he was walking across to his helicopter. Mr Evans maintains that the weather conditions while he was at Coffs Harbour were strange. As at 2019 Mr Evans had been a pilot for 17 years. The Bureau of Meteorology (BoM) issued a Significant Meteorological

Information Advisory at 14:36 for severe turbulence below 10,000 ft from 15:00 to 21:00. It is unclear whether David Kerr was aware of this warning, however the visible changes regarding the environment associated with this warning could not have gone unnoticed by David Kerr, and the evidence is that the weather was discussed with him by Mr Evans.

71 Video footage was captured of the UVC taking off from Coffs Harbour and was described by witnesses as being 'unusual'. The front of the aircraft rapidly nosedived towards the ground that seemed dramatic. It did not appear to be a normal departure, but it cannot be certain if this was an unintentional act or deliberate to get forward speed. It is suggested that because of the time of day and poor weather conditions, the decision to depart Coffs Harbour was flawed. The video footage also shows the port side rear door was open on take-off.

72 The following chronology is revealed by the evidence in relation the flight between Coffs Harbour and Williamtown Air Space, having regard to telecommunications and other evidence.

73 **Chronology**:

- 14:29 UVC takes off from Archerfield Airport

- 14:37 Jocelyn Villanueva sent a photo to her sister of Archerfield Airport and the city skyline.

- 14:39 Jocelyn Villanueva sent a text message to her family:

  flying south; 'Greg has the stick'; Passing Coolangatta (attached with a photo of Coolangatta)

- 15:05 The following conversation took place between Jocelyn Villanueva and her family via text:

  Jocelyn Villanueva: Byron Bay (attached with an image)
  Athena: How's it so far?

Jocelyn Villanueva: A bit smoky & windy. All good.

- 15:22 The following conversation took place between Jocelyn Villanueva and her family via text:

Athena: You're not going to see whales over land!
Jocelyn Villanueva: They were moving towards Byron Bay…A bit smoky & windy. All good.

- 15:10 UVC lands at Coffs Harbour airport

Athena: I thought you said no stops. What time will you get into SYD?
Jocelyn Villanueva: Fuel stop.

- 16:01 Jocelyn Villanueva sent a text, 'Landed at Coffs Harbour'.

- 16:08 Stephanie Miller received a text from Greg Miller saying they were halfway there with a photo of 'welcome to Coffs Harbour' sign attached

- 16:26 Jocelyn Villanueva text message exchange:

Jocelyn Villanueva: Bit cooler here, bush fires nearby.
Athena: Finished fuelling. It'll be dark by the time you arrive in SYD.
Jocelyn Villanueva: Very likely. Be nice flying around at night.

- 16:47 Stephanie received another text from Greg Miller with a photo of the sun.

- 16:48 UVC departed Coffs Harbour Airport en route to Bankstown Airport.

- 16:51 Jocelyn Villanueva shared images of coast via text.

- 16:52 Greg Miller sent text to Richard Johns who was at Bankstown Airport: 20mins into the leg h adding to you now

- 17:06 Greg Miller and Richard Johns text message exchange:

Richard: You NVRF? (meaning are you Night Visual Flight permitted)

Greg Miller: Dave is
Richard: Might need it

- 17:38 Time of sunset.

74 On 6th September 2019, the Air Traffic Controller supervisor, Flight Lieutenant James Swan was performing duty as the Approach Controller alongside John Bowden at Williamtown RAAF base under the call-sign, “Willy Delivery”. Williamtown “Domestic” Air Traffic Control (ATC) is restricted airspace that generally encompasses a 25 nautical mile surface up to 12,500 feet above mean sea level. At 17:53, Lt Swan first noticed the UVC on the radar at Sugar Loaf Point, Seal Rocks, heading south by the coastline flying under VFR. He suspected that the UVC would call him up for clearance as it appeared he was joining the VFR coastal lane and flying through Williamtown Domestic Airspace. At the time, there was a strong westerly wind with significant dust in the air reducing visibility to 7 kilometres. Lt Swan stated that 30 minutes earlier, a Virgin Boeing 737 had reported that the wind between 2,000 and 3,000ft was in the vicinity of 45 knots. Lt Swan was also aware that the BoM had published a last light at 18:03, however due to the amount of dust in the air, it was likely last light would have been earlier.

75 The UVC established radio contact with the Tower Controller, Flying Officer Rhiannon Wares requesting for an airway’s clearance. It remains unknown why UVC called the Tower Controller, when it was suggested that the pilot should have known to call the Approach Controller. It is assumed that the pilot was David Kerr and will be referred as such.

76 At 17:57, David Kerr contacted Lt Swan requesting airways clearance through the Willliamtown Airspace via the VFR lane at a non-standard high altitude than is published on aeronautical documents to the wind. David Kerr stated:

> “…intending to ah [sic] track on that VFR lane through to the south ah [sic] request if available to track at a a higher altitude to uh try and maintain a bit of tailwind to push me through there.”

77 Lt Swan enquired about the number of passengers, confirming there were 4 on board. Lt Swan also asked David Kerr if he had a Civil Aviation Regulation (CAR) 174B exemption, which would allow him to fly lower minimum altitude at night. On receiving no acknowledgement, Lt Swan advised David Kerr that 2,400 ft was the lowest altitude that could be offered. The authority was given to fly at 3,000 to 3,5000 feet AMSL.

78 At 18:00, David Kerr made the request to track about 8 nautical miles east off the coast out to sea to make it "more efficient and comfortable". Lt Swan found this illogical because in the event of engine failure, it would be unlikely he would make it to land. Also, it would be unlikely that the conditions would be better flying over sea. Lt Swan clarified David Kerr's request and permitted David Kerr maximum flexibility to manoeuvre the helicopter. Based on investigations conducted after the crash, it is most likely David Kerr made the request as it provided a more direct route to Bankstown Airport. It seems that he was struggling to control the UVC in the weather and wanted to get to Bankstown as soon as possible. However, this is not certain.

79 At 18:05, Lt Swan noticed the UVC dropped below the cleared level of 3,000 ft, flying at 2,700 ft. David Kerr confirmed he had, "dropped a bit with a little bit of gust in that one". Lt Swan increased the vertical level clearance allowing David Kerr to fly between 2,400 to 3,500 ft to give David Kerr more room to move whilst keeping him above the Lowest Safe Altitude (LSAT). David Kerr told Lt Swan, he would try to maintain an altitude of 3,000 ft as, "it's just a little bumpy out here still".

80 At 18:10, the UVC continued flying within the approved clearance and was tracking along the coastline flying at a speed of 70 knots. At the same time, witnesses on the ground at Boat Harbour, heard the UVC flying overhead. This was not far from Anna Bay. Peter Munro recognised the sound of the helicopter as a "Huey" after being in the Vietnam war. Mr. Munro saw the UVC's white landing lights under the aircraft were on and thought it was unusual as the helicopter was not going to land. There was gusting wind from the west about 0 to 20km/h. The UVC was estimated to be approximately

1000 metres above sea level and continued to move along the coastline past Samurai Point before disappearing on the seaward side of One Mile Beach headland of Morna Point. At the time, there was no moon, and it was dark where witnesses could only see the silhouette of the aircraft.

81 The UVC's flight path was heard and seen by residents who described it flying 'very low and not far above the tall trees'. Others recognised how windy the weather was and were 'shocked' that an aircraft would be flying in those conditions. Mr Dargeavel considered that the aircraft may have been RAAF as they had been performing manoeuvres in the area that day. However, Mr. Dargeavel also identified a 'dramatic change in engine pitch' like it was 'faltering'. As a former employee of Qantas, Mr. Dargeavel was able to distinguish that normal operation in revolutions for a helicopter is 3000 revs a minute, however the helicopter that passed over his home on the evening of 6th September, 'lost revs' decreasing to about 1500 revs. At the time, Mr. Dargeavel reported the sound to his flatmate, "I think they've got an issue with it". Mr. Dargeavel opined that there was a loss of power. However it is noted that there were reportedly gusty winds at this time, perhaps impacting on the sounds heard at ground level.

82 The UVC continued over Stockton Beach moving in a south, south-westerly direction. Simon Visser who was on Stockton Beach with his wife, Evelyn, saw the helicopter going:

> 'down at a very rapid pace towards the East downward on a 30-degree angle'.

83 Mrs. Visser added,

> '…all of a sudden he just went really fast down, like, real, that's what we noticed, really, really fast down, straight in front of us.'

84 The white light on the helicopter was seen to go out approximately 300 feet above the water and then out of sight. The Vissers struggled to see or hear anything after that. Simon described the wind:

> ‘blowing hard by that time, and a lot of sand and a lot of sea mist, it was getting thicker’.

85 Investigations confirmed that at 18:11:23 the UVC was 2.3km west-south-west of Anna Bay. It continued to track offshore for about 90 seconds maintaining an altitude of between 2,568 and 3,168 ft before commencing a rapidly descending left turn at 18:12:55; 12 minutes after published last light. At 18:13:12, the radio transmission records a ‘short, loud indistinct transmission, suspected to be a shout or scream. UVC is observed on radar to begin an immediate rapid descent from 2,800 ft AMSL, disappearing from radar coverage 14 seconds later passing 900 ft AMSL’. Lt Swan immediately tried to raise UVC on the radio but received no response. The UVC disappeared from radar at 18:13:26. Lt Swan then issued a safety alert.

86 Subsequent enquiries found that at 18:14, the UVC had turned 91° to the left on a track of 053° and descended 1,700 feet to a recorded altitude of 1,450 feet, showing a rate of descent of 8,448 feet per minute.

87 The GPS coordinates confirmed that the UVC was last detected at 32’ 49.15 South and 152’ 02.67 East, approximately 2.4 nautical miles south east of the Birubi Point Surf Lifesaving Club. Later enquiries confirmed that the sun had set at 17:38 and civil twilight had ended at 18:03. The end of Evening Astronomical Twilight was at 18:59 and the moon rose at 21:05 as a Half Moon. Therefore, at the time the aircraft disappeared into the water, large objects would stop being discernible in the absence of artificial light.

88 No criticism is made against the staff working at Williamtown Air Traffic Control on 6th September 2019. The ATSB investigators confirm staff acted in accordance with the published rules and procedures.

The search for VH-UVC and its passengers

89 The disappearance of UVC was reported to the NSW Police Marine Command at 18:26 and a search commenced that evening, coordinated by

the Australian Maritime Safety Authority – Joint Rescue Coordination Centre (JRCC).

90 Police and NSW Ambulance were deployed to the Birubi Beach Surf Lifesaving Club where a command post was established under the supervision of the NSW Marine Area Command. The GPS coordinates for the last sighting of UVC was provided to water police who concentrated their search on that location. This location was considered to the "splash point". The weather when police arrived at the splash point was a gale wind warning and strong westerly wind blowing at 30 to 40 knots. It was also dark making visibility poor during search efforts.

91 JRCC had tasked two rescue helicopters to the splash point providing aerial support to the ground search. At 20:25, an oil slick was located by one rescue helicopter and an object described as possibly being the tail rotor could be seen floating on the surface. The GPS coordinates of this discovery provided to Marine vessels who moved to this location; however, no debris was located on the water's surface. By 00:50 on the morning of 7th September, the search was stood down to re-commence in daylight hours.

92 By 08:00 on 7th September, search vessels from the Sydney Water Police and aerial support from the JRCC returned to the last known splash point. The weather had not improved much with 25 to 30 knot westerly winds blowing and sea of 2-4 metres in the morning increasing to 4-6 metres by the afternoon. At 08:50, police retrieved the first piece of debris, being a small fragment of the aircraft fuselage. This was found at GPS coordinates 32'50.32 South; 152'08.91 East. Police divers were sent to this location to perform a line search. After seeking advice from Dr. Paul Luckin, Australian Maritime Safety Authority expert in survival, it was determined by midday on 7th September 2019, that the search was unlikely to find any survivors. By 15:00 on 7th September 2019, the search was suspended until the following day.

93 The search continued over the next several days utilising the police vessel's sonar to try and detect any wreckage. A number of points of interest were

identified on the sea floor but the equipment could not definitively determine if it related to the wreckage. Therefore, a request for the Defence Assistance to the Civil Community (DACC) was made to assist in a search of the sea floor. In response, the Australian Navy Vessel HMAS HUON (a mine sweeper) was deployed on 17th September 2019 and commenced sonar operations.

94 On 19th September, the HMAS HUON located the tail boom section of the helicopter at position 32°49.085 South, 152°03.296 East. Operations were suspended over the next two days due to poor sea conditions, but search operations recommenced on 22nd September. Just after midday, several targets of interest were located and investigated using the Remotely Operated Underwater Vehicle (ROV). Images from the ROV identified debris from the UVC as well as human remains. The GPS coordinates were 32°49.05718 South, 152°03.23260 East at a depth of 34 metres. HMAS HUON departed the search and police marine vessels returned to the location on 23rd September to begin dive operations.

95 On the 24th and 25th September, several items of interest were located including the tail boom, the engine cowl, and the main rotor. Human remains entwined in aircraft wreckage was also found. The human remains were recovered. Afterwards, divers returned and salvaged the tail boom and winched it onto the police water vessel. All these findings were recorded on the police diver's go pro devices. The tail boom and other pieces of debris that had been found on nearby beaches were provided to the ATSB to assess and examine.

96 The search operation concluded on 25th September 2019 after covering over 143 square nautical miles. No recovery of the remaining wreckage will be undertaken and remains in situ.

Autopsy reports

97 The human remains located at the wreckage site were conveyed to the Department of Forensic Medicine for the purposes of establishing identity and

cause of death. Two reports were produced confirming the remains belonged to two of the passengers of the flight, Gregory Miller and Grant Kuhnemann.

Post-mortem for Gregory Miller

98 The autopsy report was submitted by Dr. Elsie Burger, confirming that the identity of the remains belonged to Greg Miller. DNA analysis was completed using samples obtained from Greg Miller's biological parents.

99 A sample of muscle was analysed for drug and alcohol. The analysis detected a small quantity of ibuprofen.

100 The cause of death could not be ascertained with absolute certainty, however the forensic pathologist stated in the autopsy report that, relying on the circumstantial evidence presented, and the post mortem autopsy findings, that multiple injuries was the probable cause of death.

Post-mortem for Grant Kuhnemann

101 The autopsy report was submitted by Dr. Elsie Burger, confirming that the identity of remains belonged to Grant Kuhnemann. DNA analysis was completed using samples obtained from Grant Kuhnemann's biological children.

102 The muscle sample sent for toxicology analysis was not suitable for testing.

103 The pathologist found the cause of death could not be ascertained with absolute certainty, however, the pathologist stated in the report that relying on the circumstantial evidence presented, and the findings of the post mortem examinations, multiple injuries was the probable cause of death.

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104 The Australian Transport Safety Bureau (ATSB) is a Commonwealth Government statutory Agency whose function is to improve safety and public confidence in the aviation, marine and rail modes of transport. They are

independent of any transport regulators to ensure complete impartiality in their investigation and subsequent recommendations. The police investigation relied on their expertise regarding the mechanical and aeronautical details provided in their report. The ATSB report was completed and published on 23rd June 2021.

105 ATSB considered whether mechanical failure of the UVC was a factor to the crash. It was determined that the UVC's total time in service was about 6,790.0 hours based on David Kerr's logbook. The 50-hour inspection was due at 6,743.0 hours as well as the voltage regulator inspection. These checks had not been endorsed on the maintenance release as having been completed. The UVC's logbook did not contain details of maintenance activity beyond the completed refurbishment and maintenance release issue on 16th October 2018. Unfortunately, it cannot be confirmed if the required maintenance had been performed.

106 The ATSB were provided with all the underwater footage taken by NSW Police Divers and the wreckage that had been recovered. The heaviest items, including the main rotor system and engine were located within 10 metres of each other on the sea floor. The tailboom was examined and investigators failed to identify any pre-existing defects likely to have contributed the accident. They considered the loss of control commenced about 1.2 km from the "splash" site. As the tailboom was found about 51 metres away from the engine, they concluded that the tailboom likely separated from the helicopter very close to the impact point and did not contribute to the loss of control. The damage was consistent with a high-speed impact with water.

107 As the engine, rotor and flight control systems could not be examined, investigators analysed the helicopter's flight path after 18:22:15 in order to determine if it was consistent with a system fault. Three possibilities were considered, (1) a loss of drive to the main rotor; (2) loss of thrust from the tail rotor; or (3) loss of hydraulic power. Referring to the Operator's Manual, if there was a loss of drive to the main rotor, an autorotational descent is required. If a loss of tail rotor thrust or hydraulic power occurs, the pilot is

required to maintain an airspeed above 30-70 kt and to position the aircraft for a run-on landing at a suitable flat location. The left turn made at 18:12:55 was inconsistent with a track to a suitable landing site due to the proximity of Stockton Beach to the right of the UVC and the absence of a mayday call which would have been likely. Also, the airspeed was above the recommended speed if there was a loss of tail rotor drive or hydraulic loss. Based on these inconsistencies, it was determined that the aircraft control and propulsion systems were serviceable and did not compromise the operation of the helicopter.

108 ATSB investigators then turned their mind to the pilot and the role he played in the crash. They sought expert advice regarding the medications David Kerr had been prescribed and whether this may have contributed to the crash. It was opined that diazepam, olanzapine and naltrexone were 'incompatible' with the CASA guidelines. The expert also advised that based on David Kerr's medical history and occurrence information, it was unlikely that David Kerr would have suffered from a medical episode at the time of the accident.

109 Spatial disorientation defines the natural human ability to maintain body orientation and/or posture in relation to the surrounding environment at rest and during motion. It is when a pilot fails to correctly sense the position, motion, or attitude of the aircraft or of themselves with respect to the ground. For pilots, flying under VFR, seeing the horizon is crucial for orientation. Where low visibility exists and the horizon cannot be seen, a pilot can become rapidly disorientated. Spatial disorientation is affected by pilot fatigue, medication, and workload. Aircraft factors contributing to spatial disorientation include autopilot or stability augmentation system and serviceable cockpit instrumentation as well as environmental factors, such as the time of day and ambient weather conditions. Between 2010 and 2019, there were 11 fatal accidents where loss of control was a factor in five of them. Spatial disorientation was found to have contributed to three out of the five.

110 The ATSB formed the following conclusion:

> That the pilot continued to fly after last light without the appropriate training and qualifications, and then into dark night conditions that provided no visual cues. That significantly reduced the pilot's ability to maintain control of the helicopter, which was not equipped for night flight. Once visual references were lost, the pilot likely became spatially disorientated and lost control of the helicopter, resulting in a collision with water. Further, the pilot did not disclose on-going medical treatment for significant health issues to the Civil Aviation Safety Authority. That prevented specialist consideration and management of the ongoing flight safety risk the medical conditions and prescribed medications posed.

111 The conclusion of the ATSB is, in my view, supported by evidence given by other witnesses. It is noted that Mr Cullen was of the opinion, a short time after the accident, that spatial disorientation could be a cause for the accident, this was before the ATSB had issued its report; and that Mr Whitehead and Mr Beck also agreed with the ATSB finding.

112 It is noted the ATSB findings are also consistent with the observations of witnesses – witnesses perceived a sudden and rapid descent by the helicopter, which would be consistent with spatial disorientation.

Missing persons

113 It is established on the evidence that the three missing persons were present in the helicopter when it took off from Archerfield, and were present in Coffs Harbour. The evidence supports the conclusion that the three missing persons remained as passengers after the fuel stop in Coffs Harbour – this is consistent with witness observations, text messages by passengers during the flight, and the report to ATC, Williamtown that there was the pilot and 4 passengers on board.

Did any mechanical fault contribute to the crash?

114 I note that all the evidence, as above detailed, including as to the rebuild of the UVC, and the examination of the wreckage during the ATSB investigation, and the nature of the flight path leading up to the crash, indicates that the helicopter crash was not due to a mechanical fault with the helicopter. The officer in charge, Detective Sgt Michael O'Keefe, undertook a thorough review

and investigation of the rebuild of the UVC. At paragraph 414 of his witness statement, Detective Sgt Michael O'Keefe states:

> "I do not intend to summarise the technical section of the statement of Whitehead further, suffice to say that having reviewed his evidence I am satisfied that the rebuild of [the UVC] by Jetpoint and Beck Helicopters and the ultimate placement on the Australian Civil Aircraft register … was a quality job. Both engineers were well qualified to complete this job and refused to utilise any components that did not have records to determine the assigned life of those parts. They have reconstructed the historical service record cards… [produced to the police].

115 Mr Whitehead stated:

> "having been intimately involved in the rebuild process and maintenance [of the UVC] I can state that I was very proud of the work completed by Matt Beck and I on the rebuild and assembly….It is my opinion that the machine was in very good condition. Was put on the register using quality parts and was serviced and maintained….

116 Mr Beck also gave detailed evidence to police in relation to the helicopter. He also stated he was very proud of the work done on the helicopter to get it flying again and put it on the register. He stated:

> "the work that Paul and I did on the machine was also reviewed and checked by the Australian Warbirds Association to ensure it was up to a serviceable standard to be eligible to fly under a Warbirds Certificate of Airworthiness. This also included a review of all of the associated logbooks accompanying [the UVC].

117 I note also that the statement from Mr Stephen Aldered, aircraft maintenance engineer, who conducted a visual inspection of the structure of the helicopter, the UVC, on 6 September 2019, before it left Archerfield airport, including inspection of its oil and fluid levels and the general condition of all rotating components - he noted no leakages or other matters of significance, and he noted no anomalies in the driveshaft and rotating parts. The inspection process took about one hour. No parts required replacement or retention. This adds to the evidence which, coupled with the findings of the ATSB investigation set out above, indicate that it was not a mechanical fault which caused the crash.

Did weather conditions contribute to the crash?

118 The brief of evidence establishes that the weather on 6th September 2019 was likely to be a contributing factor to the crash of UVC. The evidence provides lay opinion of observers, supported by raw meteorological data that has been interpreted by an expert, Mr. Andrew Haigh, Senior Aviation Meteorologist from the BoM, that the prevailing weather conditions on the flight route were:

- Strong north-westerly winds generally, with some local coastal sea-breezes at low levels at more northerly locations and associated moderate to severe turbulence (more severe further south where the wind was stronger) and possible moderate mountain waves.

- Clear skies but with some mid-level cloud developing at the southern end of the route, likely overcast or nearly so in the Anna Bay area by the time of the incident.

- Areas of reduced visibility from time to time from blowing dust and/or smoke, but also likely large areas of good visibility.

- Generally dry conditions and likely no rain over the flight route, though some showers were possibly occurring further south and perhaps some isolated thunderstorms offshore.

- At the crash site, the BoM suggested that broad scale severe turbulence was likely to be present with strong and gusty west to north-westerly winds. This wind crossing the mountains to the west of the Newcastle area would have caused mechanical turbulence in the area, particularly downwind of the ranges.

- The evidence of witnesses as to weather conditions on the day indicate that some witnesses who were themselves experienced pilots did not consider the conditions suitable for continuing the flight later on the day

of 6 September 2019 and that it would have been safer to have stopped at Coffs Harbour.

119 The ATSB report also noted the weather conditions around Williamtown around the time of the crash(aerodrome forecast (TAF)) included winds at 20 knots gusting 35knots; from 16.00, moderate to severe turbulence below 5000 ft until 18.00; and from 16.00 a 40 percent probability of visibility reducing to 4000m in blowing dust until midnight; and severe turbulence below 5000 feet. The BoM summary of actual conditions at the time stated broad scale severe turbulence likely present. Records showed that the cloud cover started to build from 17.28 and was likely overcast by 17.51, and considered overcast by 18.02. Visibility at Williamtown reduced markedly from 35.7 km at 17.42 8.34 km by 18.11. Further the ambient light by 17.50 had degraded and by 18.20 the available light had reduced to 0.

120 I consider that while the cause of the crash was the pilot error as found by the ATSB, and opined by other witnesses such as Mr Cullen, the evidence of the worsening weather and visibility conditions at the time of the crash, leads me to find on the balance of probabilities that the adverse and worsening weather conditions in all likelihood contributed to the crash. The evidence includes that David Kerr reported turbulence and wind gusts.

Who was flying the UVC when it crashed?

121 The brief of evidence confirms that Greg Miller was also a pilot and during the flight, text messages sent by Jocelyn Villanueva state Greg Miller “has the stick” during part of the flight. Therefore, the pilot flying the UVC at the time of the crash needs to be determined. The evidence on this issue includes the the messages sent between Mr Richard Johns and Greg Miller on 6th September 2019. At 17:06, Mr. Johns asked Greg Miller if he was Night Visual Rules qualified. Greg Miller replied, “Dave is”. It can be concluded from this that David Kerr had control of the UVC from this point – this can be inferred as Greg Miller was free to text at this time, and he responded that Dave was Visual Night Rules qualified – this is a responsive answer to a question about

night flying, which indicates Mr Miller's view that David Kerr, as pilot, was Night Visual Rules qualified. This response, in its context, supports a finding that David Kerr was flying at that point in time. This was the time when it was darkening and conditions were deteriorating. I am satisfied on all the evidence, as above detailed, that David Kerr was the pilot of UVC when it crashed into the water. It is my finding that this is established on the balance of probabilities. An inference also arises from the exchange of messages, that David Kerr had represented to his passengers that he was qualified to fly at night.

Was the crash an accident or deliberate?

122 Investigators disclosed material pertaining to the mental health status of David Kerr as of 6th September 2019. It raises the possibility that the crash may have been a deliberate act of self-harm. It is acknowledged that David Kerr had been struggling with depression and anxiety, however messages he exchanged with his father, Mr Godfrey, on 6th September also provides evidence of forward planning. He had made plans to meet with Mr Godfrey that weekend and was planning to continue his business flights. These were sentiments he expressed to Dr Andrzejewski three days before. I am not satisfied given the evidence overall in this matter that the crash was a deliberate act, or arose from any suicidal intent.

Was David Kerr intoxicated on 6th September 2019?

123 Whether David Kerr was intoxicated at the time of the crash cannot be established. David Kerr remains a missing person eliminating the possibility of a toxicology analysis. To suggest that David Kerr may have used an illicit substance or alcohol before the flight would be speculation only. I also note that the evidence suggest he had ceased use of cocaine some six months prior, and that he was an occasional user before that, although there were continuing issues with alcohol. That he used alcohol before the flight is not supported by other evidence – there were a number of witnesses who observed David and interacted with him on the day, and at the airports, and none observed any indicators of alcohol use. I note that there is also no

evidence from any witness indicating he had previously flown when intoxicated. There is simply no evidence on which a conclusion that David Kerr was intoxicated could be drawn.

The search for UVC and it's passengers.

124 I have carefully considered all the evidence, including as to actions taken to rescue and/or recover the five persons after the helicopter crash. I find that the evidence supports a conclusion that those involved made every effort. There are no issues arising from the search and rescue efforts by all involved. Every available asset and technology were utilised in order to locate the passengers and UVC wreckage. At the inquest, some family members conveyed their appreciation for the efforts made.

Conclusions

125 The opinion of investigating police, and ATSB investigators, was that the accident occurred because of pilot error, as detailed above. For reasons detailed above, I find that the pilot was David Kerr.

126 The evidence establishes on the balance of probabilities that the crash was a result of 'pilot spatial disorientation'. I note other plausible hypothesis (issues with fuel, issues with mechanical fault in the helicopter) are not probable causes of the crash, having regard to the evidence obtained by the police and also the ATSB. The finding of the ATSB that the crash was the result of 'pilot spatial disorientation' is credible and based on evidence, and is made after other alternative causes have been appropriately considered but found to not be consistent with what was observed by or known to witnesses. In addition I note that witnesses who were experienced pilots came to the same view, independently of the ATSB, (eg Mr Cullen) while other witnesses who were experienced in the helicopter flying industry (Mr Whitehead and Mr Barry) agreed with the ATSB finding.

127 Mr Mick CULLEN, a qualified and skilled helicopter pilot best described 'disorientation' as:

> '…most of the flying that, that we would do in training here, is what we call…visual flight rules. So, it's the flying with some kind of reference to the horizon. And then, as the pilot sets out that reference to the horizon, our visual thing's our biggest (way) of telling what's up and what's down and orientating ourselves. Once we start getting into night flying or … flying through cloud or conditions where we just don't have that visual acuity (we) use dedicated instruments inside the aircraft for that. One of the things that makes (lack of visual cues) hard is your appropriative senses…the fluid in your ears which tell you if you're accelerating or de-accelerating normally, of if you're in a turn without reference to some kind of visual stimuli, they can give you an indication that you are turning one way…when in fact you're actually straight and level (or vice versa). So, people who have no night training or don't have the instruments, you have 30 seconds before you lose control.'

128 Mr Cullen told police that the UVC did not have anything extra in terms of night flying, and he added that the helicopter did not have an artificial horizon which would normally be in the centre of the display. Mr Cullen told police that there were lots of case studies where someone is put into a cloud and it results in a spiral, where the aircraft starts rolling to the left and it really plays with how the pilot's inner ear works. Mr Cullen said it is very hard, without an artificial horizon in front of you, to work out where up is.

129 Mr Cullen was assessed by Detective Sergeant O'Keefe to present as a well qualified and experienced helicopter pilot, prepared to answer questions in a forthright manner even if the answers caused him minor embarrassment. Mr Cullen spoke of David Kerr as being likeable, and a reasonable pilot, but disorganised and always seemed to be in a hurry. To his knowledge not only did Kerr not hold night flight qualifications but had done no night training flights, and the UVC was not equipped for night or instrument flight.

130 The evidence establishes that the purpose of the flight on 6th September 2019, was to re-house the UVC to Bankstown Airport, to facilitate the new part owners, Greg Miller and Villanueva. There was a significant delay in taking off from Archerfield Airport, what was planned to be a mid-morning take-off did not take place until 14:30. By this time, it was forecast that weather would not be favourable for the trip. There does appear on the evidence to have been some disorganisation in departure - a number of witnesses in statements to police, indicated that there was some disorganisation leading to a late

departure on the day. Other witnesses indicated this was something they had seen before, including that David was often seemed rushed.

131 Upon reaching Coffs Harbour for the fuel stop, the unfavourable weather was apparent with reports of increased winds. David Kerr would have been aware of this. He further would have anticipated that the time of day would have resulted in arriving at Bankstown Airport after last light. A reasonable and prudent course would have been to have suspended the flight and continued the next day. However, it may have been that David Kerr was experiencing 'Plan Continuation Bias' – to continue and complete the initial plan which was to travel to Bankstown airport – so he made a decision to continue through to Bankstown in spite of changed and worsening conditions.

132 The ATSB determined that the cause of the crash on 6th September 2019 was the result of Spatial Disorientation. During the police investigation, witnesses who were pilots and colleagues of David Kerr provided their opinion as to whether they would have flown during the weather conditions as known to them on 6th September 2019. Their opinions should be given some weight as the evidence indicates they were pilots and/or experienced members of the helicopter aviation community. Their comments support the conclusion that the adverse weather conditions were a contributing factor.

133 However despite the contribution made by adverse weather conditions the evidence clearly establishes that, without appropriate flight instruments in the helicopter, and without night flight training, the pilot exposed everyone to risk by flying with the aid of visual cues only once daylight had receded. The evidence establishes that the pilot flew in darkness when he was not Night Visual Rules qualified.

134 Mark Pearce, an experienced helicopter pilot of 22 years, stated:

> "I am aware that the area around Stockton Bight can be particularly turbulent. I found it unusual that David Kerr was flying at dusk particularly given the weather conditions and potential for bush fire haze…I would have left early morning when conditions are usually calm…If wind gusts were forecast, rain and dust low visibility I would choose to land and not continue…He left late

> and as such should have not pressed on past Coffs Harbour given the time of day, fading light and weather forecast for dust, rain and very strong wind gusts forecast on his planned route. Park up and live to fly another day."

135 Paul Whitehead, a Licensed Aircraft Maintenance Engineer (LAME) involved in the rebuild of UVC stated:

> "I recall the weather conditions for that date were not suitable for flying, knowing how bad the weather was and the fact that David was flying after last light over water I made an assumption that it was likely that he had become disorientated and flown into the water.'

136 I also note that the occurrence of crashes of aviation craft, including helicopters, due to spatial disorientation experienced by the pilot is not unusual -the ATBS report noted that between 2010 and 2019, of 11 fatal accidents investigated, involving aircraft flown after last light in dark night conditions, that resulted in a collision with water or terrain, loss of control was a factor in five of them, with spatial disorientation found to have contributed to 3 of the five. Of the 11 incidents, five involved pilots who were qualified to fly an aircraft at night, six of the accidents involved helicopters, two of which were flown by pilots who were qualified to fly at night. The remaining four accidents involved non-night qualified, day VFR rated pilots

137 I note the submissions as to whether certain recommendations should be made. I do note that the manner of death was pilot error due to the pilot flying at night when not trained or qualified to do so, and in weather that was increasingly unfavourable for flying and particularly night flying.

138 The ATSB report stated on this issue:

> The ATSB found that the pilot continued to fly after last light without the appropriate training and qualifications, and then into dark night conditions that provided no visual cues. That significantly reduces the pilot's ability to maintain control of the helicopter, which was not equipped for night flight. Once visual references were lost the pilot likely became spatially disoriented and lost control of the helicopter, resulting in a collision with water.[The ATSB continued in a section entitled "Safety Message" –] Various ATSB research and investigation reports refer to the dangers of flying after last light without the appropriate qualifications and experience. The ATSB report, *Avoidable Accidents Number 7*, highlights the risks of visual flight at night. Risks include, reduced visual cues, increased likelihood of perceptual illusions, and spatial

> disorientation. A VFR flight in dark night conditions should only be conducted by a pilot with instrument flying proficiency as there is a significant risk of losing control if attempting to fly visually in such conditions. If day VRF – rated pilots find themselves in a situation where last light is likely to occur before the planned destination is reached, a diversion or precautionary landing is probably the safest option. Air traffic control assistance with available landing options is also available.

139 The ATSB has previously issued safety reports focusing on this issue.

140 Issues have been raised in relation to the mental health of the pilot and non disclosure by Mr David Kerr of medical conditions and medications. The evidence supports the conclusion that by relying on self-disclosure of medical information, there is a probability of a person failing to disclose necessary information for fear they will be grounded. It has been submitted that a possible recommendation would be for changes regarding the current process by CASA of obtaining medical information during a licence application or renewal.

141 There is no clear evidence that Mr Kerr's medical condition or medications contributed to the helicopter crash in this matter.

142 The OIC in his statement proffers 2 recommendations:

> (i)To consider implementing mandatory reporting obligations on doctors who are treating persons known to them to be commercial pilots, for conditions that may affect their ability to manage an aircraft or for conditions that they have prescribed drugs listed by CASA as notifiable drugs; and
>
> (ii) That consideration be taken in mandating the commercial pilot license application or renewal process to include the pilot granting permission for Medicare and PBS to provide CASA with information about the applicant's medical background where CASA can perform a dip sampling process. This would be promoted with an education program to discourage commercial pilots from having more than one medical practitioner or "doctor shopping".

143 In relation to (i), there are significant ramifications of such a system. If medical practitioners were to become mandatory reporters, it would be a greater disincentive for a pilot to disclose any issues they may have for fear of losing their licence. Many medical conditions can be successfully treated and monitored and safety thereby ensured – lack of treatment because of fear of

consequences of mandatory reporting may lead to many conditions being undiagnosed, and thereby not being treated and stabilised, with a possibility of even greater safety risks.

144 It is noted that the ATSB report confirms that there are pathways in place for the management of certain medical conditions that would not preclude a pilot from flying. The report acknowledges that the disclosure of medical information comes from the pilot and is essential to allow CASA to manage any on-going flight safety risk for both the individual and flight safety overall. In relation to proposed recommendation (ii) by requesting the pilot to give consent to CASA or DAME to access their medical history, this may reduce the risk of future incidents. However, there are significant privacy concerns with such a wide-ranging recommendation. Further, the problem with access to medical records would be the same as with a move to mandatory reporting – a disincentive to a pilot to obtain diagnosis and treatment, which possibly increases safety risks.

145 On the current matter there not clear evidence establishing that a medical condition of the pilot contributed to the accident or to the deaths in this case, and the finding is that it was flying at night when not trained or equipped to do so, and in unfavourable conditions, which caused the crash. A recommendation about mandatory health reporting would not prevent a similar situation in the future.

146 In this matter the cause of the crash was clear, on all the evidence, as being the pilot continuing after last light to fly a helicopter which was not equipped for night flying and where the pilot was not trained for night flying with visual cues only. Poor weather contributed to the risks of flying after last light as detailed above. The cause of the crash was the spatial disorientation experienced by the pilot when he proceeded with the flight after last light.

147 Given these findings this has not been an inquest where exploration of medical reporting/screening for pilots' licences has been subject of investigation. Changes to the current system would require detailed research

and review, and consultation with stakeholders and experts. For the reasons detailed, this has not been part of the current inquest. For these reasons no recommendations in relation to medical screening and/or mandatory reporting of medical conditions in relation to pilots and their licence to fly have been made.

148 In considering this issue I also considered that the ATSB report did also comment:

> This accident also highlights the importance of aviation medical certificate holders reporting relevant conditions and medications to their Designated Aviation Medical Examiner….[as this]… enables management of the risk for both the individual and flight safety overall."

149 Whilst it may be appropriate that privacy concerns take second place to safety concerns where licencing of pilots is concerned - given the potential for pilots to cause significant harm to others - in the present case, given the role of night flying and spatial disorientation in causing the crash, this is not a case where the Coroner has investigated, and consulted with stakeholders, about the appropriateness of recommendations in relation to medical reporting.

Conclusions – missing persons

150 I note the evidence at the inquest that there have been no signs of life of the missing persons, Jocelyn Villanueva, David John Kerr, and Jamie Ogden, since the crash on 6 September 2019. I also note that the missing persons were close to their families and loved ones so would have been in contact if alive. I am satisfied on the evidence for reasons above detailed, that the missing persons, Jocelyn Villanueva, David John Kerr, and Jamie Ogden, were all on board the helicopter when it left Coffs Harbour and when it flew near Williamstown, and that they were on board the helicopter at the time of the crash. On all the evidence, the crash was not survivable and I am satisfied on the balance of probabilities that the missing persons are deceased.

Cause of death

151 For reasons detailed above and having regard to all of the evidence and findings made on that evidence, I am satisfied that all five passengers aboard on the helicopter, the UVC - being Grant Kuhnemann, Gregory Miller, Jocelyn Villanueva, David John Kerr, Jamie Ogden - are deceased, and the cause of death in each case was multiple injuries sustained in the helicopter crash.

Manner of death

152 I refer to the evidence and conclusions detailed above as to the cause of the helicopter crash. The evidence establishes, on the balance of probabilities, that the helicopter crash was unintentional and was a tragic accident. The manner of death for all five deceased - Grant Kuhnemann, Gregory Miller, Jocelyn Villanueva, David John Kerr, Jamie Ogden - is therefore misadventure.

CONCLUSION

153 In conclusion I make the following findings in this inquest.

FINDINGS in relation to the deceased, Gregory Miller

154 The findings I make in relation to the deceased, Gregory Miller, under section 81(1) of the Act are:

Identity: Gregory Miller
Date: 6 September 2019
Place: Anna Bay, New South Wales, 2316

Cause of death: multiple injuries (sustained in helicopter crash)

Manner of death: misadventure

FINDINGS in relation to the deceased, Grant Kuhnemann

155 The findings I make in relation to the deceased, Grant Kuhnemann, under section 81(1) of the Act are:

Identity: Grant Kuhnemann
Date: 6 September 2019
Place: Anna Bay, New South Wales, 2316

Cause of death: multiple injuries (sustained in helicopter crash)

Manner of death: misadventure

Findings in relation to the missing person, Jocelyn Villanueva are:

Conclusion

(1) I am satisfied on the balance of probabilities that the Missing Person Jocelyn Villanueva, is deceased.

Findings

(2) The findings I make in relation to the deceased, Jocelyn Villanueva, under section 81(1) of the Act are:

Identity: Jocelyn Villanueva
Date: 6 September 2019
Place: Anna Bay, New South Wales, 2316
Cause of death: multiple injuries (sustained in helicopter crash)

156 Manner of death: Misadventure

Findings in relation to the missing person, David John Kerr are:

Conclusion

(1) I am satisfied on the balance of probabilities that the Missing Person, David John Kerr, is deceased.

Findings

(2) The findings I make in relation to the deceased, David John Kerr, under section 81(1) of the Act are:

Identity: David John Kerr
Date: 6 September 2019
Place: Anna Bay, New South Wales, 2316
Cause of death: multiple injuries (sustained in helicopter crash)

157 Manner of death: Misadventure

Findings in relation to the missing person, Jamie Ogden are:

Conclusion

(1) I am satisfied on the balance of probabilities that the Missing Person Jamie Ogden, is deceased.

Findings

(2) The findings I make in relation to the deceased, Jamie Ogden, under section 81(1) of the Act are:

Identity: Jamie Ogden
Date: 6 September 2019
Place: Anna Bay, New South Wales, 2316
Cause of death: multiple injuries (sustained in helicopter crash)

158 Manner of death: Misadventure

Closing

159 I acknowledge and express my gratitude to Sergeant Christine Xanthos, Coronial Advocate Assisting the Coroner, for her assistance both before and during the inquest. I also thank the Police officer in charge, Detective Sergeant Michael O'Keefe, Marine Area Command, for his work in the Police investigation and compiling the evidence for the inquest.

160 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to the families of Grant Kuhnemann, Gregory Miller, Jocelyn Villanueva, David John Kerr, Jamie Ogden.

161 I close this inquest.

Magistrate Carolyn Huntsman

Deputy State Coroner

Coroners Court of New South Wales

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