Chapter 1
Introduction

Inquiry terms of reference

1.1 On 13 September 2012, the Senate referred the following terms of reference to the Regional and Rural Affairs and Transport References Committee for inquiry and report by 29 November 2012:

(a) the findings of the Australian Transport Safety Bureau into the ditching of VH-NGA Westwind II, operated by Pel-Air Aviation Pty Ltd, in the ocean near Norfolk Island airport on 18 November 2009;

(b) the nature of, and protocols involved in, communications between agencies and directly interested parties in an aviation accident investigation and the reporting process;

(c) the mechanisms in place to ensure recommendations from aviation accident investigations are implemented in a timely manner; and

(d) any related matters.

Conduct of the inquiry

1.2 Notice of the inquiry was posted on the committee's website. The committee also advertised the inquiry in *The Australian* and wrote to key stakeholder groups, organisations and individuals to invite submissions.

1.3 The committee received 22 public submissions as well as supplementary submissions which are listed at Appendix 1. The committee also received several *in camera* submissions.

1.4 The committee received a large volume of material from the Australian Transport Safety Bureau (ATSB) and the Civil Aviation Safety Authority (CASA), as well as a number of late submissions. The reporting date for this inquiry was extended several times to enable the committee to further consider the written evidence received and to hold a number of additional hearings.

1.5 The committee held public hearings in Canberra on 22 October, 19 November and 21 November 2012, as well as 15 and 28 February 2013. The committee also held several *in camera* hearings. A list of witnesses who gave evidence at the public hearings is available at Appendix 2. A Hansard record of the committee's public hearings is available on the committee's website at www.aph.gov.au.

Order for the production of documents

1.6 The committee decided that there was a need to access relevant information from the ATSB and CASA to be able to judge for itself the internal processes undertaken by each agency and the inter-agency dealings. Many thousands of internal ATSB and CASA documents were received through an order for the production of

documents.[1] This material was received confidentially and the committee takes the protection of such material very seriously.

1.7 Before deciding whether to publish any of the documentation, the committee discussed the ramifications at length. In doing so it weighed up the request for confidentiality against the public interest of the aviation industry and the travelling public having confidence in the key agencies responsible for civil aviation safety in Australia. Wherever possible, the committee sought the views of the ATSB or CASA prior to publication. The committee also considered that it needed to be able to support its analysis and conclusions as the internal documents appeared at odds with the evidence given publicly. The committee also wanted to provide the agencies with the opportunity to explain key documents in public. For these reasons the committee took the decision in the public interest to publish a small number of documents but did so with care, selecting only those documents needed to support its conclusions.

1.8 Of the thousands of documents received from the ATSB and CASA, the committee published 12. At the conclusion of this inquiry, the committee decided to return all unpublished documents to their respective agencies.

Acknowledgements

1.9 The committee thanks those organisations and individuals who made submissions and gave evidence at the public hearings.

1.10 The committee recognises the ATSB and CASA for their cooperation with the committee's order for the production of documents.

1.11 The committee in particular acknowledges the contributions of the VH-NGA flight crew and passengers, and thanks them for their time and effort. Their ordeal was traumatic, and rebuilding their lives has not been easy. The committee wishes to single out the nurse who kept the patient afloat until they were rescued, despite difficulties with her own lifejacket, which has unfortunately resulted in a painful and permanent disability. The committee hopes to see her receive the assistance she needs and deserves as soon as possible.

1.12 The committee extends its appreciation to the Department of Defence for facilitating the two-week secondment of an officer with extensive aviation accident investigation experience. The committee thanks the officer, the department and the minister for making the officer available. The committee emphasises that the secondment served purely to assist the committee in understanding issues which required technical expertise.

1.13 Finally, the committee is always grateful for the hard work and diligence of the secretariat. In this inquiry, the enormous volume of material and its highly

1 See correspondence between the committee and the ATSB regarding request for documents, received 3 October 2012, available at http://aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=rrat_ctte/pel_air_2012/submissions.htm (accessed 9 April 2013).

technical nature put additional demands on the secretariat, who rose to the challenge in an exemplary fashion.

Scope and structure of this report

1.14 The report is comprised of 10 chapters as follows:

Chapter 2	Background
Chapter 3	The ATSB investigation and methodology
Chapter 4	The ATSB's accident investigation processes
Chapter 5	System failures
Chapter 6	Regulatory issues
Chapter 7	Communication between CASA and ATSB
Chapter 8	Human Factors
Chapter 9	Key issues around recommendations and ensuring action
Chapter 10	Proposed changes to mandatory and confidential reporting

1.15 The committee notes that additional comments or reports in relation to this inquiry may be tabled in the Senate at a future time.