COLLAERY & COLQUHOUN

LAWYERS

Our ref: BC:LMN S4150/99

30 October 2001

Mr. Michael Halliday
Brisbane Coroner
GPO Box 1649
BRISBANE QLD 4001

Dear Coroner

RE: INQUEST INTO THE DEATH OF ANTHONY EDWARD SHORT

1. We confirm that we act for Dr. Kim Short widow of the deceased Anthony Short and are instructed to request you to conduct an Inquest into the death of the late Anthony Edward Short. Squadron Leader Short is also survived by three children namely, Benjamin David Short born 4 August 1989, Sophie Jordan Short born 1 November 1993 and Abbey Jade Short born 14 October 1995. We are instructed to seek your leave to appear at any Inquest. Our client is distressed by her inability to determine the true cause of her husband's death and seeks the earliest possible Inquest.

Jurisdiction

2. Squadron Leader Short then flying as Flight Lieutenant Short, 6 Squadron, RAAF, was killed on 18 April 1999 at or about 20.21 hours when the F111G he was piloting struck trees on the small island of Pulau Aur in the South China Sea, Malaysia during a Maritime Strike (MARSTR) component of an Air Defence Exercise (ADEX 99-2). Flight Lieutenant Short's remains were returned to Australia by RAAF aircraft on 26 April 1999 and those remains were cremated at Heritage Park Crematorium, Goodna, Queensland on 29 April 1999.

Background

3. The circumstances of the fatal accident are set out in Volume 2 of the Report of the RAAF Board of Inquiry (BOI) dated 2 August 1999 into the accident involving F111G aircraft number A8-291. Volume 2 is the Aircraft Accident Investigation Report dated 11 June 1999. We have prepared a synopsis of the Accident Report **Attachment 1**. The Terms of Reference for the BOI are at **Attachment 2** and are to be compared with your statutory powers pursuant to the Coroners Act 1958. The deceased was, at the

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time of his death a member of a Detachment from No. 82 Wing based at Amberley, Queensland. A copy of the Operation Order for 82 Wing assets to be deployed to Royal Malaysian Air Force Base Butterworth is at Page 1, volume 7 of the BOI Report.

4. Although the Aircraft Accident Report (AAR) identified a number of alleged active failures by the crew these were found to be "…the culminating factors in a combination of local factors, organisational deficiencies and inadequate safety defences." The subsequent RAAF BOI failed to adequately pursue the serious organisational and safety deficiencies identified in the AAR. Instead the findings of the BOI were fragmented so far as they address the manner and cause of Flt. Lt. Short's death. The BOI emphasised systemic failures and a Squadron culture of, "...trust and complacency...".

Relevantly, the BOI found:

- that there had been inadequate pre-flight preparation for the mission including Flt. Lt. Short's failure to adequately check the aircraft route proposed by the navigator Squadron Leader Neil Hobbs so as to realise the significance of the topography of the smaller islands;
- that a primary cause of the accident was "...the failure of Flt. Lt. Short to use all the aircraft systems available to him including Terrain Following Radar (TFR) to reduce the hazards posed by the smaller islands".

Submissions

5. It will be submitted that the findings of the BOI are flawed and in certain aspects contrary to undisputed evidence before the Board. The evidence revealed, inter alia, that Flt. Lt. Short was complying with a standing practice to not employ TFR during a Straight In Silent and Low (SISAL) strike attack.

6. In accordance with SISAL tactics Sqn. Ldr. Hobbs as Mission Navigator planned a two aircraft maritime strike against a shipping convoy in darkness utilising two F111G's code-named respectively, Pisces 1 and Pisces 2.

7. Primary elements of the mission were to ensure simultaneous missile launches at optimal range from low altitude utilising minimal forward radar emissions and exploiting a cluster of islands around which Flt Lt. Short's aircraft Pisces 1 would approach to minimise detection.

8. The evidence before the Board revealed that although of easy going disposition Flt. Lt. Short the RAAF's leading F111 test pilot, was highly competitive in operational sorties. Sqn. Ldr. Hobbs, though less easy going than Flt. Lt. Short set high standards for himself and colleagues. A finding of crew complacency is unsupported by this background evidence and contemporaneous testimony.

9. Moreover, the Mission Plan met the exacting Squadron ethos of the SISAL attack. The BOI finding that Flt. Lt. Short failed to check the aircraft route proposed by the Mission Navigator is inconsistent with undisputed evidence from the accompanying crew of Pisces 2 that the presence of the island cluster was an integral part of the attack plan discussed prior to the Mission. An informed witness told the BOI that he

considered the Squadron had conducted a reasonable risk analysis of the terrain. (Vol. 5 P368).

10. Far from not informing himself of the presence of the islands Flt. Lt. Short (Pisces 1) expected to launch his attack after using the cluster to assist with concealment (BOIR Vol 8 P223 see also Vol 4 P311). Against this evidence the BOI findings against Flt. Lt. Short of complacency, inadequate recognition of topographic hazards and a failure to check the aircraft route are questionable.

11. It will be submitted that most of the evidence before the BOI was uncontroversial. Important issues adverted to in the Aircraft Accident Investigation Report (AAIR), now Vol 2 of the BOI Report were not explored by the BOI. Instead the BOI over emphasised pilot issues and down played serious organisational factors identified by the AAIR. It will be asserted that the unsupported findings against Flt. Lt. Short conveniently exculpated persons of senior rank from prime responsibility for individual command failures.

12. It is relevant that the BOI Report into the 18 April 1999 tragedy is not the first time a BOI Report has been utilised by the RAAF to deflect criticism from command deficiencies. In 1988 a Coronial inquiry at Newcastle NSW into the death of Flying Officer Craig Mackelmann discredited the Report of an RAAF BOI that made unfounded though convenient findings against a pilot. A subsequent apology by the RAAF appears to have been lost sight of.

13. Against this background and subject to the evidence before the Inquest we shall submit that any finding that Flt. Lt. Short was not primarily to blame for the Pulau Aur tragedy should be brought to the attention of the Minister for Defence.

14. The integrity of Boards of Inquiry established under the Defence Act and Regulations is of legitimate public interest. Coronial inquiries into the deaths of Australian Defence personnel depend in large measure upon an honest service inquiry into the death(s) of those whose manner and cause of death is often known only to those within a service structure.

15. Too often a finding of 'systemic failure' is used to blunt enquiry and conceal serious command failures. In this manner breaches of duty of care embraced by the Occupational Health and Safety (Commonwealth Employment) Act 1991 are not pursued. This is an affront to ordinary standards of justice.

16. Significantly, following a similar 'systemic failure' smoke screen by the RAN at the Inquiry into the 5 May 1998 fire aboard HMAS Westralia the worker's compensation insurer Comcare launched its own investigation. In this regard there are close parallels between the issues before the WA State Coroner in the HMAS Westralia tragedy and this Inquest. Defence personnel and their families are members of the public. Coronial findings and recommendations relating to public safety are as apposite for them as they are for the community at large. Dr. Short states that she had little capacity to influence either the Terms of Reference, the membership, or the evidence before the Board of Inquiry into her husband's death.

17. The Terms of Reference for the BOI into the loss of Pisces 1 were oversighted by command officers who were, we shall submit, material witnesses as to command deficiencies that led to the choice of F111G aircraft for the Exercise the deployment of "non-current" aircrew, and the absence of a risk assessment of F111G use in the Maritime Strike role.

18. We are particularly concerned with respect to the advice sought on 18 August 1999 by Air Vice Marshall P.J. Criss then Air Commander Australia from a reserve defence lawyer Lieutenant Colonel R.R.S. Tracey QC. At that time relatives of the deceased were critical of the BOI. It appears that Air Vice Marshall Criss was seeking to deal, *inter alia,* with that criticism. A copy of the BOI Report together with certain other documents were forwarded to Lt. Col. Tracey with a request to, "...conduct a legal review of ...the processes of the Board of Inquiry... and ... the content of the report itself." Lt. Col Tracey's opinion dated 16 September 1999 advised, *inter alia*, that the findings of the BOI were open to the Board **on the evidence**.

19. It is not known to what use Lt. Col. Tracey's opinion was put. We have grave concerns that it was employed to obscure command deficiencies about which there had been correspondence with the Minister for Defence.

20. The inadequacy or irrelevance of seeking a legal view of the BOI is starkly illustrated by Lt. Col. Tracey in his conclusion where after reviewing the Board's findings including the finding that no person was considered blame worthy or negligent in regard to the primary or causal factors he said:

> *15. These findings were open to the Board on the evidence. The picture painted by its report is one of a tragic accident caused by momentary errors of judgment on the part of a pilot and a navigator who were functioning under great pressure whilst flying at great speed at night in unfamiliar airspace. The Board's findings disclose no proper basis for the taking of disciplinary or administrative action against any other Defence members.*

21. It is difficult to comprehend how legitimate public concerns are met by the seeking of an opinion in this matter from a Department of Defence Consultant. Although the Air Accident Report (Vol. 2 of the BOI Report) raised serious OH & S concerns not explored by the Board Lt. Col Tracey restricted his opinion to findings on the evidence without addressing the Air Accident Report itself evidence before the Board. It appears that Lt. Col. Tracey was not briefed on the concerns our client now wishes to bring out from under the carpet at an Inquest.

22. We shall, with respect, be asking that you make comment on any aspect of the BOI that may have obscured the truth as to manner and cause of death. If our submissions are sustained we shall ask that these concerns be brought to the attention of the next Conference of Australian Coroners with a view to eventual discussion by the Standing Committee of Australian Attorney's General.

FURTHER EVIDENCE

CAVR Tapes

19. We are anxious to determine whether the tape from the Compact Airborne Video Recorder (CAVR) recovered from Pisces 1 is of longer duration than the short transcription in the BOI report. We ask that you issue a subpoena for the full tape; any transcription thereof and any Transcriber's Notes. We understand that due to tape play limitations the CAVR would be switched on by the navigator only during significant manoeuvres. As Pisces 1 and Pisces 2 were exchanging route information we ask that you include the Pisces 2 CAVR tape in the subpoena.

BOI Report

20. We submit that the heavily censored BOI Report provided to Dr. Short is unacceptable for coronial purposes. Deletions are excessive and patently unjustifiable in certain instances. For example, deletion of Harpoon missile launch distance data that is already within the public domain.

Model of Sqn. Ldr. Hobbs' Tasks

21. The documentation made available to Dr. Short does not include a modelling of the data entries Sqn. Ldr. Hobbs made to bring his launch coordinates almost onto Pulau Aur.

22. We ask, with respect, that you subpoena all documents relating to any inquiry into the on-board calculation or replication of the navigation tasks undertaken by Sqn. Ldr. Hobbs in the minutes prior to the Pisces 1 simulated missile launch on 18 April 1999. If such documentation is available we request that you issue appropriate directions for the RAAF to produce the data so that Your Worship can be assisted by a model of the calculations. The RAAF does not have a F111G Simulator in which you might view a replication of the tasks undertaken by Sqn Ldr Hobbs.

23. This analysis of Sqn. Ldr. Hobbs' actions is important because the BOI Report does not adequately clarify why he committed such a fundamental error. The evidence shows that Sqn. Ldr. Hobbs planned for Pisces 1 and Pisces 2 to fly around different sides of an island cluster that would serve as the axis for both aircraft to swing around to launch missiles at a naval task force. At a certain juncture both aircraft would ascend momentarily to view the target and to simulate the launch of a Harpoon Missile. The simulation required each aircraft's navigator to broadcast a give-away position called a 'Bruiser' call.

24. The Report of the BOI does not adequately clarify how Sqn. Ldr. Hobbs committed such a fundamental error after carefully planning the mission. In navigating Pisces 1 to a missile launch position Sqn. Ldr. Hobbs directed his missile, his aircraft and his pilot into a island peak he knew about. The fatal directions lasted over four (4) minutes during which time Sqn. Ldr. Hobbs was, according to the Report of the BOI, most probably distracted by mental and physical (knee pad calculations) demands. These are the tasks that we now wish to model. On our instructions it would be relatively easy to simulate the tasks that Sqn. Ldr Hobbs undertook. Modelling Sq.

Ldr. Hobbs tasks of physically loading calculated data into the F111G navigation system such as turn points and dealing with new data points en route for a moving target with TFR off will establish the unsuitability of the F111G aircraft for such operational use.

25. With the TFR off the pilot of Pisces 1 was totally dependant upon the navigator monitoring the Attack Radar (AR) scope. The F111G cockpit configuration allows only the navigator to view the AR scope at night. We also seek further technical evidence with respect to the CAVR recorded performance of the Attack Radar in F111G-A8-291.

Categorisation and Currency

26. We are instructed that Sqn. Ldr. Hobbs lacked 'currency' and his assignment to the Mission breached RAAF procedures. We ask that you issue a subpoena for the production of all records, correspondence and documents relating to Sqn. Ldr. Hobb operational currency for navigation duty on the Exercise. As we are instructed that none of the aircrew in Pisces 1 or Pisces 2 were "current". We ask that the subpoena includes Flt. Lt. Choma, Flt. Lt. Riddell and Sqn. Ldr. Short. This evidence needs to be examined against the 82WG Airworthiness Board Submission for 1988 (82WG 2501/128/Tech 18 September 1998) in particular the claim that the 82 Wing Categorisation and Currency schemes, "...are both extant".

27. Annex F to 82 Wing Standing Instruction (OPS) 2-1 issued 14 December 2000 indicated that the 82 Wing Executive Officer is responsible, "...for ensuring that commitment to exercise and defence support tasks facilitates achievement by operational crews of the current scheme requirement."

28. 82WGS1 (OPS) 1-1 issued 6 January 2000 made Squadron Commanding Officers responsible for flight authorisation of all aircraft operations undertaken by their unit. It has been found that Sqn Ldr. Hobbs authorised the Pisces 1 and 2 Mission. At that time neither he nor other crew were current. The 6 January 2000 S1 makes clear that authorisation cannot be delegated until the delegate has either completed an RAAF Flying Supervisors course or the requirement has been waived by HQ Air Commanding. We ask that you subpoena all 82 Wing Standing Instructions relevant to currency requirements and aircrew supervision as at 18 April 1999. We shall require as witnesses the relevant Wing and Squadron officers who we believe to be Wing Commander David Steele and Flt. Lt. Robert Denny.

TFR Capacity

29. It was Flt. Lt. Short's legitimate expectation that the navigator assigned to the Mission would adhere to the Mission Plan of not overflying any surface contact (BOIR Vol 5 P365). The BOI finding that a primary cause of the tragedy was the pilot's failure to employ TFR did not address the known weakness of TFR in circumstances remarkably similar to the dangerous nature of low level over water flight in conjunction with vertical obstacles with low reflectivity. During Operation Desert Shield USAF aircraft encountered difficulty with TFR operations during low level flight intersections with sand dunes.

30. United States Department of the Air Force Air Combat Command Instruction 11-FM Vol. 5 para 7.16.9.4 15 August 1994 lists tall trees, sand dunes or snow covered peaks in this category. The BOI Report does not contain any indication that a trial flight with TFR operating was undertaken along the same speed, track and attitude to test TFR performance on the approach to Pulau Aur, a steep tall tree canopied volcanic peak rising abruptly out of the South China Sea. Nevertheless the BOI appears to have proceeded in the assumption that TFR would have prevented the impact.

AIDEX Flying Programme Safety

31. It will be our submission that neither the aircraft nor the navigator should have been assigned to the Pisces 1 Mission. In this regard Sqn. Ldr. Hobbs was a victim of command negligence. Although Squadron Executives had attended the Mass Briefing for the AIDEX no risk assessment for the F111G missions was undertaken. The BOI failed to call evidence from the Chief Safety Officer (CSO) whose duty included reviewing the ADEX-99-2 flying programme. We believe the inquest would be assisted by evidence from the CSO. The RAAF should be requested to identify this officer and to produce the minutes of the Mass Briefing. The BOI failed to adequately pursue the circumstances that led to Sqn. Ldr. Hobbs "self-authorising" the Pisces 1 & 2 Mission.

32. These circumstances set uneasily with the 82WG Airworthiness Board Submission eight (8) months earlier:

> "*23. Flying Supervision. In both squadrons only the executives are flight authorisers. CDRSRG and OC82 Wing self-authorise for non-formation sorties. All executives have substantial hours on-type and all have completed the Flying Supervisor Course. All flights are briefed and cleared with the authorising officer if single aircraft sorties and for formation missions the authorising officer monitors the formation brief. Wing SI(OPS) 1-1 is specific regarding the responsibilities and duties of authorising officers and implicitly contains a risk management methodology for aircrew supervision. Developments in a more structured and formalised risk assessment methodology are being monitored*".

F111G Acquisition

33. The F111G aircraft were acquired from the United States Government in the knowledge that the avionics would not be compatible with the Avionics Update Program (AUP) underway for the F111C models.

34. The obsolete F111G analogue systemed aircraft were amalgamated with the digitally systemed F111C aircraft in Nos 1 and 6 squadrons of 82 Wing in the Strike Reconnaissance Group (SRG) with the F111G aircraft intended as an in-use reserve.

35. Although the F111G has no capacity to carry Harpoon missiles it became expedient to use F111G aircraft operationally to relieve pressure on the more serviceable F111C RAAF model that had easier to fly digital systems. Not only was Sqn. Ldr. Hobbs out of practice he was also without the faster less manual digital combat navigation system that went with, inter alia, Harpoon Missile capacity.

36. No operational protocol for the extra demands F111G aircraft imposed on Navigators appears to have been developed. Except for escape procedures no F111G Flight Simulator was provided for F111G crew training. Deploying out of currency aircrew for hazardous and low level strike activity in the IADS Exercise was, we shall submit, a serious command deficiency. We ask that you subpoena all documents relating to crew adaptability training for F111G avionics. We also ask that you subpoena the Statement of Operating Intent (SOI) issued by the Operational Air Worthiness Board from 1998.

37. It will be our respectful submission that command negligence placed an out of currency navigator in an unsuitable aircraft working to F111C SISAL tactics with no risk assessment.

38. We ask that you subpoena the 1999 RAAF Submission to the Airworthiness Board and the 501 Wing Airworthiness Board submission on F111 maintenance for the 1999 Report. These documents were not before the BOI and contain, on our instructions, relevant evidence as to the F111G airworthiness issues. We believe that the BOI findings failed to address time lags in the fitting of essential safety equipment to the F111 aircraft, and, subsisting problems with the F111G airframe and avionics.

Value of the Mission

39. The BOI Report failed to adequately expose the lack of value of the Mission to the RAAF and the RAN.

40. The training for the naval elements of the exercise required Pisces 1 and Pisces 2 to 'paint' or identify their positions immediately after launch and then to fly on at the target as if they were the missiles. This has questionable training value for naval anti-missile warfare personnel and no training value at all for the RAAF. SISAL does not anticipate either missile launch directly at targets or aircraft overflight of a target.

41. In the 21st Century the RAN trains to combat a sea-skimming missile. The BOI did not explore the value of these exercises and no person from Headquarters IADS where the fatal 'exercise' was planned gave evidence at the BOI. We have clear and positive evidence that neither the USAF nor the RAF would countenance such deployment.

42. No evidence as to the operational utility of such a low value high risk utilisation of RAAF assets was given to the BOI. The reason(s) for an essentially symbolic deployment of RAAF resources may relate to the Five Power Defence Agreement and other defence policy issues outside your jurisdiction. Our instructions are to ask that you recommend an Independent Inquiry into RAAF command deficiencies exposed by

this tragedy. In the Thredbo Landslide Inquest the Coroner dealt with management deficiencies by recommending an independent inquiry into the NSW National Parks and Wildlife service. Issues disclosed by the Pulau Aur tragedy have significant implications in Coronial terms for current F111 crew safety. Other matters relating to premature retirement of F111 aircrew (pilot and navigator wastage) and failure to meet RAF and USAF standards of operational effectiveness are properly for an independent inquiry. Likewise, systemic issues that may be of concern with respect to the general defence capacity of the RAAF F111 Squadrons.

Crew Interaction

43. Although the lack of a cockpit voice and data recorder in the F111G was noted by the BOI findings unsupported by the evidence were made critical of interaction between Flt. Lt. Short and Sqn. Ldr. Hobbs. No explanation was given as to why recorders had not been installed.

44. It is regrettable that the only crew conversation records are from the CAVR tape. The CAVR system is not intended as a dynamic record of cockpit conversations. The CAVR shows that in the 3 minutes prior to the 'Bruiser' call Pulau Aur's radar echo passes clearly from top to bottom of the Navigator's Attack Radar screen in direct line of flight. This extraordinary evidence was not the subject of any findings by the BOI. The CAVR tape was not released by the BOI. Flt. Lt. Short is criticised by the BOI for not reminding his navigator of the islands, yet there is no evidence that he did not.

45. Apportioning blame to a pilot avoided the unpalatable fact that the RAAF placed the life of one of its most qualified albeit 'non-current' F111 pilots in the hands of an out of practice navigator who was not equal to his own flight plan. Any competent risk assessment would have identified the risks inherent in assigning the Pisces 1 and 2 aircrews to the Mission.

Global Positioning

46. If crew are to be exposed to such high risk situations then the provision of an enhanced ground proximity warning system should have been a fundamental safety requirement. We are instructed that there were systems such as TERPROM available to reduce risk without give-away radar emissions. We are instructed that USAF and RAF strike aircraft have such equipment. We request that you subpoena all documents relating to proposals to install such equipment in RAAF F111 aircraft. We understand that proposals were long standing at the time of the Pulau Aur tragedy.

47. The US Federal Aviation Authority (FAA) requires all commercial passenger aircraft to have an enhanced ground proximity warning system installed. Our client and the public, particularly those resident near exercise areas are entitled to know why commercial aircraft have a more reliable terrain warning system than the RAAF F111. It is apparent from documentation available to us that RAAF F111G deployment did not meet the USAF Air Combat Command Instructions existant in 1999.

48. Maintaining SISAL procedures without TFR when terrain avoidance systems were being sought by aircrew requires explanation from the RAAF. In this regard we propose to seek your leave to call certain evidence from a former RAAF flight and research and development officer.

USAF Evidence

49. We also have to hand USAF training manuals used by Sqn. Ldr. Short and evidence from a USAF former F111 Navigator. It is apparent that the USAF would not employ the RAAF SISAL no TFR procedure. As this witness is currently deployed on active duty calling him is impractical. We need to reach an understanding with the RAAF on the admission by consent of evidence that neither the RAF nor USAF conduct SISAL no TFR low level strike activity. Otherwise, we propose that you seek assistance through the Office of the Defence Attache, Embassy of the United States, Canberra.

Directions

50. We respectfully ask that there be an early Directions Hearing with respect to the Inquest.

Witnesses for Subpoena

GRCPT Kevin Paule former (02 82 Wing, Department of Defence, Russell Offices, Canberra
WG. Cdr. David Steele Department of Defence, Russell Offices CBR
Flt. Lt. (Retired) Gregory CHOMA (Pilot of Pisces 2)
Sqn. Ldr. Geoff Harland RAAF (Navigator)
Flt. Lt. David Riddell (Navigator Pisces 2)
Flt. Lt. (Retired) Brendan Williams, Electronic Engineer.
Flt. Lt. Robert Denny, (former Categorisation and Currency Officer 6 SQN) RAAF Base Edinburgh S.A.

Yours sincerely

BERNARD COLLAERY

COLLAERY & COLQUHOUN

LAWYERS

Our Ref: BC:TH:S4150/1

19 December 2001

Honourable Senator Robert Hill
Minister of Defence
Parliament House
CAPITAL HILL ACT.

Dear Minister

We act for Dr Kim Short widow of Squadron Leader Anthony Short RAAF who died on 18 April 1999 during a maritime strike mission in the South China Sea.

Your colleague Bruce Scott MP wrote to our client on 15 November 2001. Mr Scott's letter represented a reply to our client's letter of almost 12 months earlier. In the intervening 12 months we have requested, and the Brisbane Coroner has acceded to an inquest into the death of Squadron Leader Short.

We have made detailed submissions to the Brisbane Coroner. We shall be agitating a number of issues at the inquest and at large with respect to the inadequacy generally of Defence Boards of Inquiry into, *inter alia* tragedies of this kind.

The self-serving propositions put forward in Mr Scott's letter are deeply flawed. The *Caesar unto Caesar* aspect of Boards of Inquiries has been of concern generally within the legal profession for some years. That concern is well illustrated with respect to two recent BOI's affecting the deaths aboard HMAS Westralia on 5 May 1998 and the F111 accident on 18 April 1999. We are retained in respect of both of these inquests.

The F111 BOI failed to adopt terms of reference responsive to an earlier Air Accident Report on the tragedy. This deflected the Inquiry onto flight and crew issues and away from lamentable occupational health & safety shortcomings identified by the Air Accident Inquiry. The Board of Inquiry failed to properly pursue why both of the aircrew who died were uncurrent and why serious command deficiencies placed aircrew in adverse circumstances.

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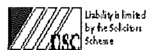

The employment of "defence consultants" to "represent" relatives' interests is a serious shortcoming identified over the years and a matter that we strongly enjoin you to look at early in your term as Minister.

With respect to the F111 accident a defence consultant Richard Tracy QC gave an opinion conveniently sought by the RAAF and relied upon by Mr Scott to suggest that the findings of the BOI were open to the Board on the evidence. This fatuous claim had relevance only so far as the evidence presented to the Board was relevant to the primary cause(s) of the accident. The primary causes in our view and the view of the Air Accident Report included command deficiencies and these matters were barely touched upon by the BOI.

Lt. Col. Tracy, as he is otherwise known, said *inter alia*:

> *15. These findings were open to the Board on the evidence. The picture painted by its report is one of a tragic accident caused by momentary errors of judgment on the part of a pilot and a navigator who were functioning under great pressure whilst flying at great speed at night in unfamiliar airspace. The Board's findings disclose no proper basis for the taking of disciplinary or administrative action against any other Defence members.*

This simplistic picture may have pleased those in command however we doubt that it will satisfy the Coroner. It was distressing for Dr Short to receive such an insincere letter from Mr Scott – drafted no doubt by the RAAF.

We shall be addressing you again following the forthcoming inquests on the need for a full review of the law, practices, procedures of Defence Boards of Inquiry.

Yours sincerely

BERNARD COLLAERY

cc. **Dr Allan Hawke**
Secretary
Department of Defence

We advise that our office will be closed over the Christmas period from 5:00pm Friday 21 December 2001 until 8:30am Monday 7 January 2002.

The staff of Collaery & Colquhoun wish you and your family a Merry Christmas and a Happy New Year.