First Supplemental Submission of the Civil Aviation Safety Authority

to the Senate Standing Committee on Rural and Regional Affairs and Transport

Inquiry into Aviation Accident Investigations (Pel-Air)

1. Introduction

1.1 The Civil Aviation Safety Authority (CASA) welcomes the opportunity to provide the Committee with 'specific responses' to the submissions of Mr Mick Quinn, Mr Bryan Aherne and Mr Gary Currall, before those submissions are published on Monday, 29 October 2012.

1.2 We do so on the understanding that CASA may make further supplemental submissions after that date, and in anticipation of a possible opportunity to appear again before the Committee to provide additional evidence.

1.3 On this basis, CASA provides here our first supplemental submission, which contains:

- general remarks about each of the three submissions mentioned above; and
- some specific and necessarily limited responses to certain claims, contentions, allegations and statements appearing in those submissions, in respect of which we believe it is important to ensure that the Committee has correct and complete information.

1.4 CASA looks forward to a further opportunity to elaborate on aspects of the comments we provide here, and to respond to some of the similarly inaccurate, incomplete, ill-informed and consequently misleading information that was given in oral evidence by some witnesses before the Committee in the hearing on 22 October 2012.

2. Submission of Mr Mick Quinn—General Remarks

2.1 CASA does not question Mr Quinn's credentials and qualifications as an aviation safety advisor with considerable experience. However, we find it passing strange that Mr Quinn fails to mention in his submission that he served as CASA's Deputy Chief Executive Officer for Operations from December 2007 until June 2009, and as CASA's Deputy Director from July 2009 until he separated from CASA in January 2010.[1]

[1] In his oral evidence before the Committee on 22 October 2012, Mr Quinn acknowledged only, and inaccurately, that he served as 'the deputy chief executive officer of CASA, until January 2009'.

2.2 This is important because, during the whole of Mr Quinn's tenure at CASA, he held the most senior position in the Authority, below that of the Director of Aviation Safety, with responsibility for what today constitutes CASA's Operations division. In that position, Mr Quinn himself would have had penultimate accountability for any alleged shortcomings or deficiencies in CASA's safety oversight functions in relation to Pel-Air during an extended period of time prior to the accident, and for a shorter period of time after the accident.

2.3 In light of the 20-year personal relationship Mr Quinn acknowledges he has had with Mr James, CASA believes questions may fairly be raised about Mr Quinn's ability to maintain an appropriate measure of objectivity and professional detachment in relation to his assessment and analysis of aspects of the issues canvassed in his submission. Such questions, CASA submits, are at least as deserving of consideration as are Mr Quinn's unsubstantiated and frankly offensive suggestions of a collusive relationship between CASA and the ATSB.

2.4 Mr Quinn devotes a considerable portion of his submission to the overriding significance of the role of certain 'organisational factors' within Pel-Air as more likely to have caused or contributed determinatively to the accident than any 'individual active/failures' for which Mr James might be held accountable. In advancing these arguments, Mr Quinn draws extensively on the well-known model developed by Professor James Reason, as a device to explain what Professor Reason described, in 1997, as 'organisational accidents'.[2]

2.5 CASA has the highest regard for the important, seminal work Professor Reason has done, and the invaluable contribution his theories have made to the enhancement of aviation safety. At the same time, however, we recognise—as Professor Reason himself does in his more recent analytical work in this field[3]—that the significant role and potential consequences of decidedly individual conduct should not be discounted.

2.6 As readily as Mr Quinn is inclined to press an organisational analysis into service in this particular case, conveniently shunting responsibility away from his friend, Mr James, and towards Pel-Air, CASA and the Bureau of Meteorology, he has been quite prepared in at least one other recent case to effectively turn this kind of analysis 'on its head', in support of the air service provider that had engaged his services as an expert in that instance, Avtex Air Services Pty Ltd (Avtex).

2.7 In an unsuccessful challenge of CASA's decision to cancel the Avtex's Air Operator's Certificate in 2010, Mr Quinn offered evidence of that organisation's approach to safety in terms similar to those he invokes in his characterisation of Pel Air. Having found that Mr Quinn sought and relied on factual input more or less exclusively from persons who would offer only a favourable assessment of his client's operations, the Tribunal said:

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[2] James Reason. *Managing the Risks of Organizational Accidents.* Aldershot: Ashgate Publishing Ltd, 1997.

[3] See James Reason, *The Human Contribution: Unsafe Acts, Accidents and Heroic Recoveries.* Farnham: Ashgate Publishing Ltd, 2008.

'With the greatest respect to Mr Quinn, I find it difficult to understand how he could come to the conclusions he has without interviewing Mr [M] and Mr [C]. Given that Mr Quinn was asked to advise Avtex for the purposes of the hearing before this Tribunal regarding the suspension of the Avtex and Skymaster AOCs, if his investigation was truly impartial, he would have interviewed not only Mr [M] and Mr [C], but also Mr [O] and Mr [L]. By doing so, he may have been able to determine whether those persons were acting from their own volition, or whether their acts . . . was something which had become inculcated into those organisations. In my opinion, simply interview personnel who have a very strong interest in having the suspension of the AOCs overturned . . . is unlikely to produce a balanced view.'[4]

2.8 In conclusion, the Tribunal said:

'As for the independent expert evidence given by Mr Quinn, while I have no doubt that Mr Quinn provided a forthright account of his findings when examining Avtex's operations, it was based on very limited material. . . . His interviews were with persons who had an interest in putting forward the best possible view of Avtex's operations. He nevertheless concluded that Avtex's operation was between reactive and calculative . . . . Despite that, Mr Quinn provided a favourable report regarding Avtex's safety culture. . . .In my view, Mr Quinn's assessment was correct, but his conclusion is plainly incorrect.'[5]

3. Submission of Mr Mick Quinn—Specific Responses

3.1 Organisational Latent Conditions

3.1.1 At pages 4 to 8 of his submission, Mr Quinn lists, in 'dot points' without elaboration or substantiating detail, instances of what he identifies as evidence of latent organisational deficiencies within Pel-Air, the ATSB, the Bureau of Meteorology and CASA. Reserving our prerogative to further address the claims Mr Quinn has made in relation to CASA and other organisations where these are incorrect, incomplete or otherwise misleading, the focus of our comments in this submission is on a selection of the claims Mr Quinn has made that are expressly directed at CASA.

3.1.2 At page 5 of his submission, Mr Quinn states:

[CASA] FAILED TO PROVIDE ADEQUATE OVERSIGHT OF PEL-AIR OPERATIONS. IT IS UNLIKELY THAT THE DEFICIENCIES LISTED IN THE CASA SPECIAL AUDIT HAD MATERIALISED SINCE THE PREVIOUS PEL-AIR AOC AUDIT

CASA rejects this contention.

3.1.3 Consistent with CASA's audit schedule and surveillance protocols current at the time, CASA conducted audits of Pel-Air's operations in 2006, 2007 and 2008. In the course of each of these audits, findings and observations were

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[4] *Avtex Air Services Pty Ltd and Civil Aviation Safety Authority* [2011] AATA 61, at para 192.

[5] Ibid., at para 388.

made and conveyed to the operator, who was expected (and in some cases, required) to address any deficiencies identified.

3.1.4 CASA's 2006 audit of Pel-Air was an entry control assessment exercise, conducted in connection with Pel-Air Pty Ltd's application for an Air Operator's Certificate, combining the operations previously carried out by Doskite Pty Ltd and Pel-Air Express Pty Ltd. In the course of that audit, findings related to maintenance control, training and checking, fatigue risk management and pilot rostering. As Mr Quinn himself has noted, it is not unusual, and not necessarily a matter of significant concern, that findings in a range of areas should be made during the course of an audit. What is important is that the operator demonstrates both the ability and the willingness to address those issues in a timely and effective manner. In this instance, Pel-Air implemented appropriate corrective action.

3.1.5 The audit CASA conducted in 2007 was a systems audit, in the course of which findings were made in relation to Pel-Air's training and checking and fatigue risk management systems. On this occasion too, the operator implemented appropriate corrective action.

3.1.6 In 2008 CASA's audit of Pel-Air was risk-based and initiated (6 months after the 2007 audit) on account of certain recurrent findings, particularly in relation to fatigue risk management. Further findings in this connection were again made, identifying deficiencies in the training of pilots in the application of the company's Fatigue Risk Management System. CASA issued a Safety Alert to Pel-Air, requiring the operator to address this matter before further operations were conducted.

3.1.7 Having particular regard to the recurrent findings identified in the 2008 audit, CASA raised its concerns with Pel-Air, and the operator's parent company, Regional Express, about the performance of Pel-Air's then chief pilot, Mr Ian 'Wally' Meyer.

3.1.8 In response to the concerns raised by CASA, Pel-Air identified and nominated a new chief pilot, Mr John Wickham, who was employed by Regional Express at the time. CASA assessed Mr Wickham and approved his appointment as chief pilot for Pel-Air on 21 November 2008.

3.1.9 Audits involve a sampling process of operational compliance, effectively amounting to a 'snap shot' of activities at the time the audit is conducted. In intervals between audits, CASA must necessarily rely on operators, and such other credible advice as may come to CASA's attention, to inform CASA of any changes to their operational activities that may have significant safety-related and regulatory implications.

3.1.10 It is not unusual that issues identified in the course of an audit should appear again in the course of a subsequent audit. The nature of the issues involved and the nature of the action CASA had taken (or has required the operator to take) in relation to those matters on previous occasions will determine the action CASA may take when they are identified in a subsequent audit.

3.1.11 That some of the findings made in the course of the post-accident special audit involved issues that may have existed earlier, but had not come to CASA's attention until then, reflects the fact that CASA's current approach to the conduct of audits utilises multi-disciplinary teams consisting of airworthiness, flying operations, safety systems and fatigue-management experts. Such an approach, which is now commonly employed in CASA audits, is calculated to yield better and more refined results. It is indicative of the continuing improvement approach CASA takes to its audit and surveillance processes that some issues identified in the special audit had not been identified earlier.

3.1.12 It is also important to recognise that details provided by operational personnel spoken to in the course of an audit will often be more revealing, candid and informative in the wake of an accident than they will normally be under ordinary circumstances. Most of Pel-Air's Westwind pilots were interviewed in the course of the special audit, whereas normally only a sample of pilots would have been interviewed.

3.1.13 CASA readily acknowledges that its audit and surveillance processes were better in 2010 than they were in earlier years, and that they are better today than they were even two years ago. For all that, we reject Mr Quinn's claim that CASA 'failed to provide adequate oversight of Pel-Air Operations'. If Mr Quinn is of the view that this is so, perhaps he is in the best position to address the matter, since he was the senior CASA executive accountable for CASA's oversight functions in the years preceding the accident.

3.1.14 At page 6 of his submission, Mr Quinn states:

CASA SURVEILLANCE DID NOT IDENTIFY THE INADEQUACIES OF PEL-AIR'S FATIGUE MANAGEMENT SYSTEM

CASA rejects this contention.

3.1.15 In its special audit, CASA most certainly did identify inadequacies in Pel-Air's Fatigue Risk Management System (FRMS) and the audit report discusses those inadequacies in some depth. If Mr Quinn is suggesting these inadequacies ought to have been detected earlier, it is important to understand that the science informing modern fatigue-related analyses and the development of appropriate FRMS is a modern, evolving process, involving issues on which reasonable experts may differ.

3.1.16 CASA's assessment of Pel-Air's FRMS in years past was based on then contemporary theories and understandings. As discussed above, CASA identified deficiencies in Pel-Air's FRMS, and the operator implemented corrective action to address these issues. On finding, during the course of the audit conducted in 2008, that Pel-Air had failed to provide required training for its pilots in the application of the company's FRMS, a Safety Alert was issued accordingly.

3.1.17 CASA's approach to FRMS at the time the special audit was conducted, like our approach today, is further advanced and more sophisticated than it was previously, and it will surely be advanced further still in the future.

3.1.18 At page 6 of his submission, Mr Quinn states:

CASA SURVEILLANCE FAILED TO IDENTIFY THAT THE WESTWIND AIRCRAFT WERE NOT SUITABLE FOR OPERATIONS IN INTERNATIONAL AIRSPACE, PARTICULARLY WITH REGARD TO RVSM, DESPITE ADVICE FROM ICAO

CASA rejects this contention.

3.1.19 There is no requirement for aircraft to be approved for Reduced Vertical Separation Minimum (RVSM) operations. Moreover, although the Westwind aircraft involved in the accident was not RVSM approved, it was perfectly capable of operating at RVSM altitudes (29,000 to 41,000 feet), and indeed did so.

3.1.20 Aircraft that are not RVSM approved may lawfully operate at those altitudes, if a timely request of the responsible air traffic control (ATC) authority is made and granted. If a proper request has been received by an administering ATC authority, it will be granted so long as the operation does not conflict with the operation of RVSM approved aircraft.

3.1.21 At page 6 of his submission, Mr Quinn states:

HIGH RISK OPERATIONS SUCH AS EMS WERE CATEGORISED AS AERIAL WORK AND NOT DIFFERENTIATED BASED ON RISK I.E. PASSENGER/PARTICIPANT CARRYING EMS OPERATIONS

CASA rejects the contention that emergency medical service (EMS) operations are inherently 'high risk' operations.

3.1.22 The level of risk involved in any aviation operation will depend upon the nature of the operations being conducted, and the circumstances under which they are conducted at the time. A turbo-prop aerial ambulance operation transferring a seriously ill patient from a regional centre to a capital city many not involve any particularly significant risks attendant on the nature of the operations involved. Likewise, the transfer of a patient in a jet aircraft, from an overseas location to Australia will not necessarily entail significant risks inherent in that type of operation. By way of comparison, a helicopter making a road-side landing in marginal weather to remove a trauma victim from the scene of an accident may well involve considerably elevated risks.

3.1.23 In each of the cases described immediately above, proper flight planning and fuel management by the pilot-in-command will normally help to ensure the operations can and will be conducted safely. Poor planning and mismanagement of crucial fuel-related considerations can easily have the opposite effect.

3.1.24 Aerial ambulance operations are classified as 'aerial work' operations under the *Civil Aviation Regulations 1988*.[6] They have been so classified under the applicable civil aviation legislation since at least 1964,[7] and nothing in the 'classification of activities' policy Mr Quinn quite incorrectly and misleadingly described in his oral evidence before the Committee on 22 October 2012 would necessarily have operated to move 'aerial ambulance operations' into the more rigorously regulated 'passenger transport operations' classification—a classification that has not yet been adopted in the legislation.

3.1.25 Indeed, one of the reasons the current Director of Aviation Safety suspended the policy to which Mr Quinn referred in 2009 was to better ensure that aerial ambulance operations might be classified as passenger transport operations, once the new operational regulation suite was enacted. CASA is currently consulting with relevant stakeholders with a view to that re-classification.

3.1.26 At page 6 of his submission, Mr Quinn states that, at the relevant time, there was a:

LACK OF SPECIFIC GUIDANCE RELATING TO THE APPLICATION OF IN-FLIGHT WEATHER REGARDING LANDING AND ALTERNATE MINIMA

CASA rejects this contention.

3.1.27 This issue was examined by CASA at the time the ATSB brought it to CASA's attention as a critical safety issue. On review, CASA considered that there was sufficient guidance material available to help inform decision-making in response to the variables that relate to flight planning.

3.1.28 CASA remains satisfied that the existing materials (and the coverage of these issues in the relevant pilot training syllabi) are adequate. That said, CASA is considering the inclusion of explicit fuel planning and alternate requirements for aeromedical flights in proposed Part 135 (Australian Air Transport Operations—Small Aeroplanes) of the Civil Aviation Safety Regulations.[8]

3.1.29 At page 6 of his submission, Mr Quinn states:

UNICOM OFFICERS WERE NOT APPROVED METEOROLOGICAL OBSERVERS AND COULD HAVE CONSIDERABLE INFLUENCE ON PILOT DECISION MAKING DUE TO THEIR LOCAL KNOWLEDGE.

Mr Quinn's submission misleadingly characterises the authority and prerogatives of UNICOM officers, and misleadingly suggests that any deficiencies in the services the Norfolk UNICOM officer provided were in some way a reflection of a failure on CASA's part.

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[6] See regulation 206(1)(a)(vii).

[7] See paragraph 191(b)(vii) of the former *Air Navigation Regulations 1920*.

[8] Draft Part 135 of the regulations has gone out for public comment.

3.1.30 Under the Civil Aviation Regulations[9], CASA may approve a person to provide reports of actual or forecasted meteorological conditions. Specified training and qualifications are required. CASA has received no applications from Norfolk Island UNICOM operators for such an approval.

3.2 Task/Environmental & Local Conditions

3.2.1 At pages 8 and 9 of his submission, Mr Quinn makes a number of assertions relating to the EMS aspects of the flight and the patient's condition that are incorrect, incomplete or otherwise misleading.

3.2.2 In the course of its special audit of Pel-Air, CASA specifically explored the potential for pressure to be brought to bear on pilots-in-command of aircraft involved in EMS operations, on account of a patient's medical condition. Contrary to Mr Quinn's assertions, through its discussions with CareFlight and Pel-Air management, CASA found that the inter-hospital transfer of patients was only done on the recommendation of the CareFlight physician. In accordance with the applicable protocols, it is a requirement that patients to be transferred be in a 'stable' medical condition before undertaking an inter-hospital transfer by air.

3.2.3 The Pel-Air pilots CASA interviewed commented that they neither needed nor wanted to know what the medical condition of the patient was. In their view, this was not a factor for them to consider, but rather one that would already have been addressed by the responsible medical experts. They did not consider these issues to be relevant to the conduct of the flight.

3.2.4 CASA is not in a position to form an authoritative view on Mrs Currall's condition. Manifestly, however, she was deemed by the CareFlight doctor to be suitable for air transport to an Australian hospital.

3.2.5 There is no evidentiary basis for Mr Quinn's suggestion that Pel-Air pilots generally are under undue or otherwise extraordinary pressure on account of the condition of the patients they transport, or that Mr James was under such pressure on the night of the accident.

3.3 Active Failures

3.3.1 At page 9 of his submission, Mr Quinn states:

THE P[ILOT] I[N] C[OMMAND] ELECTED NOT TO UPLIFT FULL FUEL (TIP TANKS), ALTHOUGH THERE WAS NO REGULATORY REQUIREMENT TO DO SO. IF FULL FUEL WAS UPLIFTED THERE WAS A POSSIBILITY IT MAY NOT HAVE CHANGED THE FUEL STATUS AT NORFOLK ISLAND HAD THE AIRCRAFT HELD BELOW RVSM AIRSPACE AT F[LIGHT] L[EVEL] 280 [28,000 FEET]

This statement is misleading.

[9] Regulation 120

3.3.2 By suggesting that there was no regulatory requirement to uplift 'full fuel', Mr Quinn belies the fact that Mr James elected not to uplift *sufficient* fuel to allow for the very kind of contingencies a responsible pilot is expected to contemplate, including depressurisation and engine failure, which *is* a regulatory requirement.

3.3.3 Mr Quinn's suggestion that, even if he had uplifted full fuel, that would not necessarily have made a difference had the aircraft been held below RVSM airspace, is also misleading. In the event permissive access to RVSM airspace should be denied—a very real possibility Mr James ought seriously to have contemplated—the pilot-in-command is obliged to consider the implications of such an eventuality and determine if there would be sufficient fuel remaining to allow the aircraft to continue to its destination; or if not, whether to return to the point of departure or divert to a suitable alternative.

3.4 Defences – Absent or Failed

3.4.1 At pages 9 and 10 of his submission, Mr Quinn makes a number of statements, in the form of unsubstantiated 'dot point' assertions, about allegedly absent or deficient processes and procedures, within Pel-Air and on CASA's part. Many of these statements are simply incorrect and others are misleading.

3.4.2 CASA welcomes the opportunity to respond to those points at a further hearing of the Committee and/or in a further supplemental submission.

3.5 ATSB/CASA Review

3.5.1 CASA rejects Mr Quinn's suggestion that the pertinent recommendations of the Miller Review he identifies in his submission have not been honoured by CASA and the ATSB. In rejecting that suggestion, we note that Mr Quinn appears to have formed this view solely on the basis of his assumptions and, in some cases quite illogical, deductions about the consultative processes leading up to the preparation of the final ATSB accident report.

3.5.2 To be sure, much of the adversarial features that were seen to have affected relations between CASA and the ATSB in years past, culminating in the Lockhart River coronial proceedings, have disappeared. That is a good thing, and a development that is decidedly conducive to the improvement of aviation safety.

3.5.3 Exchanges between the agencies today are cordial, civil and mutually respectful. This does not mean, however, that a degree of distance between the agencies, appropriate to preserve impartiality, has not been, and is not being, maintained. Mr Quinn's assertion that, what he describes as an 'absence of constructive criticism by the ATSB of CASA' in the final accident report 'indicates that the ATSB are not maintaining appropriate distance', is untenable.

3.5.4 Communications between the agencies, pursuant to an MOU that fully reflects the principles of the applicable Miller recommendations, do involve a robust exchange of opinions—opinions that often differ—with a view to achieving optimal safety outcomes. These exchanges frequently lead to constructive criticisms of

CASA by the ATSB. To the extent such matters are taken on board and addressed nowadays well before a final accident report is produced, serves to enhance safety, even if it may mean that, from time to time, there is no need to elaborate quite so fully on those issues in a report itself.

3.5.5 The creative interagency tension to which the Miller Review refers is very much a part of CASA's contemporary relationship with the ATSB, and effectively serves the constructive safety-focused purposes Mr Miller saw as properly attending such a relationship. The absence of a once decidedly unhelpful inter-agency antagonism should not be confused for what Mr Quinn wrongly and unfairly characterises as self-protective inter-agency harmony—in this particular instance or more generally.

3.5.6 In his oral evidence before the Committee at the hearing on 22 October 2012, Mr Quinn observed that, whilst he saw no particular problems with the CASA/ATSB MOU itself, he was of the view that the way in which those provisions of the MOU dealing with inter-agency exchanges had been interpreted and implemented ought to be reviewed. In that connection, Mr Quinn said:

> I think in terms of doing that review it would be pretty wise to have a look at what the NTSB and the FAA do in the US, because they seem to have it fairly right, in my view. . . .[10]

3.5.7 With this consideration in mind, the Committee's attention is drawn to Federal Aviation Administration Order 8020.11C, which provides, in pertinent part:

> FAA must at all times have a coordinator (FAA IIC) designated as its principal representative until the [accident] investigation is complete. . . . Through this principal representative, NTSB will make available to FAA documents, reports, and other evidence from the investigation and any tentative recommendations so that the FAA may immediately take the necessary corrective actions.[11]

A corresponding provision in the relevant National Transportation Safety Board (NTSB) manual provides:

> By statute, the FAA is automatically a participant in Safety Board investigations. Many FAA personnel have worked closely with Board investigators over the years and are familiar with major investigation procedures. The role of the FAA representatives is to support the Safety Board's investigation and determine if immediate regulatory action is necessary to prevent another accident.[12]

3.5.8 Mr Quinn claims that the practice of ensuring each agency is aware of the fact that the other is conducting an investigation into an accident, as recommended by the Miller Review and as provided for in the current CASA/ATSB MOU, appears *not* to have been implemented in the case of the Pel-Air Westwind accident. That is incorrect.

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[10] Senate *Hansard* (Proof), Rural and Regional Affairs and Transport References Committee, Monday, 22 October 2012, p. 20.

[11] FAA, *Aircraft Accident and Incident Notification, Investigation and Reporting* (Order No. 8020.11C), section 11 'FAA and NTSB Accident and Incident Investigation Agreements', para a.(2), p. 1-9 (2 February 2010).

[12] NTSB, *Aviation Investigation Manual Major Team Investigations*, para 2.4.1, p. 6.

3.5.9 As described in CASA's initial submission to the Committee, CASA and the ATSB kept one another advised about the progress of their respective parallel investigations from the outset, entirely in accordance with the governing provisions of the inter-agency MOU.[13]

3.6 Weather Forecasting

3.6.1 CASA may comment on Mr Quinn's submissions in relation to these issues in a further appearance before the Committee and/or in a further supplemental submission.

3.7 UNICOM

3.7.1 CASA may comment on Mr Quinn's submissions in relation to these issues in a further appearance before the Committee and/or in a further supplemental submission.

3.8 Pel-Air ban by the French/New Caledonian Authority

3.8.1 At page 17 of his submission, Mr Quinn states:

ON 27TH FEBRUARY THE FRENCH CIVIL AVIATION AUTHORITY BANNED PEL-AIR FROM OPERATING IN NOUMEA AIRSPACE DUE TO THEIR AIRCRAFT NOT BEING FITTED WITH TCAS II AND EGPWS . . . . VH-NGA WAS SUBSEQUENTLY FITTED WITH THIS EQUIPMENT TO ADDRESS THIS DEFICIENCY. HOWEVER, CPT JAMES HAD NOT BEEN TRAINED IN THE USE OF THE EQUIPMENT AND THEREFORE, SHOULD NOT HAVE BEEN FLYING AN AIRCRAFT INTO THIS AIRSPACE.

CPT JAMES WAS AWARE THAT PEL-AIR HAD BEEN BANNED FROM OPERATING IN NOUMEA AIRSPACE HOWEVER, HAD NOT BEEN ADVISED OF THE STATUS OF THE BAN BY MANAGEMENT PRIOR TO THE ACCIDENT FLIGHT. . . .

These statements are inaccurate and misleading.

3.8.2 On 28 February 2009, CASA received from the French National Airworthiness Authority Regional Office in New Caledonia a letter advising CASA of the matters raised with Pel-Air along with a copy of the letter sent to Pel-Air (included in Mr Quinn's submission). CASA contacted Pel-Air and was advised that Pel-Air had ceased flights to Noumea until further notice.

3.8.3 On 6 May 2009, Pel-Air provided CASA with a copy of correspondence to the French Authority advising that the operator had ceased flights to Noumea until such time as its aircraft were appropriately equipped.

3.8.4 On 19 October 2009 the French Authority approved Pel-Air to conduct a flight to Noumea in Westwind aircraft VH-NGA.

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[13] Submission of the Civil Aviation Safety Authority to the Senate Standing Committee on Rural and Regional Affairs and Transport, Inquiry into Aviation Accident Investigations (Pel-Air), paras 3.1-3.4 (12 October 2012).

3.8.5 On 17 November 2009, the day prior to the accident flight, Mr Dominic James conducted a flight, as pilot-in-command from Sydney to Norfolk Island then to Apia Western Samoa. On the flight from Sydney to Norfolk Island Mr James nominated Noumea (La Tontouta) as an alternate due to the weather forecast for Norfolk Island.

3.8.6 Mr James' nomination of Noumea as an alternate would indicate that he was aware the accident aircraft VH-NGA was suitable to operate to Noumea.

3.9 DIP Response Process

3.9.1 CASA may comment on Mr Quinn's submissions in relation to these issues in a further appearance before the Committee and/or in a further supplemental submission.

3.10 ATSB Drafting Process

3.10.1 CASA may comment on Mr Quinn's submissions in relation to these issues in a further appearance before the Committee and/or in a further supplemental submission.

3.11 Diminishing Culpability

3.11.1 At page 22 of his submission, Mr Quinn asserts that, on the basis of an application of a 'just culture' process developed by Professor Reason, Mr James's conduct in the context of the accident is 'in terms of culpability', in Mr Quinn's opinion, a 'blameless error'.

3.11.2 Whether Mr Quinn's 'analysis' in this connection is faithful to the process reflected in Professor Reason's model is neither here nor there. Whatever its content and contours may involve, 'just culture' is a concept developed for intra-organisational purposes, and it has no formal application in the context of an individual's dealings with the regulatory authority. In this connection, any question of 'blame' or 'culpability' is (or would have been) a matter between Mr James and Pel-Air.

3.11.3 Importantly, however, at no time have CASA's actions in relation to Mr James involved 'blame' or 'culpability'. The enforcement action CASA has taken in respect of Mr James was not, and should not be characterised as, punitive. Rather, the only actions CASA has taken in respect of Mr James have been *protective* and *remedial*:

- requiring him, *in the interests of safety*, to undertake certain tests and examinations designed to demonstrate that he has acquired the knowledge and proficiency appropriate to the operations in which his flight crew authorisations permit him to engage;

- suspending, *in the interests of safety*, some of his flight crew authorisations pending the successful completion of those tests and examinations; and

- imposing, *in the interests of safety*, certain conditions on his privilege to fly as pilot-in-command in certain kinds of operations, again, pending his successful demonstration of relevant competency.

3.11.4 CASA welcomes the opportunity to canvass these issues more fully in a further appearance before the Committee and/or in a further supplemental submission.

3.12 CASA Suspension of Cpt James's Licence

3.12.1 Following on from his discussion of 'diminishing culpability', at pages 23 to 29 of his submission Mr Quinn raises a number of issues related to CASA's decision to require Mr James to undertake certain tests and examinations, to suspend some of his flight crew authorisations pending his successful completion of those tests and examinations and, ultimately, imposing conditions on some of Mr James's authorisations pending an as yet incomplete demonstration of proficiency.

3.12.2 Further to these submissions, in his oral evidence before the Committee on 22 October 2012, Mr Quinn provided what purported to be a chronological account of the process by which Mr James sought to challenge CASA's decisions, how those matters were disposed of and the basis on which they proceeded in the way they did. Mr Quinn's account is replete with numerous and fundamental errors of fact.

3.12.3 The following exchange occurred between Mr Quinn and Senator Xenophon in the Committee hearing held on 22 October 2012:

> **Mr Quinn:** There was a finding put down that basically found in favour of CASA and that his licence should remain suspended.
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> **Senator XENOPHON:** And then you went to the Federal Court?
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> **Mr Quinn:** I was not involved in that process; Mr James was. But then it went to the Federal Court, and that was sometime later.
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> **Senator XENOPHON:** And you do not know what the outcome of that was?
>
> **Mr Quinn:** I know the outcome of that was that his licence was reinstated.[14]

3.12.4 The Administrative Appeals Tribunal (AAT) did not conduct any hearing or determine any issue in connection with Mr James's claims. However, a conciliation conference was convened by the AAT on 18 August 2010.

3.12.5 Neither Mr James nor CASA made any application to the Federal Court of Australia, and no proceedings in relation to CASA's actions in relation to Mr James's flight crew authorisations have been before that court.

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[14] Senate *Hansard* (Proof), Rural and Regional Affairs and Transport References Committee, Monday, 22 October 2012, p. 17.

3.12.6 It is not correct to say, as Mr Quinn does, that the AAT process led to Mr James's licences being 'reinstated' or restored. A brief chronology of the two proceedings commenced by Mr James in the AAT is set out below.

First AAT application

On **24 December 2009**, CASA suspended Mr James's Commercial Pilot (Aeroplane) Licence (CPL), Airline Transport Pilot (Aeroplane) Licence (ATPL) and multi-engine Command Instrument Rating (CIR) under regulation 265 of the *Civil Aviation Regulations 1988* (CAR), for the purposes of examination and tests under CAR 5.38. Mr James was also required to pass a CPL flight test and a CIR flight test.

On **26 February 2010**, following correspondence with Mr James's lawyers, CASA modified the examination requirements by removing 3 theory examinations.

On **26 February 2010**, Mr James applied to the Administrative Appeals Tribunal (AAT) for review of CASA's decision made on 24 December 2009.

On **18 August 2010**, a conciliation conference was convened by the AAT in which CASA and Mr James attended. *This did not result in CASA's decision being altered.*

On **31 August 2010**, Mr James withdrew his application to the AAT without proceeding to a hearing. This was *prior* to the suspension of his CPL later being lifted on 25 July 2011 (and the suspension of his ATPL later being lifted on 27 March 2012). In both cases, these suspensions were lifted because Mr James had ultimately passed the examinations and flight test required of him by CASA.

Second AAT application

On **25 July 2011**, CASA imposed the following conditions on Mr James' flight crew licences:

> 1. The licence holder is to notify CASA of the name and address of his employer in commercial flying operations within 7 days of commencement of employment or change to employment;
>
> 2. The renewal of the licence holder's Command Instrument Rating must be conducted by CASA or a person specifically approved by CASA for the purpose of conducting the renewal.

At the same time CASA decided to lift its suspension of Mr James's CPL and CIR. CASA refused to lift the suspension of Mr James' ATPL because he had not as yet passed the ATPL flight planning exercise specified in the decision of 14 January 2011.

On **18 August 2011**, Mr James applied to the AAT for review of this decision.

On **9 March 2012**, Mr James withdrew his application to the AAT without proceeding to a hearing because CASA agreed to vary the decision by substituting it with the following one:

> (i) the conditions imposed on his commercial pilot (aeroplane) licence (CPL) and airline transport pilot (aeroplane) licence (ATPL) by paragraphs 16(a) and (b) of the decision made by a delegate of CASA on 25 July 2012 are revoked;

(ii) the following conditions are imposed upon Mr James' ATPL:

(1) The holder may not conduct a flight as pilot in command of a multi-crew aircraft in any commercial operation for which his airline transport pilot (aeroplane) licence is required unless the holder has first passed an aeroplane proficiency check.

(2) The aeroplane proficiency check must:

(i) be conducted in the multi-crew aircraft type on which the commercial operation is proposed to be conducted;

(ii) incorporate an assessment of the holder's management of an unplanned weather related diversion designed to assess the holder's in-flight command decision making;

(iii) be supervised by a check captain acceptable to CASA who is approved to conduct training and checking duties within the training and checking organisation of the operator conducting the operation; and

(iv) be observed by a CASA flying operations inspector or flying training examiner.

3.13 Pel-Air Safety Policy

3.13.1 CASA may comment on Mr Quinn's submissions in relation to these issues in a further appearance before the Committee and/or in a further supplemental submission.

4. Submission of Mr Bryan Aherne—General Remarks

4.1 In his submission Mr Aherne states that he has assisted Mr Dominic James and Ms Karen Casey 'in the providing independent advice regarding the accident flight and the subsequent CASA action taken against the pilot'.

4.2 Mr Aherne's credentials indicate that he is a person with both regulatory and accident investigation training and experience. In both endeavours it is essential that objectivity and detachment prevail. Regrettably, throughout Mr Ahern's submission he arrives at conclusions that are unsubstantiated, factually incorrect and misleading.

5. Submission of Mr Bryan Aherne—Specific Responses

5.1 Executive Summary

5.1.1 In the Executive Summary of Mr Aherne's submission he makes the following statements:

THE ATSB AND CASA NEVER INTENDED THE SPECIAL AUDIT TO BE IN THE PUBLIC ARENA. THE ACCIDENT THEY [DOMINIC JAMES AND KAREN CASEY] WERE INVOLVED IN IS NOW THE VEHICLE TO UNCOVER DELIBERATE OMISSION OF SAFETY CRITICAL INFORMATION BY BOTH THE ATSB AND CASA.

CASA IN TURN, DID NOT RESPOND AS A DIRECTLY INTERESTED PARTY THAT SIGNIFICANT DEFICIENCIES WITH THE OPERATOR AND ITS MANUAL EXISTED AT THE TIME OF THE ACCIDENT. THE CASA SPECIAL AUDIT IDENTIFIES MANY DEFICIENCIES AND BY CASA KNOWINGLY ALLOWING THE ATSB STATEMENTS THAT THE OPERATORS' PROCEDURES AND MANUALS COMPLIED WITH THE REGULATIONS IS INTENTIONAL, DELIBERATE AND HAS OMITTED OVERSIGHT DEFICIENCIES WHICH HAVE AN ADVERSE AFFECT ON SAFETY OF THE TRAVELLING PUBLIC AND THEIR CONFIDENCE IN OUR AVIATION SAFETY ADMINISTRATION.

5.1.2 CASA may comment on Mr Aherne's submissions in relation to these issues in a further appearance before the Committee and/or in a further supplemental submission.

5.2 Critical Safety Issue

5.2.1 On page 3 of his submission Mr Aherne states:

THE CHANGE OF CRITICAL SAFETY ISSUE FROM ONE OF INTOLERABLE RISK TO MINOR SAFETY ISSUE DEMONSTRATES BOTH ATSB AND CASA AGREED IN 2010 THAT THE LACK OF REGULATION AND GUIDANCE WAS INTOLERABLE. THAT IT CHANGED TO MINOR IS SOMETHING ONLY THE COMMITTEE WILL BE ABLE TO ANSWER WHY

5.2.2 Mr Aherne is inferring that it is impossible for the ATSB to change its position. He incorrectly and misleadingly states that CASA agreed with the ATSB's initial classification that the matter was a critical safety issue. This was not the case.

5.2.3 In accordance with the terms of the MOU the ATSB advised CASA of its preliminary view. CASA did not agree with that position and following an exchange of letters and two meetings with CASA Standards Division, CASA understands the ATSB revisited its risk assessment with the result the issue was reclassified.

5.2.4 CASA rejects Mr Aherne's unsubstantiated assertion that there was in any way inappropriate action by CASA in this regard.

5.3 CASA Response to the ATSB Report

5.3.1 On page 3 of his submission Mr Aherne states:

THERE ARE SIGNIFICANT DEFICIENCIES IN THE REGULATIONS AND THE AERONAUTICAL INFORMATION PUBLICATION (AIP). REGULATIONS REQUIRE PILOTS TO HOLD ALTERNATED ON FORECASTS, AND THE AIP ALSO STATES FORECASTS WHIST EN-ROUTE NOT ON REPORTS OR OBSERVATIONS. ONLY AT THE FLIGHT PLANNING STAGE DOES THE AIP CONSIDER REPORTS FOR ALTERNATES. YET, THERE IS NO CHANGE BEING ANTICIPATED IN CASA'S RESPONSE TO THE REGULATIONS OR AIP

5.3.2 CASA is aware of the differing views of pilots regarding the planning requirements and the guidance given in the Aeronautical Information Package (AIP) in relation to in-flight diversion. However, Mr Aherne's statement that no change is

anticipated in CASA's response to the regulations or AIP is misinformed and incorrect.

5.3.3 Mr Aherne's arguments, like Mr Quinn's, relating to providing for alternates revolve around planning criteria and forecasts. They weave an elaborate web that rests on the premise that at no time during the preparation for or execution of the flight of 18 November 2009 was Mr James required to consider the possibility of planning for or diverting in flight to an alternate.

5.3.4 What Mr Aherne and others have failed to draw to the Committee's attention are the *operational requirements* contained in the AIP, the wording of which has been consistent over a number of years, and reads:

> **DIVERSION TO AN ALTERNATE**
>
> **The pilot in command is responsible for taking appropriate diversion action based on information received. The pilot must provide the latest diversion time from the destination or from a point en-route and, if required the time interval.**

5.3.5 CASA is finalising the new Civil Aviation Safety Regulations and expects these will be completed and made by the end of the first quarter of 2013. Three months before the accident CASA initiated an internal project to examine all aspects of fuel planning and its relationship to inflight decision making. Finalisation of this work is critically dependent on the receipt of associated International Civil Aviation Organization (ICAO0 Standards and Recommended Practices, now expected by the end of November 2012. CASA intends to draft Civil Aviation Orders and guidance material which will include amendments to the AIP.

5.3.6 Any inference that flights in the aerial ambulance category are operating at high risk is misinformed and misleading. Immediately following the accident CASA audited all aeromedical operators and confirmed that operations manuals were appropriate for these flights.

5.3.7 In the same section of his submission, at page 7, Mr Aherne makes the claim at point 2:

> **IF THE OPERATOR HAD TO COMPLY WITH THIS FLIGHT AS A CHARTER, THE OPERATION COULD NOT BE CONDUCTED IN A WESTWIND AS IT IS NOT CAPABLE OF UPLIFTING ENOUGH FUEL TO HOLD AN ALTERNATE FOR NORFOLK ISLAND ON A FLIGHT FROM SAMOA**

5.3.8 CASA has examined the operations of Pel-Air Westwind aircraft into and out of Norfolk Island between February 2003 and November 2009. Over that period 78 flights transited Norfolk Island with only four arriving without the fuel on-board to divert to Noumea (Tontouta). Mr James was the pilot-in-command on two of these four occasions, including the flight on which the ditching occurred. Three of the 78 flights departed Apia, and the only pilot-in-command who did not fully fuel the aircraft was Mr James on the night of 18 November 2009.

5.3.9 Given the evidence it is apparent that company pilots were carrying alternate fuel when transiting Norfolk Island. Only Mr James on the night of the ditching considered it unnecessary to fully fuel the aircraft for a flight from Apia to Norfolk Island.

5.3.10 Accordingly, the claim by Mr Aherne is false and misleading, and brings into question the many other claims he makes throughout his submission as to the capabilities of the Westwind aircraft and its suitability to conduct operations in this role.

5.3.11 CASA would welcome the opportunity to discuss this issue more fully in a further supplemental submission and/or in an appearance before the Committee.

5.4 Removal of Critical Safety information from Draft Reports

5.4.1 On page 10 of Mr Aherne's submission he states:

RECORDS ARE AN INTRINSIC PART OF AVIATION SAFETY, IF THE STATEMENT "THERE WAS NO REQUIREMENT IN THE OPERATIONS MANUAL TO RECORD TRAINING" IS ACCEPTABLE AS EVIDENCE TO THE ATSB, THEN THIS MUST SET A NEW BENCHMARK IN ATSB INVESTIGATIONS AND CASA'S FUTURE AUDITING OF AVIATION OPERATORS WHEREBY OPERATORS CAN JUST CLAIM THE OPERATIONS MANUAL DOES NOT REQUIRE TRAINING TO BE RECORDED, BUT 'PLEASE TAKE OUT WORD THAT THE TRAINING WAS CONDUCTED".

5.4.2 Regulations and Orders specify what documentation an operator is obliged to retain. CASA inspectors routinely audit these records during inspections. Mr Aherne's comment implies that CASA does not or might not audit records appropriately. This is inaccurate and misleading.

5.4.3 In the same section of his submission, at page 11, Mr Aherne makes the statement:

. . . AS THE CASA SPECIAL AUDIT FOUND THE OPERATOR DID NOT COMPLETE THE IN-FLIGHT NAVIGATION LOGS

5.4.4 This statement is false and misleading. CASA issued the operator with a Request for Corrective Action (RCA) when it found that there were deficiencies in the *retention* of certain documentation not the completion. The completion of the documentation is a crew function.

5.5 Regulatory Context of the Flight

5.5.1 On page 20 of his submission Mr Aherne states, in relation to the ATSB's conclusion that the Norfolk Island Airport was suitable in all respects, that this is factually incorrect. He then states:

INFORMATION RECEIVED SUGGESTS THE AERODROME WAS 15 M SHORT OF THE REQUIRED OVERRUN DISTANCE.

5.5.2 This statement is imprecise and misleading and could be taken to mean that the entire aerodrome was below standard in terms of runway overrun.

5.5.3 Norfolk Island Aerodrome is regulated by CASA. The standard for the Runway End Safety Area (RESA) is required under Part 139 of the *Civil Aviation*

Safety Regulations 1998 to be 90m by 90m from the end of the runway strip. Runway 29 at Norfolk Island can provide a RESA that is 90m wide at the end of the RWY strip and 90m long, but at the far end the corners are tapered inwards.

5.6 Records

5.6.1 On page 22 of his submission, Mr Aherne notes:

AN OBSERVATION WAS RAISED BY CASA REGARDING THE LACK OF DETAIL IN THE TRAINING FORMS

5.6.2 An Observation is issued by CASA as a means of identifying to the operator that an opportunity for improvement exists. It is not a finding of a regulatory breach. The text of the Observation makes it clear that there was scope to improve the format and content of the relevant Pel-Air form.

5.7 RVSM Procedures

5.7.1 At pages 22-33 of his submission, Mr Aherne argues that, because the aircraft was not RVSM approved, it could not lawfully operate the sector from Apia to Norfolk Island. The merits of this argument were addressed earlier in this document in relation to an identical assertion by Mr Quinn and it will not be re-ventilated here, other than to address Mr Aherne's statement that:

. . . AND THE ABSENCE OF THE REGULATOR TAKING ACTION APPEAR TO BE AN ORGANISATIONAL AND REGULATORY SYSTEMIC ISSUE WHICH WOULD HAVE PREVENTED THIS ACCIDENT. CAPTAIN JAMES WAS DOING WHAT HE WAS TOLD TO AND THIS ROUTE WAS SELECTED BY THE COMPANY ON MANY OCCASIONS

5.7.2 This amounts to a kind of Nuremberg defence. As pilot-in-command of the aircraft, Mr James was responsible for taking into account at the planning stage all pertinent factors that could influence the safe completion of the flight. Had Mr James determined that he had insufficient fuel on-board to complete the flight below RVSM airspace he had other planning options available. Surely Mr Aherne cannot be arguing that Mr James merely acquiesced and proceeded with a flight he knew he could not complete.

5.7.3 It would also be difficult for Mr Aherne to argue that on the day the company applied directive pressure on Mr James as the record shows Mr James had not been able to contact the company prior to the flight.

5.7.4 On page 33 of his submission, Mr Aherne raises the question of entry into New Caledonian airspace. While he mentions the supposed ban on Pel-Air aircraft (which the French authorities refer to as a restriction), Mr Aherne fails to say that, following modifications to certain company aircraft, VH-NGA being one, the French authorities lifted the restriction insofar as it applied to modified aircraft.

5.7.5 Mr Aherne also fails to mention that, although Mr James claims not to have been trained on the newly fitted aircraft equipment, clearly that did not dissuade him from nominating Noumea (Tontouta) as the alternate for Norfolk Island on his

flight from Sydney the day before he was forced to ditch VH-NGA on the inbound flight from Apia.

5.8 Analysis

5.8.1 Throughout his submission Mr Aherne is scathingly critical of the ATSB, characterising what he considers to be factual errors as evidence of bias. On page 40 of his submission Mr Aherne make comments about HF radio communications as follows:

> THE **SPECI** WHICH SHOWED CLOUD AT **1100** FEET MAY NOT HAVE BEEN HEARD BY THE CREW DUE TO THE NOTORIOUSLY DIFFICULT EFFECTS OF **HF** TRANSMISSIONS AND THE IONOSPHERE. **WHAT** WAS RECEIVED AND RECORDED BY **AUCKLAND'S** LARGE AERIAL, AND USED AS THE BASIS FOR ATTRIBUTION OF THE FLIGHT CREW MAY NOT BE THE SAME AS WHAT THE CREW HEARD *BECAUSE OF THE AIRCRAFT WHIP ANTENNA.* [EMPHASIS ADDED]

5.8.2 In the following paragraph Mr Aherne recounts the difficulties he has personally experienced receiving HF transmissions *when flying helicopters* fitted with whip antennas.

5.8.3 VH-NGA was fitted with two HF radio systems and utilised a long wire antenna that ran between the mid upper fuselage to a mounting point approximately three quarters up the vertical stabiliser. Long wire HF antennas are commonly found on fixed wing aircraft.

5.8.4 Reference to the transcripts of the crew's HF contacts with air traffic services does not reveal any apparent communications difficulty and in interviews with CASA Mr James has never expressed that there were any HF communications irregularities. The first CASA became aware of Mr James's supposed HF communications difficulties was when he raised it on the recent *4 Corners* television program.

5.9 AIP Interpretation

5.9.1 On page 42 of his submission Mr Aherne returns to the issue of the nomination of alternate aerodromes stating:

> . . . IN OTHER WORDS **CASA'S** OPINION APPEARS TO CORRELATE WITH A BREACH AND **ZERO** TOLERANCE WHEN IT SUITS **CASA** IN THIS CASE WHERE PILOT **DOMINIC JAMES** DOES NOT LEGALLY REQUIRE TO NOMINATE AN ALTERNATE IN FLIGHT IS NOT GOOD ENOUGH.

5.9.2 The issue of planning requirements and the operational requirements set out in the AIP has been discussed above in paragraph 5.3.4.

5.10 Analysis

5.10.1 At page 49 of his submission, Mr Aherne states:

> IN THIS ACCIDENT, THE PILOT IS SINGLED OUT AS THE ATTRIBUTOR, BUT CLEARLY THE EVIDENCE THE **ATSB** AND **CASA** DO NOT WANT PUBLISHED INDICATES OTHERWISE

5.10.2 It is at this point Mr Aherne moves from attempting to deal with what he identifies as factual and methodological issues needing attention to unsubstantiated claims that CASA does not want certain things published. The ATSB had access to all of CASA's documentation regarding its dealings with Pel-Air and was free to utilise that material as it felt it needed to in its investigation of this accident. CASA rejects any assertion that it has acted to supress or keep from the ATSB any information relevant to the latter's investigation. Once again, CASA categorically rejects any assertion or suggestion that it has colluded in any way with the ATSB.

5.10.3 On page 50 Mr Aherne makes the following statement:

THE 2014 PROPOSED CHANGE FROM ARIAL WORK FOR AIR AMBULANCE OPERATIONS IS A VISIBLE SIGN OF REGULATORY INCOMPETENCE. THE INDUSTRY HAS HAD ENOUGH OF THE SAME PERSONNEL IN CASA WHO HAVE SURVIVED UNDER VARIOUS DIRECTOR'S PLACING BARRIERS IN THEIR WAY TO KEEP THEIR OWN AGENDAS' AND WHO HAVE WILFULLY OBSTRUCTED SAFETY IMPROVEMENTS BY BLATANT MISTRUTH'S, AND WHO ARE IN MY OPINION INDIRECTLY ATTRIBUTABLE TO THIS ACCIDENT SEQUENCE.

5.10.4 This allegation indicates that Mr Aherne has little or no knowledge of the history involved. While he may be frustrated at what he perceives to be the slow pace of regulatory reform, his unsubstantiated claims that certain individuals in CASA have wilfully obstructed the program are not tenable. Over the last three years, since the Standards Division was re-established, CASA staff have worked tirelessly to progress regulatory reform. It may be of interest to the Committee to know that elements of the aviation industry are now calling for CASA to slow the pace of change and in some cases stop it all together.

5.10.5 At page 50 of his submission, Mr Aherne states:

THE PUBLIC RESPONSE BY CASA WHICH INDICATED THE POST ACCIDENT SPECIAL AUDIT HAD NO RELATIONSHIP OR LINKS TO THE ACCIDENT IS NOW VERY PROBLEMATIC FOR AVIATION SAFETY

ANY FUTURE REGULATORY ACTION BY CASA AGAINST AN OPERATOR WITH SIMILAR CLASSES OF REGULATORY FAILINGS OR BREACHES OF S28 OF THE CIVIL AVIATION ACT, PUTS THOSE OPERATOR' IN A POSITION TO LEGALLY ARGUE THAT CASA TOOK NO ACTION AGAINST AN OPERATOR NOR DID THEY BELIEVE THOSE FAILINGS OR BREACHES CAUSED AN ACCIDENT SEQUENCE

5.10.6 Mr Aherne's assertions are unfounded and ill-informed. CASA treats each case on its merits, and on the basis of the relevant facts and circumstances.

5.10.7 In the final paragraph on page 50 of his submission, Mr Aherne states:

CASA DOES NOT EVEN APPEAR IN THIS COMPLEX ORGANISATION ACCIDENT. BY WHOM AND AT WHO'S DIRECTION?

5.10.8 Again Mr Aherne is asserting 'skulduggery'. What can be said is that if this were the case CASA was not involved.

5.10.9 On page 51 Mr Aherne states:

I WOULD DESCRIBE THE CAPITAL R REGULATOR AS A CAPITAL R FOR REVENGE. JUST CULTURE IS DUST IN THE PAST WITH THIS NEW DIRECTION. CAN THE COMMITTEE REQUIRE CASA TO DETAIL HOW MANY PEOPLE THEY HAVE PROSECUTED SINCE 2009 WHO SUBMITTED INCIDENT REPORTS TO THE ATSB UNDER THE TSI ACT WITH CASA USING THAT INFORMATION AS THE BASIS FOR THEIR EVIDENCE GATHERING WHICH HAS BEEN SHARED.

5.10.10 As discussed briefly above in responding to Mr Quinn's similarly convenient invocation of 'just culture', we reiterate here that it is a concept meant to adhere within organisations and has no bearing on the relationship between the regulatory authority and the regulated community. As a regulatory authority, CASA is obliged to respond to a far more rigorous and demanding standard: the rule of law and the principles of natural justice. CASA is publicly accountable for all of its actions at multiple levels, including its many appearances before this Committee. CASA would welcome the opportunity to address these issues in a further supplemental submission and/or in a further appearance before the Committee

5.10.11 In his zeal, Mr Aherne misses a significant point, namely, that CASA has no power or authority to prosecute anyone. Those powers reside exclusively with the Commonwealth Director of Public Prosecutions (CDPP). Acting in accordance with CDPP Prosecution Guidelines, CASA may submit a brief of evidence to the CDPP, with a recommendation that a prosecution be commenced. It is the CDPP's decision whether or not to proceed.

5.10.12 There is much confusion, as Mr Aherne's tendentious remarks demonstrate, about the difference between the safety-related enforcement powers CASA may exercise, all of which are reviewable in the AAT or the Federal Court, and criminal prosecutions mounted by the CDPP. And lest the point be lost, it might be noted here that, in this matter, no one—and certainly not Mr James—has been prosecuted for or charged with any offences.

5.10.13 CASA would welcome the opportunity to discuss these issues, and to clarify the matters about which Mr Aherne appears to be quite confused, in a further supplemental submission and/or a further appearance before the Committee.

6. Submission of Mr Gary Currall—General Remarks

6.1 CASA appreciates the depth and severity of the trauma Mr Currall, his wife and others who were on board VH-NGA would have experienced on that fateful night in 2009. They are all courageous survivors who deserve our sympathy, admiration and respect.

6.2 We are mindful too of the enduring pain, physical and emotional, with which Mr Currall and the others continue to contend.

6.3 In the circumstances, it is understandable that Mr Currall should feel so strongly about identifying those he might consider to be responsible for the accident, and who, in his view, should be held accountable for its terrible consequences.

6.4 At the same time, it is equally understandable that these very considerations, and the factors and personalities that invariably attend on such occurrences, should militate against the ability, and perhaps even the willingness, to form an objective, dispassionate and informed understanding of some of the most salient aspects of the events involved.

6.5 For all that, it is fairly of concern to CASA that a number of the contentions and claims in Mr Currall's submission are inaccurate, ill-informed and clearly inconsistent with the evidence, and for those reasons alone, we are obliged to correct a number of his statements, conclusions and suggestions.

7. Submission of Mr Gary Currall—Specific Responses

7.1 At numbered paragraph 1 of his submission, Mr Currall states:

THIS WAS THE THIRD CRASH OF A PEL AIR AIRCRAFT, THE OTHER TWO IN 1985 AND 1995 EACH CAUSING FATALITIES . . . .

The facts on which Mr Currall relies, and on which he presumably bases his expectation that 'such a record would require stricter supervision by the regulatory but there is no evidence of this', are incorrect.

7.1.1 The trading name Pel-Air has been utilised by three entities: Pel-Air Aviation Pty Ltd, Pel-Air Express Pty Ltd and Doskite Pty Ltd. It is CASA's understanding that the Westwind aircraft were operated only by Doskite Pty Ltd.

7.1.2 Regional Express purchased the three Pel-Air entities from the previous owners in 2006. The new owners (Regional Express) applied for a new AOC under Pel-Air Pty Ltd, which brought the jet and turbo-prop operation together under the control of a new and different company.

7.1.3 Neither of the fatal accidents to which Mr Currall refers occurred when Pel-Air was operated under the current holder's AOC. Both of the aircraft involved in those accidents were Westwind aircraft, however, these accidents occurred 10 and 20 years respectively before the companies were operated by the current AOC holder, who was the operator at the time of the accident in 2009.

7.1.4 During the period 1 June 2005 to 18 November 2009 CASA conducted 53 oversight activities in relation to Pel-Air, which included 4 audits, 22 surveillance events and 27 assessments for regulatory service requests. CASA considers that the oversight of Pel-Air entities was appropriate at all times.

7.2 At numbered paragraph 2 of his submission, Mr Currall states:

AUDITS OF PEL AIR BY CASA PRIOR TO THIS CRASH FOUND NO EVIDENCE OF PROBLEMS. THIS REFLECTS EXTREMELY POORLY ON THE PERFORMANCE OF CASA A POINT THAT IS

CONFIRMED BY AN AUDIT OF CASA CONDUCTED BY THE INTERNATIONAL REGULATOR, ICAO, AND THE AMERICAN REGULATOR, THE FAA.

These statements are incorrect.

7.2.1 During the period 1 June 2005 to 18 November 2009 CASA issued 34 Requests for Corrective Action and 1 Safety Alert to the holders of the Air Operator's Certificate under which Pel-Air operations were conducted.

7.2.2 CASA's results under the ICAO Universal Safety Oversight Audit Program were exceptionally good, and well above international averages. All areas in which room for improvement was identified have been addressed.

7.2.3. Australia has always enjoyed Category 1 status under the United States Federal Aviation Administration's (FAA) International Aviation Safety Assessment (IASA) program. All countries into which passenger-carrying US air transport aircraft operate, and which conduct passenger-carrying air transport operations into the United States, are subject to IASA audits.

7.2.4 Australia was audited under the IASA program in 2009, as a result of which the FAA was fully satisfied with CASA's performance, and on the basis of which Australia retains its Category 1 IASA status.

7.3 At numbered paragraph 3 of his submission, Mr Currall states:

A SPECIAL AUDIT OF PEL AIR BY CASA, CONDUCTED IMMEDIATELY AFTER THE CRASH, FOUND 31 SAFETY AND REGULATORY BREACHES. THESE INCLUDED SYSTEMIC ISSUES WITH FLIGHT PLANNING, FUELLING, FATIGUE MANAGEMENT AND TRAINING.

This statement raises important considerations of a kind quite different to the point Mr Currall appears to be trying to make.

7.3.1 To be sure, in the special audit CASA conducted, a number of hitherto unknown deficiencies in aspects of Pel-Air's operations were identified. In the conduct of that audit, CASA conducted comprehensive interviews with all Pel-Air Westwind pilots, to a scope and depth considerably greater than that which would be involved in a normal audit.

7.3.2 Not surprisingly perhaps, but certainly less than conducive to optimal safety outcomes, the pilots interviewed after the accident were far more candid and revealing in their comments about Pel-Air than CASA normally finds an operator's employees to be. Relying in large measure on information brought to CASA's attention as a result of this exercise, significant responsive action was taken in respect of the operator, and significant improvements have been introduced in the areas Mr Currall has identified.

7.4 At numbered paragraphs 4 and 5 of his submission, Mr Currall states:

THE DETAILS OF THE SPECIAL AUDIT REPORT WERE TO BE KEPT FROM THE PUBLIC. A POINT APPARENTLY DESIGNED TO MAINTAIN THE COMMERCIAL INTERESTS OF PEL AIR . . . .

PEL AIR WAS ALLOWED TO RECTIFY THEIR DEFECTS WITHOUT PUBLIC SCRUTINY THE PUBLIC HAS A RIGHT TO MAKE INFORMED DECISIONS ABOUT THEIR TRAVEL ARRANGEMENTS . . . .

These statements are ill-informed and consequently misleading.

7.4.1 In no case does CASA publicise its ongoing regulatory actions in relation to *any* operator, on the assumption—where such an assumption is reasonable—that responsive corrective action will be taken in an effective and timely fashion. To do otherwise would be unfair and would serve no meaningful safety-related interest.

7.4.2 If an operator's deficiencies are of a sufficiently serious nature as to make it unsafe to allow operations to continue, appropriate administrative remedies are available to CASA allowing for immediate action to be taken. Although it is rarely necessary to do so, CASA has not hesitated to exercise those powers when such action is required in the interests of safety.

7.5 At numbered paragraph 10 of his submission, Mr Currall states:

CASA TOO COULD NOT ACCEPT THE FINDINGS OF THEIR OWN SPECIAL AUDIT, IGNORING THEIR OWN IDENTIFIED INADEQUACIES AND PREFERRING TO BLAME THE PILOT . . . .

This statement is incorrect, ill-informed and misleading.

7.5.1 On the basis of the special audit, CASA took immediate, appropriate and appropriately directed action, in relation to both Pel Air and Mr James. In so far as Mr James is concerned, he clearly contravened the applicable procedures of the operator and the regulatory requirements governing flight planning and fuel management. His flight crew privileges were duly suspended pending a satisfactory demonstration of necessary proficiency. Pel Air voluntary 'suspended' their Westwind operations, pending CASA's satisfaction with the implementation of appropriate remedial actions.

7.5.2 In both instances, conditions were placed on the relevant authorisations, limiting the nature of the operations permitted pending demonstration to CASA's satisfaction that necessary improvements had been introduced and/or levels of proficiency adequately demonstrated.

7.6 At numbered paragraph 11 of his submission, Mr Currall states:

CASA APPROVED THE OPERATIONS MANUAL OF PEL AIR, ISSUING AN AIRWORTHINESS CERTIFICATE. THIS IS AN IMPLICIT ACCEPTANCE OF THE FLAWS WITH FLIGHT AND FUEL PLANNING FOUND BY THE SPECIAL AUDIT AND ILLUSTRATES THE SYSTEMIC PROBLEMS AT CASA.

This statement is ill-informed and incorrect.

7.6.1 Technically, CASA does not 'approve' Operations Manuals, although certain arrangements and procedures specified within an Operations Manual may be subject to CASA approval. There is nothing in any of the issues involved in this matter that has anything to do with airworthiness certificates. At the time it was 'accepted' in connection with Pel Air's application for an Air Operator's Certificate (AOC), there was nothing in that manual, and no information reasonably available to CASA, on the basis of which the manual might properly have been rejected, or the AOC refused.

7.6.2 Because the holders of AOCs authorising aerial work or even charter operations may not know precisely where their operations will take them, there is no way in which a manual can prescriptively address the specific details governing flight and fuel planning for specific destinations. Essential elements of the processes by which such planning is meant to be carried out are spelt out in operations manuals and in the civil aviation legislation. Pilots-in-command are expected to be familiar and comply with those requirements.

7.7 At numbered paragraphs 12 and 13 of his submission, Mr Currall states:

ICAO FOUND NUMEROUS PROBLEMS WITH THE OPERATION OF CASA IN THE MONTHS LEADING UP TO THE CRASH. THIS WAS CONFIRMED BY THE FAA IN AN AUDIT OF CASA CONDUCTED JUST WEEKS AFTER THE CRASH.

THE PUBLIC WAS INFORMED OF NEITHER OF THESE IMPORTANT FINDINGS

This statement is ill-informed and incorrect.

7.7.1 In connection with the results of the ICAO and the FAA audits, see paragraphs 7.2.2 to 7.2.4 above.

7.7.2 There was nothing 'secret' about the conduct or the results of either the ICAO or the FAA audit. Both were covered in the aviation/transport media at the time, and information pertaining to both are available to the public on ICAO's and the FAA's websites.

8. Concluding Remarks

8.1 CASA appreciates that we have been given this opportunity to respond to the submissions of Messrs Quinn, Aherne and Currall. In the limited time available, we have tried to identify and address the more significant claims, statements and assertions contained in those submissions, with clarity and cogency. In the circumstances, we have not been able to respond to all of the incorrect, incomplete and otherwise misleading claims and statements appearing in these submissions.

8.2 We thank the Committee once again for this opportunity. In the interests of fairness and in the interests of safety, we trust we will have the opportunity to make a further supplemental submission and to appear again before the Committee prior to the conclusion of this inquiry.