Findings of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Nikita Jo Walker

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Nikita Jo Walker with an inquest held at Hobart in Tasmania, make the following findings.

Hearing dates

5 – 6 April 2022 at Hobart in Tasmania

Representation

S Nicholson – Counsel Assisting the Coroner
P Jackson SC – Airline of Tasmania Pty Ltd, trading as Par Avion

Introduction

1. Ms Nikita Jo Walker died on 8 December 2018. She was born in Cairns, Queensland on 27 October 1988, and was the daughter of Ms Karen Walker and Mr Henry Wyman. She also was an older sister to Ms Mantina Walker.
2. Ms Walker was raised by her mother and enjoyed an active, happy and healthy upbringing. After completing her education, Ms Walker worked initially as a swimming teacher for around 12 months before travelling overseas where she lived and worked for approximately 6 years.
3. It is evident Ms Walker was in good health and very athletic. She was fit, ran regularly, and was a keen surfer and soccer player. Apart from a knee injury which required surgery in July 2014,[1] she had no medical history to speak of.
4. Flying seems always to have been an interest of Ms Walker's. After returning to Australia permanently, Ms Walker commenced learning to fly. Her log book indicates her first flight was on 22 October 2015 from Marcoola on Queensland's Sunshine Coast. Her first solo flight was on 3 January 2016.
5. In mid-2016, Ms Walker enrolled in the flight school operated by Par Avion at Cambridge, near Hobart in Tasmania. She was a diligent student who qualified as a commercial pilot the same year. Upon graduation, Ms Walker was offered a position with Par Avion, which she accepted. At the time of her death she was a commercial

[1] C8 – Aviation Medical Certificate and associated medical records.

aircraft pilot employed by Par Avion. The evidence at the inquest satisfies me that at the time of her death Ms Walker held all necessary qualifications to work as a commercial pilot.

6. It is also evident she was a talented and conscientious pilot, popular with her colleagues and trusted by her employer. At the time of her death she had just over 530 hours experience flying which included experience in the aircraft she was flying and on the route. Indeed, she had flown it the day before and several times in the week leading up to her death. Specifically, Ms Walker had a total of 72 hours experience in a Pilatus Britten-Norman, 57.1 hours as pilot in command. In addition her log book indicates she had 150 flights to Melaleuca in either twin engine or single engine aircraft between 22 September 2016 and 30 November 2018, 130 of those as pilot in command. Her first recorded flight as pilot in command of a Britten Norman B2 aircraft was on 27 September 2018.[2]

7. The flight to and from Bathurst Harbour is normally undertaken following Visual Flight Rules. In a general sense Visual Flight Rules permit a pilot to operate an aircraft only when weather conditions are clear enough to allow the pilot to see where the aircraft is going.[3] Responsibility for determining whether flying can be conducted in accordance with Visual Flight Rules is vested in the pilot in command. The decision is to be made in the cockpit of the aircraft when in flight.[4]

8. As at 8 December 2018, Ms Walker was the holder of a Commercial Pilot (Aeroplane) License Aviation Reference Number (ARN) 1005748. Her last flight review had been completed on 25 May 2017. She held an endorsement for Visual Flight Rules. In addition, and relevantly, as at the same date she was the holder of a current Civil Aviation Safety Authority (CASA) Class 1 (Commercial Pilot) aviation medical certificate.[5]

The coronial jurisdiction and role

9. Before considering the circumstances of Ms Walker's death it is necessary to say something about the role of the coroner, and the attendant powers and obligations. In Tasmania, a coroner has jurisdiction to investigate any death that "occurs at, or as a result of an accident or injury that occurs at, the deceased person's place of work, and does not appear to be due to natural causes".[6] Ms Walker's death meets this definition. The *Coroners Act* 1995 also provides that where a person dies as a "result of an accident or injury that occurred at his or her place of work, and the coroner is not

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[2] Exhibit C35.
[3] See generally *Civil Aviation Regulations* 1988, regulation 172.
[4] *Supra* regulation 174.
[5] Exhibit C8.
[6] *Coroners Act* 1995, section 3.

satisfied that the death was due to natural causes", an inquest is mandatory. The requirement to hold an inquest in workplace death cases is subject to a statutory exception. The exception is that if the Senior Next of Kin of a deceased person who died as a result of injuries suffered at work asks a coroner not to have an inquest then, provided the coroner is satisfied that it would "not be contrary to the public interest or the interest of justice", an inquest can be dispensed with. No such request was made in this case. Accordingly an inquest was held into Ms Walker's death. An inquest is a public hearing.[7]

10. I note that although Ms Walker died in the course of her employment, WorkSafe Tasmania did not investigate her death, taking the view apparently that CASA and the ATSB with the appropriate agencies to investigate.[8] I do not consider the Coronial investigation into Ms Walker's death was hampered by this decision.

11. When conducting an inquest, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. An inquest might be described as a quest for the truth, rather than a contest between parties to either prove or disprove a case. The coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 asks. These questions include who the deceased was, how they died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the death.[9] The job of the coroner is to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

12. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and compensation are for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation. I should add that I do not consider any offences were committed by anyone in relation to Ms Walker's death.

13. As was noted above, one matter that the *Coroners Act* 1995 requires, is a finding (if possible) as to how the death occurred.[10] 'How' has been determined to mean "by what means and in what circumstances",[11] a phrase which involves the application of the ordinary concepts of legal causation.[12] Any coronial inquest necessarily involves a

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[7] *Supra.*
[8] Exhibit C38.
[9] *R v Tennent; Ex Parte Jager* [2000] TASSC 64.
[10] *Coroners Act* 1995, section 28(1)(b).
[11] See *Atkinson v Morrow* [2005] QCA 353.
[12] See *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.

consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

14. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.[13]

15. The final matter that should be highlighted is the fact that the coronial process, including an inquest, is subject to the requirement to afford procedural fairness.[14] A coroner must ensure that any person (and person includes any legal entity) who might be the subject of an adverse finding or comment is made aware of that possibility and given the opportunity to fully put their side of the story forward for consideration.

Issues at the inquest

16. In advance of the inquest a number of issues, in addition to those mandated by the *Coroners Act* 1995, were identified as being matters to be particularly considered at the hearing. Those matters were:

    a. The circumstances of Ms Walker's flight on 8 December 2018 including:
        i. Flight path;
        ii. Weather conditions; and
        iii. Route taken.
    b. Ms Walker's access to weather forecasting information and the influence, if any, of that access on the planning of a flight such as that taken on 8 December 2018;
    c. The applicability of any standard operating procedures relevant to the flight; and
    d. The availability of any alternative route.

Evidence at the inquest

17. After several case management conferences designed to ensure issues were identified and all evidentiary material made available to all interested parties for hearing, an inquest was held in Hobart in April 2022. A significant amount of documentary material was tendered and a number of witnesses called to give evidence. The details

[13] (1938) 60 CLR 336 (see in particular Dixon J at page 362).
[14] See *Annetts v McCann* (1990) 170 CLR 596.

of the documentary material appear as Annexure A to this finding. The witnesses called to give evidence and answer questions were:

a. Sergeant Damian Bidgood, Tasmania Police – Search and Rescue;
b. Mr Bryn Watson, Pilot, Rotolift;
c. Senior Constable Joshua Peach BM, Tasmania Police – Search and Rescue;
d. Mr Shannon Wells, Managing Director, Par Avion;
e. Mr Luuk Veltkamp, Head of Operations, Par Avion;
f. Mr Ashwin Naidhu, Bureau of Meteorology;
g. Mr Colin Miller, Chief Engineer, Par Avion; and
h. Mr Mark Holdsworth, Wilderness Guide.

18. In addition a number of affidavits of witnesses not called to answer questions were tendered, so were a significant amount of other relevant documentary material. A complete list of all those affidavits and other documents appears at the end of this finding in annexure A. One of those documentary exhibits was a report prepared by the Australian Transport Safety Bureau (ATSB).

19. In addition, my finding has been informed by two inspections of the crash scene by helicopter on 22 December 2018 (with the aircraft wreckage still *in situ*), and on 12 May 2021, as well as an inspection of the aircraft wreckage, once recovered from the crash site.

20. I record that I found all witnesses at the inquest helpful, reliable and honest.

Circumstances of death

21. On 8 December 2018, Ms Walker was the pilot and only occupant of a Pilatus Britten-Norman BN-2A-20 Islander twin engine aeroplane, registered VH-OBL, en route from Cambridge Aerodrome to Bathurst Harbour, Tasmania. She took off from Cambridge at 7.48am Eastern Daylight Time (EDT), and was scheduled to arrive at Bathurst Harbour at about 8.45am to pick up five passengers for the return flight to Cambridge. The aircraft was capable of carrying 10 people.

22. Ms Walker was living at the time in the nearby suburb of Tranmere. Her house mate said in his affidavit tendered at the inquest[15] that he and Ms Walker had a cup of tea during the evening of 7 December 2018, before she retired to bed around 8.30 – 9.00pm. She got up at approximately 6.00am and made her way to Cambridge.

23. There were (and still are) two flight paths between Bathurst Harbour and Hobart. The route taken by Ms Walker is known as the direct route. The alternative is the longer coastal route. The choice of route is for the individual pilot, at the time.

[15] Exhibit C19, Affidavit of Brock James Bergseth, sworn 13 December 2018.

24. The direct route involves flying overland from Cambridge Aerodrome towards Mt Wellington, and then towards the Huon Valley, over Judbury, towards the Arthur Mountain Ranges and passing through the gap between the Eastern and Western Arthur Ranges, before landing at the airstrip at Bathurst Harbour.

25. The coastal route, as the name suggests, involves flying the southern coast of Tasmania to Bathurst Harbour. The route follows initially the Derwent River, before heading in a generally southerly direction down the D'Entrecasteux Channel, before heading west parallel to the south coast as far as Cox Bight. At Cox Bight, the pilot turns in a general north/north westerly direction for a short flight to Bathurst Harbour.

26. The evidence satisfies me that immediately after her arrival at Cambridge at 7.05am.[16] Ms Walker checked and printed weather forecasts for the area relevant to her intended flight.[17] I will return to weather forecasts later in this finding.

27. At 7.10am, Ms Walker submitted a flight plan (or notification) electronically.[18] The flight plan evinced an intention to fly by the direct route to and from Melaleuca Bathurst Harbour Aerodrome. I note it was submitted after Ms Walker had electronically access to weather information.

28. Although direct evidence was destroyed in the crash, I am satisfied that Ms Walker then carried out the necessary prescribed pre-flight checks on the Britten Norman BN2A.

29. Ms Walker took off at 7.48am. Approximately half an hour later, at around 8.16am, the Britten Norman BN2A flew through the Western Portal area in the Western Arthurs Range and entered a valley to the west of the ranges. The aircraft then completed a series of turns. The preponderance of evidence including an analysis of the flight data and known manoeuvres indicates that as Ms Walker flew through the portal and into the valley beyond she was flying visually. In addition once in the valley she completed four controlled 180° turns. The flight data, concludes with the final data point being recorded at 8.28am, at which time the aircraft collided within a matter of seconds with the mountain range.

30. At 8.29am, the Australian Maritime Safety Authority (AMSA) received advice that the Emergency Locator Transmitter (ELT) fitted to Ms Walker's aircraft's had activated. The coordinates given were 43° 11.04S, 146° 21.42E (in an area of mountainous terrain near the Western Portal of the Western Arthur Range in the Southwest

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[16] As indicated by the electronic time "stamp" record in the National Aeronautical Information Processing System.
[17] Exhibit C20, page 20.
[18] Exhibit C29.

National Park, Tasmania). AMSA immediately advised Tasmanian Police and Par Avion, and search and rescue efforts commenced.

31. Those efforts included deploying two helicopters (one of which was re-tasked from responding to an incident in Banks Straight, off Tasmania's north east coast) and a Challenger 604 search and rescue jet aeroplane. The Challenger was the first to arrive in the area, arriving over the beacon signal location at around 9.25am. However, heavy cloud prevented the crew of that aircraft from visually identifying its exact location. The cloud cover meant that the Challenger aircraft could not get below 6000 feet.[19]

32. The helicopters carrying Tasmania Police Search and Rescue personnel and Ambulance Tasmania rescue paramedics arrived in the general area of the crash by around 10.20am. The weather conditions were challenging and visibility very poor due to low cloud.[20] The weather conditions hampered the ability of the search and rescue personnel to detect a beacon signal. It was decided to fly to the north-western end of the Western Arthur Range and then follow the range on the southern side to the logged coordinates.[21]

33. Numerous attempts were made by search and rescue personnel throughout the day to locate and get to the crash site, however, due to the continued low-level cloud, those attempts were all unsuccessful.

34. Ground parties were inserted by helicopter at around 4.30pm. One of the helicopters – Polair 72 - suffered a mechanical failure which prevented it from doing any more flying that day.

35. Finally, at about 7.00pm the cloud lifted just enough to enable the crew of the remaining helicopter – Polair 71 - to visually locate the aircraft wreckage high up on the eastern face of the Western Portal.[22]

36. The tail section of the aircraft was visible. Smoke from a fire which had started when the crash occurred was clearly visible, as was the area of vegetation impacted by that fire. The helicopter crew confirmed that the signal from the ELT beacon was emanating from the aircraft wreckage. This was important because it demonstrated that Ms Walker had not removed it from the wreckage after the crash, providing more evidence – in addition to the appearance of the wreckage, the absence of any sign of life and the clear evidence of a fire - that Ms Walker could not have possibly survived the crash. The Search and Rescue helicopter crew considered winching personnel to the site; however, due to a number of risks, including potential for low cloud reforming, the time of day and lighting, and other hazards associated with the

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[19] Exhibit C11, affidavit Constable Justin Fountain, page 2 of 5.
[20] Exhibit C12, affidavit Sergeant Damien Bidgood, sworn 16 January 2019.
[21] *Supra.*
[22] Exhibit C14, Affidavit Senior Constable Joshua Peach, sworn 2 January 2019, page 2 of 4.

mountainous location, a decision was made (appropriately in my view) not to undertake that task and the helicopter left the scene. The decision was understandable in the circumstances and I consider correct.

37. The following day, Search and Rescue personnel reached the aircraft wreckage and confirmed that Ms Walker was dead. They recovered her remains. In light of the physical evidence at the scene and the results of the autopsy (to which I will shortly turn) there is no doubt in my mind that she died instantly in the crash.

Flight data and physical evidence

38. Evidence in the form of position and altitude information was obtained from software records obtained as part of the investigation. The data showed the aircraft tracking to the southwest towards Bathurst Harbour. At approximately 8.16am, the aircraft entered a valley near the West Portal in the Western Arthur Ranges, and proceeded to conduct a number of turns. The final ADS-B data point recorded was at 8.28am.

39. Summarising, the flight data showed Ms Walker passing between the eastern and Western Arthur Ranges before being manoeuvred in the valley beyond those ranges in a way that I consider was consistent with Ms Walker attempting to assess different options for possible routes either to Bathurst Harbour or safely returning to Cambridge. That data is, until the very last moment of the flight, entirely consistent with Ms Walker being in full control of the aircraft.

40. The evidence at the scene of the crash demonstrated that the aircraft collided with the Western Portal when in a relatively steep angle of bank, suggesting that Ms Walker remained in control of the aircraft and had suddenly become aware of the immediate threat of the Western Portal, and thus attempted to pull up sharply.

Cause of death and identification

41. After being recovered from the wreckage of the aircraft, Ms Walker's remains were taken to the Royal Hobart Hospital. At the Royal Hobart Hospital, highly experienced Forensic Pathologist Dr Donald Ritchey, performed a post mortem examination. Ms Walker's remains consisted of an extensively charred body with separation of the head from the vertebral column, complete absence of the middle portion of the left arm and complete absence of the legs below the mid thighs. Dr Ritchey provided a report in the form of an affidavit which was tendered at the inquest in which he expressed the opinion that the cause of Ms Walker's death was the combined effects

of multiple blunt traumatic injuries and incineration that occurred during an air plane crash. [23] I accept his opinion.

42. Ms Walker's remains were so extensively burnt that the only method of formal identification was by DNA comparison. Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania and compared to samples obtained from a roll-on deodorant and toothbrush which belonged to Ms Walker.[24] FSST provided a report following DNA biological comparison which formally established her identity.[25]

43. As I have already said, I am satisfied that Ms Walker's death was instantaneous. No one could have survived the impact and injuries she evidently sustained.

Possible reasons for Ms Walker's crash

44. The evidence at the inquest satisfies me affirmatively that mechanical defect (including contaminated fuel) did not cause or contribute to the happening of the crash[26]. I am satisfied that the aircraft itself was mechanically sound. It had undergone an inspection of its airframe, engines and propellers with a final airworthiness certificate being issued in accordance with *Civil Aviation Regulation* 42ZE on 17 August 2018.

45. As I have already mentioned, the evidence satisfies me that Ms Walker was in good health,[27] well rested[28] and unaffected by alcohol or drugs.[29] Thus, all of those factors – poor health, fatigue or alcohol and drugs – can be excluded as matters that may have caused or contributed to the fatality.

46. Furthermore I am quite satisfied that Ms Walker's death was not the result of a voluntary and intentional act on her part. First, there is a complete lack of any evidence at all that suggests suicidal ideation or intent on her part. Indeed there is clear evidence that Ms Walker was making future plans including, immediately, attending a party later that day and potentially, in the longer term, a possible return to Queensland. Second, I consider the clear evidence relating to her flight path immediately before the crash makes it obvious Ms Walker was attempting to avoid crashing, by trying to find a break in the weather.

47. It follows that I am satisfied that her death was due to misadventure, that is, an accident. I shall turn now to the likely cause of that accident.

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[23] Exhibit C5, affidavit of Dr Donald Ritchey, sworn 18 January 2019, page 8 of 10.
[24] Exhibit C6 – affidavit of Constable Ian Bellette, sworn 10 December 2018.
[25] Exhibit C4, Report – Forensic Science Service Tasmania, 13 December 2018.
[26] See the evidence of Mr Colin Miller generally and the aircraft service records C 22 A.
[27] Exhibit C8.
[28] Exhibit C19, Affidavit of Brock Bergseth, sworn 13 December 2018.
[29] Exhibit C4, *op cit.*

Weather forecasting

48. The issue of weather forecasting was extensively investigated and considered at the inquest. The scope expressly included the question of Ms Walker's access to weather forecasting information and the influence, if any, of that access on the planning of a flight such as that taken on 8 December 2018. It should, I think, be made immediately clear, that there is no evidence, at all, that access or lack of access to particular weather forecasts or information influenced in any way Ms Walker's decision as to commencing or continuing the flight or choice of route on 8 December 2018. The only source of information about that could be Ms Walker herself. There is no direct evidence as to how and to what extent or in what manner any weather forecast or other information influenced Ms Walker's decision making that day. The only evidence on the point is that Ms Walker apparently consulted weather forecasting information and within a matter of minutes completed and submitted an electronic flight plan. It is not unreasonable to conclude that she at least had the weather information in mind when she submitted that flight plan. But I do not think the evidence is capable of supporting any higher conclusion.

49. Nonetheless, an examination of the sufficiency and availability of weather forecast information is necessary, if for no other reason than logic dictates that forecasts are of fundamental importance to flight planning generally and to Ms Walker's final flight in particular.

50. The evidence was that the Australian Government Bureau of Meteorology issue a number of routine aviation weather forecasts on a daily basis. Those forecasts include a Graphical Area Forecast (GAF), a Grid Point Wind Temperature Forecast (GPWT), Terminal Aerodrome Forecasts (TAF) and, as necessary, Significant Weather Meteorological Warnings. All forecasts are recorded using Universal Time (UTC) that is to say Greenwich Mean Time. To determine Australian Eastern Standard or Daylight Time it is necessary to add 10 or 11 hours as the case may be. For ease of understanding, and a degree of clarity, I intend to use Australian Eastern Daylight Time throughout the discussion of the evidence about the forecasts.

51. GAFs combine graphical and textual information. In essence a graphic is divided into areas that share common weather characteristics which characteristics are detailed in an associated table. GAFs are specifically designed for use within the aviation sector. They provide information covering cloud, visibility, icing, turbulence and freezing levels within geographical areas on a state basis. The forecasts are routinely released at about 9.30am, 3.30pm, 9.30pm and 3.30am. The reports therefore cover a six hour period. The GAF which was current and applicable to the flight she was about to undertake, and which Ms Walker consulted had been issued at 3.42am on 8

December 2018.[30] That forecast suggested generalised scattered rain, isolated thunderstorms and sea mist within 20 nautical miles of the coast, together with widespread sea fog. It was valid for the time period 4.00am to 10.00am.

52. A second GAF was issued 6 minutes later, valid for the 6 hour period 10.00am to 4.00pm. That GAF divided Tasmania into two area, A and A1, with the dividing line running, roughly, northwest – southeast.

53. Another source of weather information available through the Bureau of Meteorology includes Grid Point Wind Temperature Forecasts which provide wind speed and direction forecasting as well as temperature forecasts at specified heights. These are also issued every six hours.

54. Finally, Terminal Aerodrome Forecasts (TAFs) were and are also available through the Bureau of Meteorology website.

55. As I noted above, a GAF had been issued which covered the time that Ms Walker was to be flying. "Unusually", according to several witnesses,[31] that Graphic Area Forecast issued at had no subdivisions over the state of Tasmania. Mr Wells was particularly critical of the forecast describing it, in the aftermath of Ms Walker's crash as *'crap'*.[32]

56. There was also evidence at the inquest of other sources of weather information including web cams at Melaleuca (owned and operated by Par Avion) and various commercially available mobile phone 'apps' such as Windy.

57. Mr Watson, the experienced pilot of one of the rescue helicopters (Polair 71), gave evidence at the inquest. In his affidavit he said that GAFs are:

> *"accepted as being very limited due to a lack of resolution for specific locations within area, i.e. the Western Arthurs. They do not provide an overview of expected weather systems (i.e. approaching France) the kiss conditions to be expected in those systems are any information relation to timeframes the onset improvement of the weather. This is because they generalise the forecast for the entire area or subdivision that entire six hour period of time. In Tasmania the conditions can change drastically within six hours. Often it is very difficult to mentally or physically transfer the written data for multiple subdivisions on the small map provided".*[33]

58. Mr Watson described a general routine each morning when commencing duty involving checking a number of weather forecasts and completing a weather assessment form. He explained a variety of sources of information which helped "build a mental picture of the weather".[34] The available sources included weather cams,

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[30] Exhibit C24, page 19 of 26.
[31] C13 Affidavit of Bryn Watson, page 2; C21 Interview with Luuk Veltkamp;
[32] C40 – Email exchange between Shannon Wells and Ashwin Naidu, BOM.

[33] C13, *supra.*
[34] *Supra.*

individual weather sensor readouts and direct contact with people actually in particular locations. He spoke of speaking directly to Hobart forecasters within the Bureau of Meteorology to obtain more detail in relation to particular locations. Indeed this is precisely what he did before he left Launceston Airport to commence the search for Ms Walker.

59. The witnessed weather conditions were observed by Mr Mark Holdsworth, a tour guide and one of the people waiting to be collected by Ms Walker on 8 December. He described the conditions as:

> *"Variable, with passing showers and the cloud base changing from near ground level to 2-300m on surrounding mountain ranges with strong winds. The cloud inland and to the east was stormy and consistently low so I expected the aircraft to fly coastal under these conditions and arrive from the south from Cox Bight. The passing showers and varying cloud base regularly obscured the view to Cox Bight and I expected the plane would not be able to fly from the coast to Melaleuca and, as I've experienced many times in the past, I expected the plane would either not have departed Cambridge or returned part way through the flight due to the unfavourable conditions."*[35]

60. I consider that given his evident experience in South West Tasmania, including many years working as a PWS Ranger, Mr Holdsworth's observations about the weather in the area of Melaleuca and Port Davey was likely to be reliable.

61. Other evidence which tended to suggest that, in fact, the weather was much as forecast came in the form of a photograph taken by Ms Walker and sent as by text message as she flew over the Huonville area approximately 74 kilometres from Cambridge. That photograph seems to show the presence of sea mist on the coast, to the south of the Recherche Bay area.[36] I note that area appears as if it may be within the general area of the coastal route flown as an alternative to the air strip at Port Davey. If that is so, and the evidence does not allow a high degree of certainty about the issue, it may be that was a factor which influenced Ms Walker's choice of the direct route to Melaleuca.

62. The evidence at the inquest the leads to a conclusion that the weather conditions for the day, from the Bureau reports coupled with imagery from a webcam at Bathurst Harbour, indicated:

    a. Unstable weather streaming into the south west of Tasmania, where a high and low were converging and a trough passing through;

    b. There was heavy cloud cover;

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[35] C34, Affidavit of Mark Holdsworth, sworn 3 August 2020.

[36] C31, ATSB Final Report, Figure 5. Unfortunately the author or authors of the report do not indicate from whom the photograph was obtained and what time Ms Walker took and sent it. This is not entirely helpful.

c. South easterly winds detected at stations at Warra (roughly 3 km north of Tahune), Hartz, Low Rocky Point and Maatsuyker; and

d. South westerly winds detected at Grove and Bushy Park.

63. There is no evidence that suggests it was inadvisable for Ms Walker to have commenced her flight. In light of both the forecast and the observed weather conditions, I consider that the choice of the direct route does not seem to have been inappropriate.

64. Nonetheless, whatever the deficiencies of the weather forecast, there were other sources of information available including viewing the web cam at Bathurst Harbour or making a 'phone call to the Bureau of Metrology'. Ultimately, as I said earlier, there is no evidence that the weather forecasting (whether good, bad or indifferent) caused or contributed to Ms Walker's fatal crash.

ATSB report

65. The Australian Transport Safety Bureau (ATSB) carried out an investigation into the circumstances of the crash pursuant to its enabling legislation. Ultimately, a draft report and later a final report were produced by the ATSB. Both were tendered at the inquest.[37]

66. It is not unreasonable to say that Par Avion was trenchant in its criticism of both the ATSB's investigation and more to the point, the report that resulted from that investigation. Some of that criticism, particularly concerning the extent to which any consideration was had of Par Avion's detailed and comprehensive response to the draft report, simply has no bearing on my function as coroner.

67. However, some of that criticism does need to be considered in the context of the evidence at the inquest and what use should be made of the ATSB report. Particular attention was focussed upon the 'finding' contained in the final report that:

> *"Airlines of Tasmania did not provide any documented guidance for the South-West operations, despite encouraging pilots to commence the flight, even when forecasts indicated they may be likely to encounter adverse weather en route. This.... increased the risk that some pilots continued into an area of high terrain in marginal conditions, where options to escape were limited."*[38]

68. Par Avion submitted that there were three serious problems with this 'finding'. Those problems were said to be:

> a) *"It is unarguable that any lack of documentation was not in any way or to any degree causative of the crash.*

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[37] ATSB Final Report Exhibit C31.

[38] *Op cit*, page 46.

b) *The unchallenged evidence of those able to give evidence on the point is that there was no such "encouragement", in the misleading sense that is here presented.*

c) *There is no evidence whatsoever to support the statement in the third sentence. There is no evidence at all of instance of a pilot flying into an area of high to rein in marginal conditions, where options to escape were limited, and especially under the influence of any "encouragement" to do so".*

69. I must say that having considered the matter carefully I think much of that criticism is justified. There is absolutely no evidence whatsoever that the absence of any 'documentary guidance' – written procedure, SOP, manual or the like - caused or contributed in any way to Ms Walker's death.

70. Similarly, there was no evidence, whatsoever of Par Avion 'encouraging' pilots to do as the ATSB report suggests. Not only did the extensive coronial investigation and the inquest fail to find any such evidence, but the report is notable for the absence of any evidence on the point too.

71. In my view, in a general sense, the report lacks much by way of reasoning, is largely speculative and is, from my perspective at least, of little forensic value. One other obvious problem with the report, aside from Par Avion's criticisms, is that there is no indication of the author or author's qualification to express the opinions and conclusions contained in it. In fact, there is even no indication as to the identity of the author or authors. The problem that causes for someone in my position is that it is virtually impossible to make any assessment of the reliability of the report in a general sense and therefore what use should be made of it.

72. Further, the report is replete with conclusions, but with no apparent basis – as Par Avion, correctly my view, submit in respect of the 'finding' set out above. And perhaps most surprisingly, despite the fact that it was in fact investigating an aircraft crash, the ATSB report does not appear to attempt to establish, at all, the reason for the crash.

73. Other matters of concern in the report include the fact that it identifies 'factors that increased the risk' of Ms Walker's crash (which factors include express and implicit criticism of the Civil Aviation Safety Authority, as well as Par Avion), but does not explain why those factors increased the risk. Indeed, given that the ATSB does not actually appear anywhere to identify why the crash occurred – other than the obvious fact that the aircraft flew into the Western Portal – identification of any causal link between these so-called increased risk factors and the crash cannot, as a matter of logic, be established. As such, in my respectful view the report really did not assist me greatly in my function under the *Coroners Act* 1995. This is a pity. The ATSB should be the subject matter experts in the area, upon whom reliance can be placed.

74. The ATSB report also included what was described as 'General Finding' to the effect that "*while flight tracking data was available, the aircraft was not fitted with an on-board recording device. This would have provided valuable information to better understand the pilot's in-flight weather-related [sic] decision-making [sic]*".[39] I note that the nature of any "on-board recording device" which it is suggested would have provided valuable information to assist in the investigation was not actually identified. Several witnesses at the inquest were asked about the availability of such a recording device. All of them, all experienced pilots in the aviation industry, were unaware of any such device.

75. Again, such an observation – 'finding' – does not assist me in the exercise of my functions under the *Coroners Act* 1995. And again such a 'finding', absent any evidentiary basis and which leaves highly experienced professionals in the aviation industry genuinely perplexed, casts real doubt on the report generally.

76. Although it is true that a coroner is not constrained by the ordinary rules of evidence and may inform themselves in any way they consider appropriate,[40] there are limits to the use to which material should and can be put. In short, the ATSB report was of so little use as to be, from my perspective, in the performance of my obligations under the *Coroners Act* 1995, worthless. I have no regard to it, other than in a general sense, and, specifically disregard the findings it contains.

Specific issues raised by the scope

77. The circumstances of Ms Walker's flight on 8 December 2018 including the flight path, weather conditions and route taken have been dealt with in detail earlier in this finding.

78. Ms Walker's access to weather forecasting information and the influence, if any, of that access on the planning of a flight such as that taken on 8 December 2018 has also been dealt with in detail earlier in this finding.

79. The applicability of any SOPs relevant to the flight may be dealt with simply by saying that it is clear to me on the evidence that Ms Walker was very familiar with the route by reason of her training and experience. As noted earlier she had flown the very route several times in the week leading up to her crash. Although criticised by the ATSB, I do not think the absence of a written SOP specifically for South West Tasmania operations at the time caused or contributed to the happening of the crash. I note and accept the extensive evidence from Par Avion as to the production of such a procedure after Ms Walker's crash.[41] In particular I have regard to the evidence from Mr Veltkemp and Mr Wells that the production of the written processes and

[39] *Op cit*, page 47.
[40] See section 51, *Coroners Act* 1995.
[41] Exhibit C42.

guidance was in effect no more than a reduction into writing (and other formats) what has already been done for many years before the crash in both operational and training settings.

80. An available route, in the form of the coastal route, existed. The issues associated with the use of that route have been dealt with already earlier in this finding.

Formal Findings

81. Pursuant to section 28(1) of the *Coroners Act* 1995 I make the following formal findings:

    a) The identity of the deceased is Nikita Jo Walker;

    b) Ms Walker died in an aircraft craft which occurred in the circumstances set out further in this finding;

    c) The cause of Ms Walker's death was multiple blunt injuries and incineration; and

    d) Ms Walker died at location 43° 11.04S, 146° 21.42E, Western Arthur Range, Southwest National Park, Tasmania, on 8 December 2018.

Conclusion, recommendations and comments

82. The evidence, viewed as a whole, does not point to any particular factor as especially causative or contributory to Ms Walker's fatal crash. The aircraft was serviceable. Ms Walker was sufficiently experienced and appropriately qualified. She was well rested and unaffected by either drugs or alcohol.

83. Before setting out Ms Walker accessed appropriate weather information. Whatever the deficiencies of that information (and it may be that the applicable GAF was less than ideal) it was not the only source of available weather information. The selection of the direct route by Ms Walker does not seem to have been inappropriate.

84. Why she flew into the Western Portal is not something the evidence enables me to determine with any real certainty. Par Avion submit with some force that;

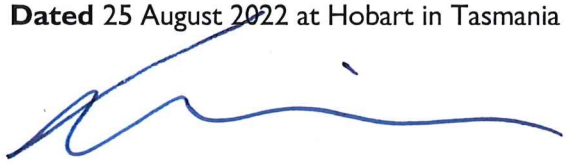
> *"The only interpretation that can be made of the flight path and the altitudes of the aircraft from the time when Ms Walker flew over the saddle between the portals, until the instigation of the left turn immediately before impact, is that she was flying visually and under control throughout that time; and, having made a decision to follow the same track out if she had continued on that part she would have been safely en route back to Cambridge.*
>
> *Whether by that point she had decided to go back to Cambridge or to attempt the coastal route can only be speculation and terms of determining the cause of Ms Walker's death".*

85. In my view, the evidence enables a conclusion that until the very last moment of the flight, immediately before colliding with the Western Portal, Ms Walker remained in complete control of her aircraft. What happened in the immediate moments before colliding with the Western Portal can only be speculation.

86. Neither Mr Nicholson, Counsel Assisting nor Mr Jackson SC on behalf of Par Avion submitted that the circumstances of Ms Walker's death required me to make any comments or recommendations pursuant to section 28 of the *Coroners Act* 1995. I agree. The provisions in the *Coroners Act* 1995 dealing with recommendations and comments are concerned with the prevention of further deaths (recommendations) and public health, safety or the administration of justice (comment). None of these issues arise in my respectful view in this case. A careful analysis and understanding of the evidence relating to her crash does not reveal any systemic issue, whether in relation to the operation of Par Avion or weather forecasting by the Bureau of Meteorology which I consider need to be addressed to prevent future deaths. Similarly, in my view, nothing arose out of the evidence touching upon public health, safety or the administration of justice.

87. In conclusion, I express my sincere and respectful condolences to all who knew and loved Ms Walker on their loss.

Dated 25 August 2022 at Hobart in Tasmania



Magistrate Simon Cooper
Coroner

Annexure A

No.	TYPE OF EXHIBIT	NAME OF WITNESS
C1	REPORT OF DEATH	I/C CONST Justin FOUNTIAN
C2	LIFE EXTINCT AFFIDAVIT	DR Lestyn LEWIS
C3	AFFIDAVIT OF IDENTIFICATION	Sergeant Robin Wilson
C4	DNA IDENTIFICATION REPORT	Carl GROSSER Forensic Scientist
C5	POST MORTEM AFFIDAVIT	DR RICHEY
C6	AFFIDAVIT DNA SAMPLING	Const Ian BELLETTE
C7	POST MORTEM PHOTOGRAPHS AFFIDAVIT	I/C Rance SWINTON
C8	AVIATION MEDICAL REPORT MEDICAL REPORTS	Nikita Jo WALKER (Deceased) Queensland Health
C9	RESUME	Nikita Jo WALKER (Deceased)
C10	AFFIDAVIT	Sergant Andrew FOGARTY
C11	AFFIDAVIT	Const Justin FOGARTY
C12	AFFIDAVIT & PHOTOGRAPHS	Sergeant Damian BIDGOOD
C13	AFFIDAVIT, PHOTOGRAPHS & AVIATION METEOROLOGICAL REPORT	Mr Bryn WATSON Rescue Helicopter Pilot
C14	AFFIDAVIT, MAP DIAGRAM	S/C Joshua PEACH Rescue Helicopter Crew Person
C15	AFFIDAVIT & PHOTOGRAPHS SCENE	Sergeant Robin WILSON
C16	AFFIDAVIT & PHOTOGRAPHS SCENE	Const Nicholas MONK Vehicle, Instruments
C17	AFFIDVIT (SNOK)	Karen Lee WALKER
C18	AFFIDAVIT (SISTER)	Mantina Lea WALKER
C19	AFFIDAVIT (FLAT MATE)	Brock BERGSETH
C20	TRANSCRIPT INTERVIEW	SHANNON WELLS
C21	TRANSCRIPT INTERVIEW	LUUK VELTKAMP
C21A	PILOT RECORDS	NIKITA WALKER
C22	TRANSCRIPT INTERVIEW	COLIN MILLER

C22A	SERVICE RECORDS	VH-OBL
C23	ATSB REPORTS	ATSB Transport Safety Reports
C24	AVATION METEOROLOGIAL REPORT	BOM weather reports
C25	SIGMET MAP	Prepared by Sgt FOGARTY from BOM Data
C26	ROUTE OVERLAY TASMAP VH-OBL FLIGHT AWARENESS LOG	Coordinates logged off Flight Awareness log- Sgt FOGARTY Plotted by Emergency Services GIS
C27	PREVIOUS PAR AVION ROUTES CAMBRIDGE TO BATHURST HARBOUR	FLIGHT AWARENESS DOWN LOAD - Sgt FOGARTY
C28	AMSA JOINT RESCUE COORDINATION CENTRE REPORT	AMSA – CHALLENGER RSCU-660 response log and debrief
C29	AIR SERVICES AUSTRALIA ICAO LOG VH-OBL	Log submitted by Pilot Nikita WALKER
C30	SUBSCRIBER MOBILE PHONE LOG	0421 195 380 Nikita WALKER
C31	ATSB REPORTS	Preliminary Report – 4/2/2019 Update Report – 6/12/2019 General Docs and Protection Orders Requests for information
C32	FLIGHT PASSENGER MANIFEST	Passenger list VH-OBL 8/12/18
C33	SAFETY MANAGEMENT SYSTEM	Par Avion Version Current as 8/12/2018 Revised version current 29/6/2020
C34	AFFIDAVIT	Mark HOLDSWORTH
C35	PILOT'S LOG BOOK	Nikita Jo WALKER
C36	CASA DOCUMENTS	CASA guidance publications
C37	PROPERTY LIST	Nikita Jo WALKER
C38	WORK SAFE	Incident Notice Form
C39	RESPOSNE REPORT	Shannon Wells

C40	EMAIL RECORD	Shannon Wells & Ashwin Naidu
C41	APPENDIX TO OPERATIONS MANUAL CHECKLIST	Par Avion
C42	SOUTHWEST OPERATIONS BRIEF PPT	Par Avion