Senate Rural and Regional Affairs and Transport Committee

Inquiry into the Administration of the Civil Aviation Safety Authority (CASA) and related matters

Introduction

My name is Anne Banks and I am the wife of Dr David Banks who was a passenger on VH-TFU which crashed near Lockhart River on 7 May 2005 with the loss of all aboard.

During the subsequent two year inquiry by the Australian Transport Safety Bureau (ATSB), I was kept informed of the progress of their independent investigation and was provided with the final report in April 2007. I attended every day of the Coronial Inquiry into the accident during June and July 2007, both on Thursday Island and in Brisbane, and was present on 17 August 2007 when Coroner Barnes handed down his findings.

Therefore I have been intimately involved in Australia's worst air disaster in 40 years which happened on CASA's watch.

I welcome this opportunity to comment as your Committee inquires into the administration of CASA and related matters.

CASA and the Lockhart River Air Disaster

The two year ATSB inquiry (costing approx $2.5 million) was followed by the Lockhart River Coronial Inquiry held over 18 days involving the Coroner, 3 Senior Counsel, 5 junior counsel and 6 firms of solicitors. Both produced significant insights into the causes of the disaster and highlighted serious shortcomings in CASA's role as regulator.

In his report, Coroner Barnes was critical of CASA. His findings included the following:

1. The Coroner did not accept CASA's submission that responsibility for the crash started and ended in the cockpit. He highlighted a number of deficiencies in CASA's surveillance and audit of Transair and its departure from its own procedures. He found that the risk of the crash occurring may have been reduced had CASA scrupulously followed all of its procedures and processes.
2. If the incident aircraft had been fitted with a properly operating and fully functional Terrain Alert Warning System (TAWS) it is probable that the accident would not have occurred. This was also the view expressed by CASA's CEO the day after the ATSB Report was published but the Coroner noted that the Agency's submission (at the inquest) departed from that position. (On the CASA website, the transcript of the press conference at the time of the release of the ATSB report in April 2007 quotes Bruce Byron as saying (in answer to the question :Could this accident have been avoided? Yes or no?) – "If the aircraft had been equipped with terrain awareness system, most definitely. In my view this accident would not have occurred."
3. In 1999, CASA announced the impending introduction of special legislation to require certain operators to install TAWS by 1 January 2001. This was then extended to 1 July 2005. The evidence at the inquiry disclosed that the extension of the implementation date to 1 July 2005 was intended to provide 'considerable scope for savings to operators of the particular older aeroplanes'…The Coroner found that the stark reality was that the delay (in implementation) produced an outcome that came tragically 7 weeks too late.

4. It was of concern to the Coroner that Australia had not yet mandated crew resource management training and that regulations doing so were said to be still in development despite CASA publishing a discussion paper in 2000 strongly advocating CRM training (i.e. 5 years before this accident.)
5. Senior CASA management failed to provide sufficient guidance to its staff to enable them to fully and effectively evaluate risk management issues associated with Transair's application to add LHR to its Air Operator's Certificate (AOC).
6. Inconsistencies between CASA's oversight of Transair and its regulatory policies and surveillance guidelines.
7. The Coroner was of the opinion that CASA had senior, expert legal representation who would not have made such a sustained attack on the integrity of the ATSB investigation report without explicit instructions.
8. CASA's submissions to the inquest suggested that there was a danger of the ATSB's recommendations being ignored and he detected a defensive and less than fulsome response to some of them.

Expectation of CASA as a firm safety regulator

The above findings and CASA's reaction to the ATSB report, together with my own observations made after attending every day of the Coronial Inquest, lead me to conclude:

1. That CASA is a defensive organisation which does not react well to criticism be it from the ATSB, the Queensland State Coroner or questions in the Senate. For example:

    i) During 2006 and 2007, CASA replies given in response to an array of Senate Questions on Notice regarding the Lockhart River Air Disaster were not *anywhere close* to the standard I would expect from the Regulator.

    ii) Furthermore, during the Coronial Inquest, I was very concerned by the hostility shown to the ATSB by the CASA legal team.

2. As an organisation they are reactive and slow to introduce and implement change. For example:

    i) The **five year** delay in implementing TAWS. Again, in the words of the CASA CEO in April 2007, – "If the aircraft had been equipped with terrain awareness system……. In my view this accident would not have occurred."
    ii) The introduction of CRM training which was advocated by CASA in 2000 had still not been mandated **seven years** later in 2007; and
    iii) The unexplained delay in the cancellation of Transair's AOC in late 2006, **eighteen months** after the disaster, an event which was revealed in Senate transcripts.

Recommendations

In order to move forward CASA needs to:

1. Be open to criticism;
2. Live up to their responsibilities; and
3. Learn from their mistakes.

Conclusion

1. Ultimately CASA has the lives of the Australian travelling public in their hands. They failed in their duty to the Lockhart River Air Disaster passengers. Their lives have been ended and the lives of their families changed forever.

2. CASA's website contains information on their priorities for aviation safety:

"Passengers are the number one priority for the Civil Aviation Safety Authority".

Their policy goes on to assert that:

"Passengers are occupants who are not expected or assumed to have knowledge of the risks they are exposed to and have little or no control over the risks (other than choosing not to fly.)

CASA does have control over the risks by scrupulously following their own procedures and policies.

3. Australians who live in regional Australia, sometimes without the benefit of all-weather roads (as in the case of the Cape York communities), depend on safe and reliable air services. They are isolated without these links. CASA's vision statement is : **SAFE SKIES FOR ALL.**

4. CASA's Challenge, they say, is "To enhance and promote aviation safety through effective safety regulation and by encouraging industry to deliver high standards of safety". I take issue with this statement. Rather than 'encouraging' industry to deliver high standards of safety, CASA should be **'enforcing'** high standards of safety. This is Australia in the 21st Century. The travelling public should expect **no less** from their Regulator.

Thank you for this opportunity to comment.

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