Executive Summary

On the night of 18 November 2009, Pel-Air VH-NGA ditched into the ocean in bad weather off Norfolk Island following several aborted landing attempts. The aeromedical retrieval flight was en route to the Australian mainland from Apia, Samoa, and planned to refuel on Norfolk Island as it had done on the first leg of its journey, from Sydney to Samoa. Six people were on board: the patient, her husband, a doctor, a nurse, the pilot in command and his co-pilot. All six survived.

Their survival is testament to skill and luck. The committee appreciates that the accident has affected their lives in ways that are impossible to fully understand. What allowed the accident to happen, however, should not be.

Although this inquiry had at its heart an Australian Transport Safety Bureau (ATSB) report into a single aviation accident, the committee's primary focus throughout was the adequacy of the ATSB's investigation and reporting process, rather than the particulars of the accident itself. The committee is not comprised of aviation experts, and although it is fortunate to have the benefit of several members who have extensive flying experience, it did not set out to conduct another investigation of the accident.

The committee accepts that the pilot in command made errors on the night, and this inquiry was not an attempt to vindicate him. Instead, the committee's overriding objective from the outset was to find out why the pilot became the last line of defence on the night and to maximise the safety outcomes of future ATSB and Civil Aviation Safety Authority (CASA) investigations in the interests of the travelling public. This report does so by asking:

- why errors were made;
- why, given that a pilot works within a system, the flight crew became the last line of defence;
- what deficiencies existed in the system, with regard to the operator (Pel-Air) and the regulator (CASA), which were not explored as fully as they could have been by the ATSB; and
- whether the travelling public can have confidence in ATSB processes, the agency's interaction with CASA and the systems in place to ensure safety.

The findings of the ATSB's investigation report are the starting point in untangling and addressing these questions. The ATSB's firm position is that the ditching was a one-off event due predominantly to the actions of the pilot, and the agency has defended this stance without, in the committee's view, a solid evidentiary base. Over the course of this inquiry the ATSB repeatedly deflected suggestions that significant deficiencies with both the operator, (identified in the CASA Special Audit of Pel-Air), and CASA's oversight of Pel-Air, (identified in the Chambers Report), contributed to the accident. The committee takes a different view and believes that ATSB processes have become deficient for reasons to be detailed in the following chapters, allowing this narrow interpretation of events to occur.

The committee also focuses on the appropriateness and effectiveness of the interaction between the ATSB and CASA. The committee notes that a systemic approach to the investigation was initially pursued, but that systemic issues were scoped out of the investigation early in the process. This led the committee to ask whether CASA exerted undue influence on the ATSB process. What is clear is that CASA's failure to provide the ATSB with critical documents, including the Chambers Report and CASA's Special Audit of Pel-Air, which both demonstrated CASA's failure to properly oversee the Pel-Air operations, contravened the Memorandum of Understanding (MoU) in place between the two agencies and may have breached the terms of the *Transport Safety Investigations Act 2003* (Chapter 7). The committee takes a dim view of CASA's actions in this regard.

The survival of all six people on board VH-NGA means that a lot went right—this should result in lessons for the wider industry, particularly operators flying to remote locations. At the same time, many things could have worked better, and industry should also learn from these. Many submitters and witnesses asserted that the ATSB's report is not balanced and includes scant coverage of contributing systemic factors such as organisational and regulatory issues, human factors and survivability aspects. Given the ATSB's central role in improving aviation safety by communicating lessons learned from aviation accidents, the committee is surprised by the agency's near exclusive focus on the actions of the pilot and lack of analysis or detail of factors that would assist the wider aviation industry. The committee notes warnings that the omission or downgrading of important safety information has the potential to adversely affect aviation safety.

The committee was understandably troubled by allegations that agencies whose role it is to protect and enhance aviation safety were acting in ways which could compromise that safety. It therefore resolved to take all appropriate action to investigate these allegations in order to assure itself, the industry and the travelling public that processes currently in place in CASA and the ATSB are working effectively.

The committee recognises that Australia has been a leader in aviation safety for a number of years through its robust adoption of the accident causation model developed by Professor James Reason (Chapter 3).[1] This approach recognises that people work within systems – the individual actions of the pilot in command have a role to play, as do the actions of the operator and the regulatory environment they work within. Each layer provides a barrier to prevent an accident and each must be examined for deficiencies when incidents occur.

Furthermore, the committee has strong concerns about the methodology the ATSB uses to attribute risk (Chapter 4). The methodology appears to defy common sense by not asking whether the many issues that were presented to the committee in evidence, but not included in the report, or not included in any detail, could:

- help prevent such an incident in the future;

1 This strong reputation was earned by the ATSB's predecessor, the Bureau of Air Safety Investigation (BASI), in particular in terms of accident reporting and its 'no-blame' approach.

- offer lessons for the wider aviation industry; or
- enable a better understanding of actions taken by the crew.

The committee examines how this methodology contributed to the downgrading of an identified safety issue from 'critical' to 'minor', and finds that the process lacked transparency, objectivity and due process (Chapter 4). The committee finds that the ATSB's subjective investigative processes are driven in part by ministerial guidance prioritising high capacity public transport operations over other types of aviation transport.

The committee considers (Chapter 8) whether the lack of formal recommendations in the ATSB report led to a lack of action on important safety issues. This absence of recommendations stems back to the Memorandum of Understanding (MoU) between the ATSB and CASA, which encourages concurrent safety action rather than action in response to recommendations. The committee believes both are necessary. It is regrettable that a Senate inquiry has had to make recommendations which should have been made by the ATSB.

A number of changes have been made by the operator (Chapter 5) and the regulator (Chapter 6) since the ditching. The committee is convinced that having these measures in place before the ditching would have significantly reduced the risk of the accident occurring. To simply focus on the actions of the pilot and not discuss the deficiencies of the system as a whole is unhelpful. It is disappointing that CASA and the ATSB continue to assert, in the face of evidence to the contrary, that the only part of the system with any effect on the accident sequence was the pilot.

It also emerged in the course of the inquiry that the previous system of mandatory and confidential incident reporting to the ATSB has been altered. Pilots have expressed concern that CASA now appears to have access to identifying information, which may inhibit pilots reporting incidents and will therefore undermine the important principle of just culture within the aviation industry (Chapter 10).

Finally, the committee notes that many submitters and witnesses provided evidence *in camera* due to fear of retribution, particularly from CASA, were they to go public with their concerns. Many who chose to give *in camera* evidence did so in the knowledge of protections provided by parliamentary privilege. The committee also notes that this reticence to speak in public has been apparent for each inquiry this committee has conducted in this area over several years, and finds this deeply worrying. Given the positive statements made about the inquiry by CASA Director of Aviation Safety, Mr John McCormick, the committee trusts that concerns about retribution are unwarranted. There is an obligation on CASA to allay these concerns that retribution could follow speaking out, which appear to be widespread within the aviation industry. The committee stresses that it takes the protection of witnesses under parliamentary privilege very seriously. Witnesses—whether public or *in camera*—should suffer no adverse consequences from providing evidence to the committee. Given the numerous concerns expressed, the committee will be monitoring this situation carefully.

If Australia is to remain at the forefront of open, transparent and effective aviation safety systems, then the goal of this committee is to help our organisations to work transparently, effectively and cooperatively. Ensuring that a systemic approach to aviation safety is in place is the best way to maximise outcomes.