



Transport Accident
Investigation
Commission

Briefing for the Incoming Minister **He kōrero whakamārama mō te Minita**

November 2023

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About the Transport Accident Investigation Commission

Te hanga nei, a Te Kōmihana Tirotiro Aituā Waka

Our purpose

Our purpose is to improve transport safety

The Transport Accident Investigation Commission (the Commission) is a standing commission of inquiry. We conduct independent, safety-focused, inquiries into certain accidents and incidents (occurrences). The purpose of an inquiry is to help avoid similar occurrences happening again, not to apportion blame or liability. We publish a report of our findings and recommendations for each occurrence we investigate. Our recommendations are not mandatory.

The Commission works in the aviation, rail, and maritime transport modes.¹

Our mission is safer transport through investigation, learning and influence

The Commission improves safety by responding to certain transport accidents, gathering evidence, undertaking in-depth analyses, and communicating what we have found as well as what needs to change. Our independence and impartiality mean that people can speak to us about what happened without fear of prosecution.

The voluntary nature of our recommendations means we rely on others to take safety actions. Many of our recommendations are to transport sector regulators – who are best placed to make system-level changes – and most of these recommendations are accepted.

Our legislation

Our legislation gives effect to International Conventions

The Commission's enabling legislation is the Transport Accident Investigation Commission Act 1990 (the Act), and we have the powers of a commission of inquiry under the Commissions of Inquiry Act 1908. The Act prescribes the Commission's purpose, which is "to determine the circumstances and causes of accidents and incidents with a view to avoiding similar occurrences in the future, rather than to ascribe blame to any person".²

TAIC was established consequent to the aftermath of the Erebus disaster. At that time, the Office of Air Accidents Investigation, which was part of the Ministry of Transport, investigated aviation accidents in New Zealand. Establishing TAIC in the form of a standing commission of inquiry meant New Zealand could achieve greater compliance with the Convention on International Civil Aviation (ICAO Convention). Annex 13 of the ICAO Convention relates to independent safety-focused aviation accident investigations.

¹ Sections 2 and 8 of the Transport Accident Investigation Commission Act 1990.

² Section 4 of the Transport Accident Investigation Commission Act 1990.

We were given the power to inquire into rail accidents in 1992. Three years later, our mandate was further extended to inquire into maritime accidents to support New Zealand's obligations as a member of the International Maritime Organization (IMO) and the International Convention for the Safety of Life at Sea (SOLAS). The IMO's Maritime Casualty Investigation Code requires an independent body to investigate maritime accidents and incidents to avoid further occurrences rather than to apportion blame or liability.

We are prohibited from disclosing evidence

Under the Act, evidence gathered during an investigation has extensive legal protection from disclosure. Further, none of the Commission's published findings, recommendations, or reports can be used in legal proceedings, except in a coronial inquest.

Our independence and protection of evidence mean people can speak to us freely about what happened in an accident without fear of prosecution. We can then better understand what happened so we can make recommendations on how to avoid similar accidents.

Our functions

Our functions are investigation, inquiry, and publication of findings and recommendations

The transport sector regulators are required under their respective Acts to notify the Commission of certain accidents and incidents. For each notified occurrence, the Commission decides whether to launch an inquiry. We must launch an inquiry if we believe that an occurrence has (or is likely to have) significant implications for transport safety or an inquiry would allow us to make recommendations that would improve transport safety.³

Each inquiry has two broad, overlapping, phases – investigation and inquiry – followed by publication of findings and recommendations.

- In the investigation phase, the Commission's investigators gather and analyse evidence using delegated powers. The Commission directs the investigation and decides which other parties (if any) should be involved.

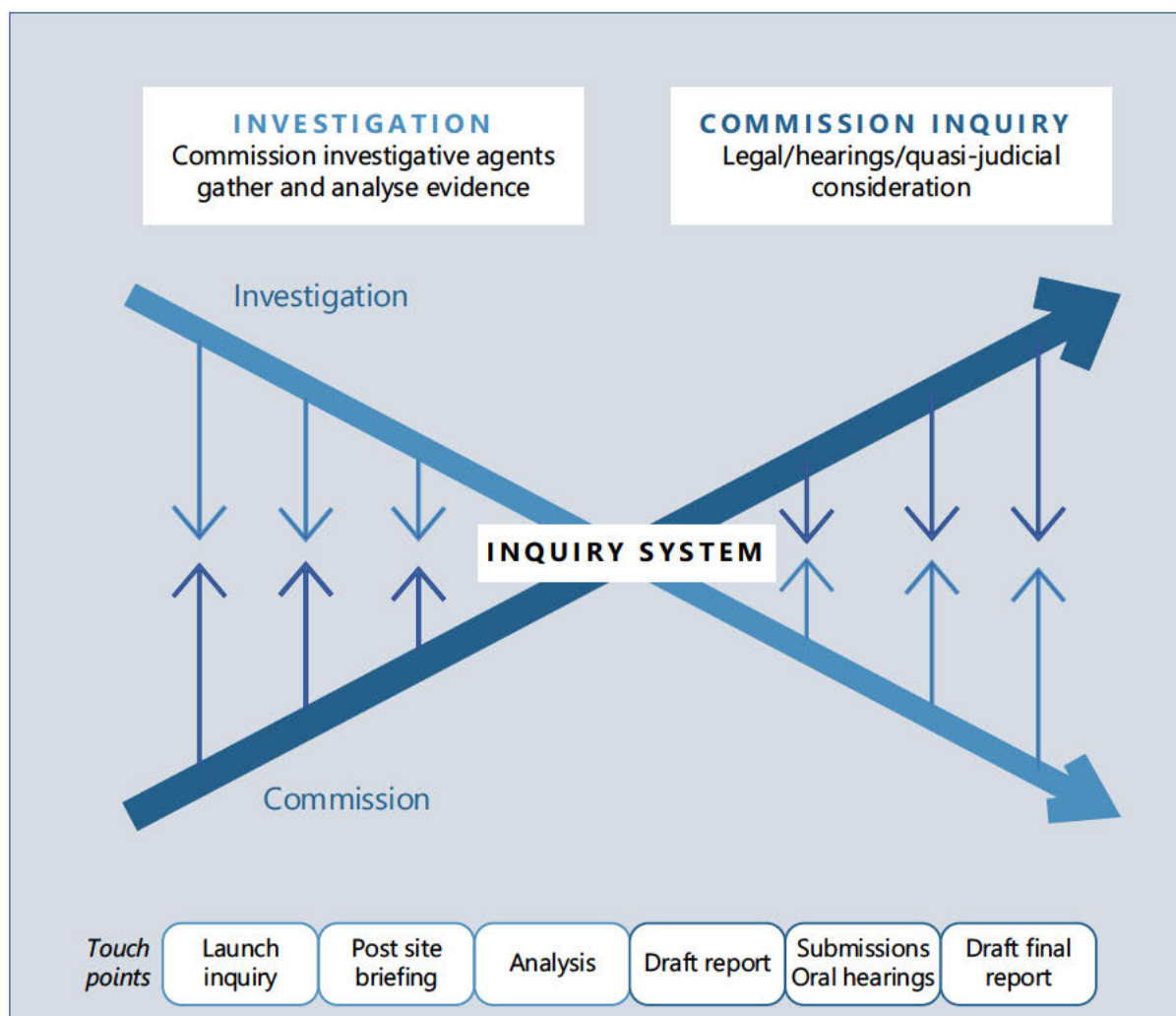
Under the Act, the Commission's investigative powers are broad, including the power of entry and inspection, and the power to seize, remove and protect evidence. We also have powers under the Commissions of Inquiry Act 1908, including the power to require a person to produce any papers, documents, records, or things; or to summons any person to appear before the Commission. The Act protects the evidence we gather from general disclosure, except for the purposes of the investigation. This includes witness interviews.

- In the inquiry phase, the Commission considers evidence gathered by investigators, expert advice, and submissions from consulted people and organisations. The Commission may also hold hearings.

³ Section 13 of the Transport Accident Investigation Commission Act 1990.

Once we have made our determinations, we publish a full report of the inquiry, including findings and recommendations. The Commission's recommendations are not mandatory.

The diagram below shows the 'touch points' between the investigation and inquiry phases.



We are an independent Crown entity

As well as being a standing commission of inquiry, the Commission is an independent Crown entity under the Crown Entities Act 2004. The Commission is Crown funded with a budget of \$9.3 million in the 2023/24 financial year.

The Commission currently has five members, the maximum permitted by law. Commissioners also act as board members for the purposes of the Crown Entities Act 2004. Appendix 1 has more information about the Commissioners and the Executive Leadership Team.

Our place within the national and international transport systems

The Commission's inquiries are concerned with system-level safety issues

A single accident or incident triggers an inquiry. The chain of events leading to it may appear to be clear, particularly those facts and factors closest to the occurrence. However, incidents and accidents rarely have a single cause; contributing factors are often complex and reach beyond the accident vehicle and its operation to wider systemic issues. The Commission's attention is on these system-level safety issues. This may include examining the performance of regulators or identifying where legislation might be improved.

The Commission directs many recommendations to regulators, who can influence and act on the whole transport system, which is highly complex. Assessing and implementing a recommendation can take a long time, especially if it requires legislative change.

TAIC's legislation places no obligation on the recipients of recommendations to report if, how, or when they intend to implement them. As a matter of good practice, every year, the transport sector regulators⁴ voluntarily report to you their response to TAIC recommendations and progress in implementing the recommendations they have accepted. TAIC collates this information on your behalf and publishes it on the TAIC website.

In 2021 TAIC met with policy officials from the Ministry of Transport and proposed a policy position where recommendation recipients must tell TAIC whether they accept, accept in part, or reject recommendations addressed to them. The Commission would have the power, at its discretion, to require an update on implementation of recommendations accepted or accepted in part and recipients would need to provide this update within a certain time. Updates may be published on TAIC's website, and reported to regulators, the Ministry, and/or the Minister.

9(2)(f)(iv)

We operate alongside other transport safety authorities

The Commission operates alongside, but independently from, regulators who may also investigate transport accidents and incidents for different reasons. Often, a regulator's focus is to determine whether an operator has complied with regulations and, if not, to establish whether it should take enforcement action. Regulators may also be responsible for pursuing health and safety prosecutions under the Health and Safety at Work Act 2015.

Coroners have an interest in transport accidents that result in fatalities. The New Zealand Police investigate an accident on behalf of the Coroner and may pursue a criminal inquiry. The Coroners Amendment Act 2016 clarified the roles of Coroners and other authorities that investigate deaths and accidents.

⁴ Maritime New Zealand, the Civil Aviation Authority, and Waka Kotahi New Zealand Transport Agency.

We are part of a global network of transport accident investigation bodies

The Commission is part of a global network of transport accident investigation bodies prepared to meet their State's obligations to conduct independent investigations consistent with international treaties. The Commission may support an international agency's investigation of an event with a New Zealand connection; and in some circumstances an international body has a right to participate in a TAIC-led inquiry (for example, if the operator is registered overseas or the vehicle involved was manufactured overseas).⁵

⁵ In accordance with Annex 13 of the ICAO Convention and s14(2) TAIC Act 1990

Strategy and organisational structure

Rautaki me te ahurea whakahaerenga

Strategic direction and objectives

Our aspirational goal is *No repeat accidents – ever!*

The Commission's strategy focuses on an aspirational goal expressed as a visionary statement: *No repeat accidents – ever!* The Commission strives for this goal by identifying safety issues, publishing our findings, and, where appropriate, making recommendations to relevant parties. The Commission is mindful of our form as an independent Crown entity, and our obligations to operate effectively and efficiently.

The Commission's *Statement of Intent 2021-2025* (SOI, Attachment 1) describes our contribution to overarching transport sector outcomes. We contribute to the outcome 'protecting people from transport related injuries' by identifying safety issues through rigorous investigation and inquiry, and transferring the knowledge we gain to transport sector participants, so they are able to improve safety systems.

The Commission has three strategic intentions:

- Be accessible – maintain an accessible body of knowledge.
- Be credible – maintain the highest standards in investigation process.
- Be ready – maintain readiness for a large-scale event.

Our strategy is strengthening human and information capital to enable knowledge transfer

The Commission is operating within an environment where rapid technological change is disrupting the transport system. For the Commission, the information we use in an investigation is increasingly digital and might not be part of the physical evidence found at the site of an occurrence (for example, cloud-based software and data used in navigation systems). The challenge for the Commission is maintaining our ability to make credible determinations in the face of advancing technology – or any other disruption.

To remain credible and influential, we must be able to:

- adapt to changes in the transport system
- properly identify safety issues
- transfer the knowledge we have gained through investigation
- communicate our findings in a way that influences others to act.

We are responding to this challenge by building resilience, specifically, strengthening human and information capital. Resilience includes having strong systems and processes to support knowledge transfer within and beyond the organisation. Knowledge transfer is about capturing and organising data and information and creating and distributing information and knowledge. It can happen from one person to another or via retrievable form (such as a document, image, or video). Physical assets, people, and processes work together to enable knowledge transfer.

The Commission's current focus is on the digital aspects of our 'Knowledge Transfer System'. This is more than IT assets – it includes the people who provide supporting capability and those who can leverage the opportunities for improved transport safety and improved organisational performance (for example, trend analysis or video presentation of findings).

We have a programme in place to develop cultural competency

TAIC is committed to developing the cultural capability and capacity of our people. We are currently in the third year of a cultural competency programme designed to weave te ao, te reo and mātauranga Māori through our investigation and Crown entity practices.

The current SOI covers a period of significant change

The Commission's current SOI covers a period of significant change to IT systems as well as to other resources and processes that will help to realise the full benefit from the new systems. (See 'Current matters – Organisational activities' below).

The current SOI builds on work in earlier planning cycles. The previous SOI was concerned with strategic review and initial planning for a contemporary knowledge transfer system. This included the development of a Digital Transformation Strategy in anticipation of the need to replace IT systems that were reaching end-of-life. The Digital Transformation Strategy has three individual but integrated strategies: a Data Strategy/Information Management and Communications Technology Plan, a Communications Strategy, and a Research Strategy.

Increased funding from 1 July 2023

The growing investment in the rail network and increased emphasis on rail as a mode of mass transit means greater potential for accidents and incidents. This is especially so in metropolitan areas where the rail network interfaces with busy road networks.

Improved safety and public confidence in the use of rail for mass transit are vital for its success. The additional resource gives us greater capacity for identifying problems within the system and opportunities for improving safety for transport users and rail workers.

From 1 July 2023, our funding increases from \$7.2 million to \$9.3 million. Most of the funding is to provide for five new FTEs to increase rail investigation capacity and capability and provide improved resilience in investigation services. As a small organisation required under our Act to respond to certain transport accidents, we have little (in some cases, no) spare capacity to manage increased demand for our services or staff turnover. (See 'organisational structure' below.)

Some of the additional funding is for managing cost pressures

Part of the additional funding will help to manage cost pressures. Again, with our small size, we can struggle to manage the effect of wage increases. Sustained pressure on capacity has the potential to reduce our ability to meet statutory obligations and New Zealand's obligations under international treaties.

Performance: volume and timeliness measures

The volume of the Commission's output is demand driven. We expect to publish 15-25 inquiry reports (including interim reports) each year, spread roughly evenly across the three modes. (This increases to 17-27 with the new funding from 1 July 2023.) We aim to close 70 per cent of inquiries within 440 working days, the equivalent of two calendar years.

The 70 per cent target recognises that the Commission's casebook always includes some complex inquiries. Complexities arise for various reasons, including the accessibility of the accident site, technical aspects of the occurrence, and the number or depth of the submissions that the Commission must consider as part of an inquiry.

The ideal loading is 30 open domestic cases to maintain the desired throughput. The Commission also expects to assist four to eight overseas investigations.

For the most recent financial year ending 30 June 2023, we published 16 reports, 15 for completed inquiries and one interim report. Eleven of the 15 completed inquiries (73%) were completed within 440 working days.

On 30 September 2023, the Commission had 28 domestic inquiries in progress: 10 aviation, 9 rail, and 9 maritime. We were assisting 5 overseas inquiries. Appendix 3 has a full list of current inquiries.

Organisational structure

A small number of investigators and corporate staff support the Commission

The Commission is required under statute to employ a chief executive.⁶ On 30 June 2023, the chief executive had an establishment of 31 permanent staff to support the Commission. Staff numbers are made up of:

- 17 investigators, specialist staff and investigation support staff (including the Chief Investigator of Accidents/General Manager Investigation Services)
- 11 corporate staff (including the Commission General Counsel/General Manager Business Services) to support the Commission's investigations and Crown entity accountability and governance functions
- 3 Executive Services staff.

From 1 July 2023, the establishment increased by five: two investigators, two specialist staff, and a support person.

Other individuals and organisations also provide investigation and support services

Suitably qualified individuals or institutions, including other state resources and international colleague agencies, provide some investigation support free under memoranda of understanding or fee-for-service contracts. The Commission sometimes also contracts support functions from individuals or firms, such as information technology, human resources, and medical advisory.

⁶ Transport Accident Investigation Act 1990, Schedule, Clause 21.

Current matters

Kaupapa i nāiane

Inquiries of note

Inquiries into fatalities during port operations

In late October 2023, TAIC published a report into two fatal accidents during ship loading operations. One accident was at Ports of Auckland on 19 April 2022. A stevedore reportedly fell from height during loading operations for a container ship.⁷ The other accident was at Lyttelton Port on 25 April and occurred during loading operations aboard a vessel while it was berthed.⁸

The Minister of Transport at the time directed TAIC to investigate the circumstances and causes of the two accidents and determine any potential system-wide lessons. Such direction is rare; without it these accidents would have been outside our mandate. The direction was made under section 13(2) of the Transport Accident Investigation Commission Act 1990.

The Commission identified broad safety issues for the whole stevedoring sector in three areas: regulatory activity, cohesion in the stevedoring sector, and individual employers' management of safety. The report contained five recommendations.

Climate change and transport safety

The Commission is giving close attention to the effects of weather on transport infrastructure – an emerging issue in the context of New Zealand's changing weather patterns and increasing frequency of extreme weather events.

The importance to transport safety of resilient infrastructure has been highlighted by several of the Commission's recent inquiries. These included three train derailments that followed bad weather (one recently published⁹ and two in progress¹⁰). The most recent of these derailments occurred in January 2023 during a period of extreme weather, particularly in the northern part of the country. Over the same weekend, an aircraft briefly lost directional control on landing during wind gusts and heavy rain¹¹.

Inquiries involving chartered vessels

The Commission has investigated two inquiries concerning chartered vessels one recently published¹² and other still in progress¹³. The accidents involved tragic loss of life, with five fatalities in both instances. The completed inquiry identified safety issues for search and

⁷ MO-2022-203 Port operations accident, Port of Auckland, 19 April 2022

⁸ MO-2022-202 Port operations accident, Lyttelton Port, 25 April 2022

⁹ RO-2021-106: Derailment of Train 220, South of Hunterville, 13 December 2021

¹⁰ RO-2021-104: Passenger train, derailment, Waikanae to Wellington, Kapiti line, 17 August 2021; RO-2023-102: Freight Train, derailment, East Coast Main Trunk Line, near Te Puke, 29 January 2023

¹¹ AO-2023-003: Boeing 777, runway excursion, Auckland International Airport, 27 January 2023

¹² MO-2022-201: Fishing vessel Enchanter, sinking off North Cape, 20 March 2022

¹³ MO-2022-206: Capsize of charter vessel, Goose Bay, Kaikōura, 10 September 2022

rescue operations across New Zealand: knowledge and training of personnel; availability of dedicated aircraft; and the effect of fuel availability on helicopter range. All require the immediate attention of the Secretary for Transport, and the Commission has made recommendations accordingly.

In the other inquiry, we made a preliminary report with three urgent recommendations to Maritime NZ related to the safety of fuel systems. We are continuing our inquiries.

9(2)(g)(i)

The Watchlist

The Watchlist communicates information about safety issues of greatest concern to the Commission

Communications about findings and recommendations is a critical way of influencing the sector to enhance safety. In January 2015, the Commission published the first 'Watchlist', which highlights the safety issues of greatest concern to the Commission.

The Watchlist is reviewed every two years. The most recent review has just been completed and *Watchlist 2023* is scheduled to be published on our website in the latter half of November. The safety issues on *Watchlist 2023* are described below.

18(d)

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Organisational activities

Current organisational focus is on implementing a new case management system

A major organisational focus for 2023 is the implementation of a new case management system, Hubstream. We purchased the system in early 2022 from our Australian counterparts, the Australian Transport Safety Bureau (ATSB). TAIC's and the ATSB's investigation processes are closely aligned. The ATSB provided generous support during the acquisition phase and continues to give valuable assistance and advice during the current implementation phase.

The six months to June 2023 have been a period of training for investigation staff in using the new system. This is progressing well, despite the challenges of also conducting day-to-day business. All new investigations are now being managed using the new system and we expect it to be embedded as 'business as usual' by December 2023.

[REDACTED]

9(2)(g)(i), 6(b)(i)

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Relationship with Ministers

Whakawhanaunga ki ngā Minita

The Commission maintains a 'no surprises' relationship with the Ministers of Transport consistent with statutory independence. Standard elements of the relationship include the:

- receipt of an annual Letter of Expectations from the Minister and preparation of Statements of Intent and Statements of Performance Expectations preparation. Reporting occurs six-monthly against the Statement of Performance Expectations; and annually (through you to Parliament) against the Statement of Intent and the Statement of Performance Expectations
- regular meetings of the Chief Commissioner with Ministers
- briefings to the Ministers about significant recent or forthcoming activity to the extent we are able bearing in mind our confidentiality obligations under the TAIC Act.

The Chief Investigator of Accidents notifies stakeholders, including your office, by email when the Commission has launched an inquiry. The notice provides a general indication of the nature of the inquiry, but the advice is tentative. In most circumstances, the Commission does not contact your office again until the inquiry report is released (unless the Commission is consulting with the regulator or Ministry on a matter).

The evidence protection regime means we are unable to inform you about the detail of specific investigations until the publication of the Commission report. We will keep you informed on progress of inquiries.

Your office receives early advice of the release of a report (including all materials) and is briefed on the release process. Usually, the release of a report involves publication on the Commission's website. Where inquiries have generated public interest, we may hold a press conference.

The Commission generally deals with media inquiries about investigations. It is usual for the Minister to maintain an arm's length from the Commission's inquiries and respond to any media inquiries by noting that an independent body, the Commission, is investigating.

The Commission's communications team will introduce themselves to your press secretary to brief him or her on the Commission's functions and processes.

Appendix 1 Commissioners and Executive Team

Commissioners

The Governor-General, on the recommendation of the Minister of Transport, appoints Commissioners for fixed, renewable terms. Under the Transport Accident Investigation Act 1990, up to five Commissioners may be appointed. There are currently five Commissioners.

Jane Meares (Chief Commissioner)



Jane Meares is a commercial barrister based at Clifton Chambers, Wellington. She is a leading legal adviser with an extensive range of advisory experience in both the public sector and the corporate world.

Alongside her legal practice, Jane has a number of significant governance roles including deputy chair of the Electoral Commission, chair of Financial Services Complaints Limited, and chair of the Royal New Zealand Ballet Foundation. She is also a board member of the New Zealand Film Commission and a member of Land Information New Zealand's risk and assurance committee.

Jane was first appointed a Commissioner in February 2015, and appointed Chief Commissioner in November 2016. Her term expires in November 2026.

Stephen Davies Howard (Deputy Chief Commissioner)



Stephen Davies Howard is a Wellington-based company director. He flew fighter aircraft for the Royal Air Force and served in the Royal New Zealand Air Force as the Training Group Commander. He attained the rank of Group Captain in both services. His strategic international experience includes being an accredited attaché to the British Embassy to the United States. He retains a commercial pilot licence and a commercially endorsed Ocean Yachtmaster's certificate.

Stephen was first appointed to the Commission in August 2015 and appointed Deputy Chief Commissioner in October 2018. His term expires in June 2028.

Paula Rose QSO (Commissioner)



Paula is a Canterbury based director. Her career has seen her in roles which focus on reducing harm. She was formerly National Manager, Road Policing with NZ Police, and deputy Chair of the Independent Taskforce on Workplace Health and Safety. Paula holds a number of governance roles including Deputy Chief Commissioner Te Kāhui Tātari Ture | Criminal Cases Review Commission and Authority Member, Electricity Authority. Previous roles include board positions on WorkSafe NZ, Social Workers Registration Board and the Broadcasting Standards Authority.

Paula is a Hato Hone St John volunteer and is currently a member of the Hato Hone St John Priory Trust Board.

Paula was appointed to the Commission in May 2017. Her term expires in June 2024.

David Clarke (Commissioner)



David brings over 20 years' experience in governance roles in the commercial, public and charitable sectors, including in Chair, finance and audit and risk roles. His 27 years of legal professional experience includes litigation, and corporate and commercial advice for private and listed company boards and public entities.

David was appointed to the Commission in December 2022. His term expires in June 2028.

Bernadette Roka Arapere (Commissioner)



He uri tēnei o Ngāti Raukawa te au ki te Tonga, o Ngāti Tūwharetoa, o Ngāti Maniapoto hoki.

Bernadette is a barrister specialising in public and administrative law litigation and Māori legal issues. She is Deputy Chair of the Teachers' Disciplinary Tribunal, a Trustee of the NZ Law Foundation and Raukawa ki te Tonga Trust, and an active member of Te Hunga Rōia Māori o Aotearoa (the Māori Law Society). Bernadette lives in Whanganui with her whānau.

Prior to joining the independent bar, Bernadette was Crown Counsel at the Crown Law Office in Wellington and a Director of Wackrow Williams & Davies Ltd in Auckland.

Bernadette was appointed to the Commission in December 2022. Her term expires in June 2028.

Executive Leadership Team

The Executive Leadership Team comprises a Chief Executive and two general managers.

Martin Sawyers (Chief Executive)



Martin leads the organisation to support the Commissioners in the delivery of their statutory purpose, which is to help improve transport safety. Martin has extensive legal and senior management experience in the private and public sectors. He comes to TAIC from being Chief Executive and Registrar of the Plumbers, Gasfitters and Drainlayers Board. Prior to that he was General Counsel and Manager of Corporate Services for the Real Estate Agents Authority and also previously managed legal operations at the Department of Corrections.

Martin also brings significant governance experience from his years as Mayor of Buller District Council, Chair of an Electricity Lines Company and Deputy Chair of a State Owned Enterprise.

Cathryn Bridge (Commission General Counsel, General Manager Business Services)



Cathryn is General Counsel to the Commission and General Manager Business Services. She joined TAIC in 2014. She provides legal, constitutional, and risk advice to the Commission on inquiry matters and leads all business services and governance functions. Cathryn has more than 20 years public management experience in legal, operational, policy, and regulatory roles in Crown entities and public service departments in social services, environmental and primary industry sectors. She managed the nationally significant proposals process at the Environmental Protection Authority and has led legal, regulatory policy, and project teams at the Ministry of Fisheries. She has an Executive Master of Public Administration from the Australia and NZ School of Government and an LLB and BA from Victoria University of Wellington.

Naveen Mathew Kozhuppakalam (Chief Investigator of Accidents, General Manager Investigation Services)



As the Chief Investigator of Accidents, Naveen leads the conduct of aviation, rail and marine inquiries opened by the Commission and leads TAIC's investigation team. Prior to this position, Naveen managed rail and maritime investigations. He joined TAIC as a marine investigator in 2011.

Before TAIC, Naveen's worked in shipyards across Japan and the Philippines overseeing the sea trials and delivery of car carrier ships and Cape size and Handymax bulk carriers, and nearly 10 years as a senior marine engineering officer on board commercial vessels plying international trade.

Naveen is a Chartered Engineer; he also holds a Master's degree in naval architecture from the University of Southampton.

Appendix 2 Commission contact

Chief Executive

Chief Executive: Martin Sawyers
Email: ceo@taic.org.nz
DDI: [REDACTED] 9(2)(a)
Mobile: [REDACTED]

Office details

Telephone: 04-473 3112
Physical Location: Level 7, 10 Brandon St
Postal address: PO Box 10 323, Wellington 6143
Website: www.taic.org.nz

Appendix 2 Inquiries in progress on 31 October 2023

Aviation

- AO-2023-011: Close proximity incident, Beechcraft BE76 and Cessna C172, Ardmore, Auckland, 3 October 2023
- AO-2023-010: Mt Pirongia, BK-117 Collision with terrain, 19 September 2023
- AO-2023-008: Close proximity incident involving Q300, ZK-NES and Beech 76 Duchess, ZK-JED, near Brynderwyn, 28 August 2023
- AO-2023-007: Bombardier DHC-8, ZK-NEM, descended below minimum safe altitude, Timaru, 13 June 2023
- AO-2023-003: Boeing 777, runway excursion, Auckland International Airport, 27 January 2023
- AO-2023-001: Airprox, AS350 and EC130 helicopters, Queenstown Airport, 27 December 2022
- AO-2022-005: Boeing 737, ZK-TLL, Incorrect configuration (fuel management), Auckland, 8 June 2022
- AO-2022-002: Helicopter, Inflight breakup, Karamea, 2 January 2022
- AO-2021-003: Helicopter, Impact with terrain, Lammerlaw Range, 16 September 2021
- AO-2020-002: Schleicher ASK 21 glider, impact with terrain, near Taupo, 31 May 2020
- AO-2018-009: MDHI (Hughes) 369D, registration ZK-HOJ, Wanaka, 18 October 2018

Rail

- RO-2023-105: Tamper machine derailment, Purewa Tunnel, Auckland, 9 October 2023
- RO-2023-104: Two passenger trains, SPAD and potential conflict, Penrose, Auckland, 17 June 2023
- RO-2023-103: Safe Working Irregularity, Johnsonville Line, Wellington, 4 May 2023
- RO-2023-102: Freight Train, derailment, East Coast Main Trunk Line, near Te Puke, 29 January 2023
- RO-2023-101: Two Hi-Rail vehicles, collision, East Coast Main Trunk Line near Te Puna, 10 January 2023
- RO-2022-104: Collision of shunt train and heavy road vehicle, Fertilizer Road level crossing, Whangarei, 7 December 2022
- RO-2022-102: Locomotive DC4605 derailment and roll over, Tamaki Auckland, 01 June 2022
- RO-2022-101: Passenger train, Fire in auxiliary generator wagon, Palmerston North, 11 May 2022
- RO-2021-104: Passenger train, derailment, Waikanae to Wellington 'Kapiti' line. 17 August 2021

Maritime

- MO-2023-206: Fishing vessel *Austro Carina*, grounding, Banks Peninsula, 24 September 2023
- MO-2023-205: Bulk Carrier *Achilles Bulker*, loss of rudder, near Tauranga Port, 24 July 2023
- MO-2023-204: Serious injury during crane operations, *Poavosa Brave*, Tauranga, 23 June 2023
- MO-2023-203: MV *Shiling*, loss of propulsion and steering, Wellington Harbour, 15 April 2023
- MO-2023-202: Collision between Passenger Ferry *Waitere* and a recreational vessel near Paihia, Bay of Islands, 13 April 2023
- MO-2023-201: Passenger vessel *Kaitaki*, Loss of power, Cook Strait, New Zealand, 28 January 2023
- MO-2022-206: Charter fishing vessel *i-Catcher*, Capsize, Goose Bay, Kaikōura, New Zealand, 10 September 2022

Overseas assist

AO-2023-009: Miscellaneous involving Embraer E190-E2, registration VH-IKJ, near Napier Aerodrome, 25 May 2023

AO-2023-002: Mid-air collision, two EC130 helicopters near Main Beach, Gold Coast, Queensland, 2 January 2023

AO-2023-005: Collision with terrain, Robinson R22, VH-LOS 36km south of Ramingining, Northern Territory, Australia, 14 November 2022

AO-2023-006: Collision with terrain involving Robinson R22, 2 October 2022

AO-2018-003: PAC 750 XL Aeroplane, engine abnormality requiring engine shut-down and glide landing, Sentani Airport, Jayapura, Papua, Indonesia, 21 May 2018