# Chapter 6

# Regulatory issues

6.1 Part of a system approach to aviation investigations is also looking at the regulatory environment. The committee is of the view that it is relevant to look at the Civil Aviation Safety Authority's (CASA) surveillance activities as they are part of the system and will influence how the operator runs its operation. As an independent investigator it is also the role of the Australian Transport Safety Bureau (ATSB) to review the adequacy of CASA's regulatory arrangements.

## Surveillance by CASA of Pel-Air

6.2 The Australian and International Pilots Association (AIPA) pointed out that the organisational climate and the operational culture of Pel-Air existed under the direct supervision of CASA and the assigned inspectors. In the absence of relevant evidence in the ATSB report, the implication is that the system was working well. AIPA highlighted that at the time of the *Four Corners* interview, the Director of Aviation Safety through the CASA Special Audit knew that the system, dominated by the actions of CASA and Pel-Air, contained significant deficiencies. AIPA concluded that the continuation of the 'it's only about the pilot' argument seems a little incongruous in the circumstances.[1]

6.3 AIPA also raised the question of whether CASA's role in the system is being adequately scrutinised. It stated:

> The complete absence of ATSB commentary on the regulatory regime and CASA's regulatory activities begs the question about the level of scrutiny now being applied to CASA.[2]

6.4 Mr McCormick informed the committee of the outcome of surveillance conducted by CASA[3] prior to the accident:

> As an A[O]C [Air Operator's Certificate]-holder, Pel-Air was regularly subject to CASA surveillance prior to the accident. Between 1 June 2005 and 18 November 2009, CASA issued a total of 34 requests for corrective action and one safety alert to Pel-Air, with the key findings relating to deficiency in the operator's fatigue risk management and the training and checking systems. The allegation is made that CASA has kept these actions secret. That is false and misleading. CASA does not publish its ongoing regulatory actions in relation to any operator on the assumption, where such

1 AIPA, *Submission 8*, p. 17.

2 AIPA, *Submission 8*, p. 26.

3 The committee notes that regular surveillance does not provide assurance that the regular audits were effective nor that the standards against which the company was being evaluated were valid. The leads to the recommendation later in the report for industry to be included in the development of standards they should be operating to.

> an assumption is reasonable, that a responsive correction action will be taken and effected in a timely manner.[4]

6.5 However, the CASA Special Audit revealed that actions that were assumed to have been taken by the operator were not and this was not checked by CASA. As pointed out by Mr Richard Davies, pilot:

> In the events and conditions associated with this accident it is apparent the risk controls were inadequate and unreliable. This in turn identifies a lack of effective regulatory oversight of the operator by CASA.[5]

## The Chambers Report

6.6 Completed in August 2010, the Chambers Report was an internal review commissioned by Mr McCormick[6] in the wake of the ditching and the CASA Special Audit, which identified serious deficiencies within Pel-Air and raised questions about the effectiveness of the regulatory oversight conducted by CASA, surveillance tools and available resources.

6.7 The committee commended the action by Mr McCormick to initiate such a review. One of the committee's concerns, however, is the significant conflict between CASA's rejection of some witnesses' evidence regarding oversight deficiencies and the position of this internal review. This review was not made public and was not made available to the ATSB.

6.8 Several witnesses contended that CASA oversight of the operator has been inadequate.[7] The response by CASA to these assertions, despite the existence of the Chambers Report, was to strongly reject this criticism.[8] Yet among other things the Chambers Report noted:

> The findings of the [CASA special] audit identified serious deficiencies within the AOC. Further it raised the question of the veracity of the oversight conducted by CASA and also questions the effectiveness of current oversight policies, surveillance tools and available resources.[9]

6.9 It added:

> In reviewing the findings of the special audit, it appears as if there were indicators that could have identified that the Pel-Air Westwind operation was at an elevated risk and warranted more frequent and intensive surveillance and intervention strategies. It was also apparent that the data systems, training, surveillance tools, resources and inspector capability showed varying degrees of inadequacy and contributed to Bankstown

---

4 Mr John McCormick, *Committee Hansard*, 22 October 2012, p. 31.

5 Mr Richard Davies, *Submission 12*, p. 14.

6 Mr John McCormick, *Committee Hansard*, 15 February 2013, p. 2. See also CASA *Supplementary submission*, 1 March 2013, p. 4.

7 See for example Mr Bryan Aherne, *Submission 10*, p. 49; and Mr Mick Quinn, *Submission 11*, p. 5.

8 See CASA *Supplementary submission.*

9 Chambers Report, p. 1.

> Operations and CASA's inability to fully understand the operator's risk exposure and consequently to intervene to ensure the operator reduced the risk appropriately.[10]

6.10 The Chambers Report noted CASA's surveillance of Pel-Air from 2005 to 2010, the various breaches issued and the key findings in the areas of Fatigue Risk Management System (FRMS) and the Training and Checking System. The report added that:

> The relative familiarity with the company and key personnel resulted in a sense that CASA had detailed knowledge of the actual operations however this clearly was not the case.[11]

6.11 In particular it noted:

> It is likely that many of the deficiencies identified after the accident would have been detectable through interviews with line pilots and through the conduct of operational surveillance of line crews in addition to surveillance of management and check and training personnel.[12]

6.12 Worryingly, the Chambers Report noted:

> CASA is concerned that in some of our oversight activities, we may be merely scratching the surface.[13]

6.13 Mr McCormick informed the committee that the information from the Chambers Report was used to seek additional funding from the government to improve surveillance activities.[14]

6.14 Mr McCormick took the view that the Chambers Report was an internal CASA document[15] and accordingly it was not provided to the ATSB under the Memorandum of Understanding (MoU). It was also not provided in response to the section 32 request for AOC surveillance.[16]

6.15 An important issue is whether the deficiencies outlined could have affected the outcome of the accident. Mr McCormick contended that the Chambers Report 'still does not indicate anything that would have affected the outcome of the accident'.[17] He added:

---

10 Chambers Report, p. 1.

11 Chambers Report, p. 5.

12 Chambers Report, p. 6.

13 Chambers Report, p. 7.

14 Mr John McCormick, *Committee Hansard*, 15 February 2013, p. 8.

15 Mr John McCormick, *Committee Hansard*, 15 February 2013, p. 2; See also CASA *Supplementary submission*, 1 March 2013, pp 6–7.

16 The committee notes the request, dated 22 October 2010, appears quite narrow, asking for: electronic copies of AOC surveillance, check and training and ops manual files for Pel-Air between 01 January 2004 and 18 November 2009; and the last surveillance check or audit of the fuel planning and management systems in the Pel-Air ops manual.

17 Mr John McCormick, *Committee Hansard*, 15 February 2013, p. 2.

> What it indicates is that our procedures and way we went about doing some things needed revision, and we were in the process of doing that. We are a different organisation from what we were in those days.[18]

6.16 He further asserted that he didn't want to influence[19] or contaminate the ATSB investigation by providing the document. However, as was noted by the ATSB, this leaves the onus on CASA to determine what is relevant to the ATSB's investigation.[20]

***ATSB position on the effect of the Chambers Report***

6.17 The ATSB advised that although it had no knowledge of the Chambers Report,[21] it was generally aware that CASA was conducting an internal review of its regulatory oversight.[22] However, the ATSB report notes that:

> Surveillance was carried out by CASA of operator's procedures and operations to ensure that such flights were conducted in accordance with those approvals and the relevant regulations and orders.[23]

6.18 This appears to indicate, which was confirmed by Mr Dolan, that in the view of the ATSB the appropriate checks and balances and protections were in place and effective.[24]

6.19 The committee questioned the ATSB on its views of the significance of the findings contained in the Chambers Report. The ATSB indicated that in its view 'the Chambers Report does not contain any new evidence that organisational factors were likely to have contributed to the accident'.[25]

6.20 The committee also asked the ATSB whether the regulatory deficiencies contained in the Chambers Report would have changed the scope of the investigation. The ATSB expressed the view that:

> In the view of the ATSB, there is insufficient additional material within the Chambers Report to support changes to the existing findings of the ATSB report or to require new findings.
>
> The Chambers Report could have been an indicator to the ATSB of potentially relevant organisational issues within Pel-Air and CASA. The report's availability to the ATSB investigation would likely have led to a review of the scope of the investigation to determine whether there needed to be further examination of possible organisational factors in the accident. That said, it is unlikely that the Chambers report would have led to substantive re-scoping of the investigation, since the CASA accident

18 Mr John McCormick, *Committee Hansard*, 15 February 2013, p. 2.

19 Mr John McCormick, *Committee Hansard*, 15 February 2013, p. 3.

20 Mr Martin Dolan, *Committee Hansard*, 15 February 2013, p. 23.

21 Mr Ian Sangston, *Committee Hansard*, 15 February 2013, p. 23.

22 ATSB, answers to written questions taken on notice from 15 February 2013 hearing, number 3.

23 ATSB report, p. 24.

24 Mr Martin Dolan, *Committee Hansard*, 15 February 2013, p. 24.

25 ATSB, Answers to questions taken on notice from 15 February 2013 hearing, number 1.

> investigation report already indicated the existence of organisational deficiencies and the ATSB safety factor identification processes include the consideration of organisational factors as part of the scope of an investigation.
>
> The ATSB does not consider that lack of access to the Chambers Report was a constraint or limitation to the ATSB investigation and its assessment of factors contributing to the accident.[26]

### *Working through the ATSB analysis model with the Chambers Report*

6.21 In an effort to understand this position, the committee discussed the ATSB analysis model which is based on the Reason model of organisational accidents and includes five levels of safety factors including organisational influences, preventative risk controls and local conditions, among others.[27]

6.22 As an example of organisational influences the committee pointed out that in the Chambers Report there is a comment on the special audit where CASA interviewed line pilots to determine if they were familiar with, understood and complied with the company's operating requirements and legislation. This process revealed deficiencies within the Westwind operation and identified key markers for subsequent investigation.[28]

6.23 Mr Dolan confirmed that the Chambers Report did not change the ATSB view of the scope of its analysis[29] and replied that in their view:

> All the information available to the investigation led us to the view that it was hard to establish that there was either an ongoing deficiency in the competence of crews or an ongoing problem with compliance with procedures.[30]

6.24 The committee then pointed out that the Chambers Report identified repeated deviations from the expected standards and that the risk controls were not effective. Mr Dolan responded:

> From our perspective, we were trying to understand whether there were deficiencies in that rules set and its applications that were relevant to understanding what contributed to this flight and therefore to arrive at questions of cause, contributing safety factors and, incidentally, to the extent necessary, examine other safety issues. That is the balance that we are always doing in these investigations. It is the separate purposes of a CASA investigation as opposed to one of ours that we would bear in mind.[31]

---

26 ATSB, Answers to questions taken on notice from 15 February 2013 hearing, number 1.

27 ATSB *Submission 2*, p. 12.

28 Chambers Report, p. 3.

29 Mr Martin Dolan, *Committee Hansard*, 28 February 2013, p. 2.

30 Mr Martin Dolan, *Committee Hansard* 28 February 2013, p. 2.

31 Mr Martin Dolan, *Committee Hansard*, 28 February 2013, pp 2–3.

6.25 The committee further noted that the Chambers Report included the effectiveness of CASA oversight and it also covered the effectiveness of the oversight of the operator of its line pilots. The committee understands that all systems safety models include organisational factors as part of the preventative controls for an accident. The ATSB's own analysis model includes organisational influences and risk controls.[32] The Chambers Report identifies that the oversight and safety outcomes were significantly flawed and is an alert that organisational influences and risk controls were not adequate. The committee therefore asked why, given the ATSB's own analysis model, this was not a contributing safety factor. Mr Dolan responded:

> There is still nothing in our assessment that we could see, acknowledging that there were deficiencies in CASA's surveillance and activities, and acknowledging that there were problems with the way Pel-Air operated its safety management system, that was going to lead us to the question of contributing safety factors and, more particularly, to the identification of areas for safety improvement.[33]

6.26 The committee pointed out paragraph 4.1 of the Chambers Report which states:

> It is likely that many of the deficiencies identified after the accident would have been detectable through interviews with line pilots and through the conduct of operational surveillance of line crews in addition to the surveillance of management and check and training personnel…
>
> If a systems audit is conducted with inadequate product checking [the line pilots] CASA is unable to genuinely confirm that the operator is managing their risks effectively.[34]

6.27 The committee again asked the ATSB to confirm its position that these statements do not indicate an organisational influence or a risk control that was a contributing safety factor in terms of not only the incident pilot but also the fact that the rest of the line pilots indicated similar lack of compliance and lack of understanding. Mr Dolan confirmed this was the case:

> It is the influence of those factors on the accident flight in particular which always has to be the principal but not the only focus of our investigation. It is the influence of those known factors in the events of this flight that we always have to come back to, because of the task that we have been given as the accident investigator.[35]

6.28 The committee then highlighted the ATSB focus on 'known factors' and posited that, had it received the Chambers Report before its final report was published, the information contained in the document would have been 'known factors'. In the ATSB submission it notes when looking at risk controls the relevant question is what could have been in place to reduce the likelihood or severity of problems at the

---

32 ATSB *Submission 2*, p. 13.

33 Mr Martin Dolan, *Committee Hansard*, 28 February 2013, p. 3.

34 Chambers Report, p. 6.

35 Mr Martin Dolan, *Committee Hansard*, 28 February 2013, p. 4.

operational level.[36] The committee explored this aspect in light of the Chambers Report. The committee pointed out the areas in the Chambers Report which contain information about inspector capability and performance:

> An inspector needs to have a level of investigative skill to drill down to find the deficiencies that are genuinely serious and often complex. Not all inspectors have this capability and it seems that this characteristic is assumed to exist in an inspector.[37]

6.29 Looking at the ATSB analysis model[38] the committee suggested that in answering the question regarding organisational influences and risk controls that could have been in place, this could be answered by competent and informed inspectors as well as an appropriate oversight program. The ATSB was asked whether those examples would fit with its definition of organisational issues. Mr Dolan responded:

> Those sorts of circumstances certainly fit in to the picture of what would constitute organisational issues. Where we appear to be at odds is in the question of the level of contribution of those factors in the particular occurrence that we were investigating. That is why we have the position that we have taken. We carefully reviewed the chamber's report, and the basis on which we responded as we did was the issue of influence, contribution, cause.[39]

## Comparison with overseas reports

6.30 The committee pointed out an investigation report conducted by Indonesia into a Dornier aircraft that had its undercarriage collapse after a heavy landing.[40] The committee is aware that in the past the ATSB has spent considerable time assisting the relevant Indonesian aviation safety organisations with their ability to conduct aviation accident investigations. The committee noted that despite the finding of pilot error, the Indonesian organisations took the trouble to highlight other issues like the runway, airport facilities, oversight and compliance. The Indonesian organisations made recommendations to other agencies and the operator which can be tracked. The committee noted that other countries appear to take the same basic analysis model the ASTB started with but put quite clear emphasis on organisational and oversight factors. The committee asked if it was of concern that the ATSB appears to be out of step with its near neighbours as well as the world leaders in aviation. Mr Dolan replied:

> Important though it is, the Norfolk Island investigation report is only one of a considerable number of reports we produce on an annual basis. Each investigation results in those reports. We have an assessment as to scope, taking account of a range of factors, and in a number of cases, because we

36 ATSB, *Submission 2*, p. 13.

37 Chambers Report, p. 7.

38 ATSB *Submission 2*, p. 13.

39 Mr Martin Dolan, *Committee Hansard*, 28 February 2013, p. 4.

40 Republic of Indonesia, Ministry of Transportation, National Transportation Safety Committee, Aircraft Accident Investigation Report, Dornier 328-100, 6 November 2008.

> think it is necessary for the purposes of the investigation to go all the way to organisational factors both at the operator level and the regulator level, we will quite often go there and make quite clear statements and findings in relation to it.[41]

6.31 Regarding scope, Mr Dolan said that critical reviews are undertaken as necessary which sometimes result in a variation of scope. It depends on whether it appears that organisational factors have had an influence in this area and if the evidence is available.[42] The committee notes with interest that ATSB documentation clearly indicates that the early expectation of the working level officers was that systematic issues would be an important part of the investigation.[43]

***Comparison with another ATSB report***

6.32 Although it was drawn to the attention of the committee very late in the inquiry, the committee notes some similarities regarding the treatment of organisational and regulatory issues with the ATSB's report on 'Collision with terrain - Piper PA-31P-350, VH-PGW, 6 km NW of Bankstown Airport, NSW, 15 June 2010' or the 'Canley Vale report'.

6.33 Also a medical flight, VH-PGW crashed while the pilot was trying to make an emergency landing after an engine failure. Tragically, both the pilot and the nurse on board lost their lives.

6.34 The ATSB report discusses significant issues within the operator (Skymaster, owned by Avtex), some of which were recognised by CASA prior to the accident. The report also acknowledges that CASA did not detect that the pilot in question, and a number of other pilots, did not receive appropriate training from Avtex.

6.35 However, the ATSB then excuses this lack of oversight by stating that this non-detection by CASA was 'probably due to the two companies having separate Air Operator's Certificates, with different CASA inspectors being assigned to the surveillance of each company'[44]

6.36 The Special Audit conducted by CASA of Skymaster following the accident in June 2010 revealed a large number of safety deficiencies in the systems and work practices in place, including issues with training and checking. The committee notes that in August 2010 CASA cancelled Skymaster's AOC, based on a serious and imminent risk to air safety if operations continued. This decision was upheld by the Administrative Appeals Tribunal (AAT).[45] The committee also notes that CASA had issued Avtex with a show cause notice on 28 May 2010, just over a fortnight prior to the accident.

---

41 Mr Martin Dolan, *Committee Hansard*, 28 February 2013, p. 5.

42 Mr Martin Dolan, *Committee Hansard*, 28 February 2013, p. 5.

43 ATSB, Additional information, number 12.

44 ATSB, 'Collision with terrain - Piper PA-31P-350, VH-PGW, 6 km NW of Bankstown Airport, NSW, 15 June 2010'. p. 49.

45 See www.austlii.edu.au/au/cases/cth/aat/2011/61.html (accessed 16 April 2013).

6.37 While the committee acknowledges it has not had the opportunity consider this report, or the transcript of the AAT hearing, in detail, it would like to express concern about the following matters, given what the committee now knows about the Pel-Air incident:

- while the incident occurred in June 2010, the ATSB only issued its final report on 20 December 2012, some two and a half years later. This is a similar timeframe to the Pel-Air report, which is discussed in Chapter 3;
- the ATSB concluded that 'it was unlikely that any deficiencies in the pilot's PA-31 endorsement training contributed to the accident',[46] despite acknowledging in its report that the pilot had not received training in mid-flight engine failure. The committee notes that the ATSB reports engine surging led to the pilot's actions, which resulted in the crash[47];
- the ATSB also concluded that 'no organisational or systemic issue was identified in respect of CASA's surveillance that might adversely affect the future safety of aviation operations'[48]. This is despite the fact that a post-incident Special Audit by CASA led to a suspension of Skymaster's AOC because of a 'serious and imminent risk to air safety' [AATA 61, point 5]; and
- the ATSB excused CASA's lack of oversight on the basis that the companies had two separate AOCs and therefore CASA investigators may not have been aware that Avtex owned Skymaster[49]. However, during the AAT review, CASA justified the cancellation of Avtex's AOC due to CASA's opinion that 'because of the close relationship between Avtex and Skymaster, and the joint resources shared by those companies, if Avtex continued its operations under its AOC, that would also result in a serious and imminent risk to air safety' [AATA 61, point 5].

6.38 The committee considers that this report, and the associated evidence from the AAT review, could point to a disturbing trend where the ATSB disregards or excuses CASA failures. It appears, from the publicly available material, that there are significant similarities between this and the Pel-Air report. The committee is of the view that the establishment of the independent panel (recommendation 8) should play a vital role in ensuring no such reporting trend continues.

46 ATSB, 'Collision with terrain - Piper PA-31P-350, VH-PGW, 6 km NW of Bankstown Airport, NSW, 15 June 2010'. p. 49.

47 ATSB, 'Collision with terrain - Piper PA-31P-350, VH-PGW, 6 km NW of Bankstown Airport, NSW, 15 June 2010'. p. iii.

48 ATSB, 'Collision with terrain - Piper PA-31P-350, VH-PGW, 6 km NW of Bankstown Airport, NSW, 15 June 2010'. p. 53.

49 ATSB, 'Collision with terrain - Piper PA-31P-350, VH-PGW, 6 km NW of Bankstown Airport, NSW, 15 June 2010'. p. 49.

### *Committee view*

6.39 The committee finds it particularly disappointing that CASA chose to strongly reject the assertions from witnesses about the adequacy of CASA oversight when the evidence in its own documents makes clear that it was deficient.

6.40 The committee is left bewildered as to why, in the face of clear and incontrovertible evidence the ATSB continues to ignore the obvious and relevant facts identified in the Chambers Report that the oversight and safety outcomes were significantly flawed and organisational influences and risk controls were not adequate. The ATSB itself recognises that when assessing risk 'even in the worst credible scenario, regard needs to be given to the normal expectation of compliance with existing risk controls'.[50] The Chambers Reports shows this was not the case. It is a key reason that the inquiry should be reopened. The committee stresses that this would not be about going over the actions of individuals again but would focus on the organisational, oversight and broader systemic issues.

**Recommendation 10**

**6.41 The committee recommends that the investigation be re-opened by the ATSB with a focus on organisational, oversight and broader systemic issues.**

6.42 The committee is concerned that the ATSB report ATSB's report on 'Collision with terrain - Piper PA-31P-350, VH-PGW, 6 km NW of Bankstown Airport, NSW, 15 June 2010' could demonstrate a trend where organisational and regulatory factors are not considered appropriately or in sufficient detail by the ATSB, despite post-accident investigations by CASA indicating there were significant deficiencies with the operator and appearing to indicate insufficient oversight by CASA. As highlighted in Chapter 5, the committee is also concerned about ATSB attempts to predict future risk for operators. The ATSB should analyse why the accident happened but operators are best placed to assess how the lessons may affect their current and future operations.

## Conclusion

6.43 CASA's internal reports indicate that the deficiencies identified would have had an effect on the outcome of the accident in several areas. It is inexplicable therefore that CASA should so strongly and publicly reject witnesses' evidence that they did not think surveillance was adequate, when CASA's own internal investigations indicate that CASA's oversight was inadequate. CASA even admitted that on the basis of the information contained in the Chamber's Report, it went to government for additional resources which were provided. In a resource constrained environment the deficiencies must indeed have caused serious concern for the funding to have been provided.

6.44 The committee is pleased that steps have been and are being taken to correct this situation. It is in the public interest for this information to be voluntarily divulged through the ATSB investigation process rather than have it become known through a subsequent Senate inquiry. The ATSB should have been provided with the

50 ATSB *Submission 2*, p. 21.

information about CASA's surveillance deficiencies so that the public can have confidence that safety issues are being appropriately reported on and corrective actions undertaken. The public need to have confidence that CASA is a responsive organisation, that it is transparent about that and the actions being taken to address it.

6.45 To reject any assertion that oversight may have been inadequate when the internal reports are damming is not in the public interest and does not inspire public confidence.

6.46 The committee recognises that action has been and is being taken to address these deficiencies. The committee argues that not disclosing this information influenced the ATSB report. The ATSB report does not identify any regulatory and organisational issues:

> Surveillance was carried out by CASA of operators' procedures and operations to ensure that such flights were conducted in accordance with those approvals and the relevant regulations and orders.[51]

6.47 However, the committee notes there is no objective measure to determine whether the findings from the Special Audit of Pel-Air or the Chambers Report have been implemented, or whether either of these documents has affected CASA operations.

6.48 Statements such as this from the ATSB report appear entirely contradictory to the information contained in the Chambers Report.

6.49 The ATSB indicated it was not looking at systemic issues and it seemed to accept that the regulator was doing its job. CASA had in its possession information that would have indicated that its oversight was not adequate. By not disclosing that information the committee believes CASA shaped the outcome of the ATSB report.

6.50 The Chambers Report highlighted surveillance deficiencies which concern the committee.

6.51 The committee believes that CASA processes in relation to matters highlighted by this investigation be reviewed. This could involve an evaluation benchmarked against a credible peer (such as FAA or CAA) of regulation and audits with respect to:

- non-RPT [regular public transport] passenger carrying operations;
- approach to audits (eg. the need to evaluate line aircrew for effectiveness of Safety Management System (SMS) not just elements of SMS itself); and
- training and standardisation of FOI [Flying Operations Inspector] across regional offices.

**Recommendation 11**

**6.52 The committee recommends that CASA processes in relation to matters highlighted by this investigation be reviewed. This could involve an evaluation benchmarked against a credible peer (such as FAA or CAA) of regulation and**

51 ATSB report, p. 24.

**audits with respect to: non-RPT passenger carrying operations; approach to audits; and training and standardisation of FOI across regional offices.**

6.53 The committee now turns to industry specific standards. Looking at the categorisation of aeromedical flights the committee notes the challenges of Emergency Medical Services operations. For example, they are short notice, there are unprepared landing strips and long hours of duty. This drives a simultaneous need for flexibility in operations but higher standards of oversight, operational airworthiness and Safety Management Systems. No existing category of operations in Australia provides this.

6.54 Given the complexity of this operation, industry needs to have a voice.[52] The committee suggests a reference group comprising representatives nominated from industry and CASA to consider the development of a new category and standards for EMS. Particularly where the CASA representative has no operational experience in the type of operations concerned, the industry appointed body must have a strong voice—even potentially a veto.[53] Industry is best placed to determine best practice. The minister should require CASA to approve the industry plan unless there is a clear safety case not to. This should be finalised within 12 months and the outcome publicly reported. This new standard would become the basis for self audit and audit of Air Operator Certificate holders by CASA. There could also be scope for industry to assist as part of an audit team with CASA, particularly where standardisation is an issue.

**Recommendation 12**

**6.55 The committee recommends that CASA, in consultation with an Emergency Medical Services industry representative group (eg. Royal Flying Doctor Service, air ambulance operators, rotary wing rescue providers) consider the merit, form and standards of a new category of operations for Emergency Medical Services. The minister should require CASA to approve the industry plan unless there is a clear safety case not to. Scope for industry to assist as part of an audit team should also be investigated where standardisation is an issue. This should be completed within 12 months and the outcome reported publicly.**

## Other issues

### *Regulatory reform*

6.56 The committee received information that there is concern in industry about the progress and direction of regulatory reform.[54] It understands that this process has

52 For example see Helicopter Emergency Medical Services (HEMS) USA industry risk profile, published by the Flight Safety Foundation, developed by Aerosafe Risk Management, April 2009.

53 In practice this would mean that if industry and CASA do not agree, the issue would be elevated to the departmental secretary and, if necessary, the minster.

54 AMROBA, *Submission 15*; *Confidential submission*.

been going on for well over a decade[55] and this extended timeframe is causing ongoing uncertainty for industry. The committee compares it with the regulatory reform process in New Zealand which has taken far less time and by all accounts has been effective.[56]

6.57 While a certain degree of concern is to be expected, the committee believes it is time to conduct a brief inquiry on the current status of regulatory reform to review the direction, progress and resources expended to date. This would include seeking perspectives from CASA and industry. It would also include benchmarking against the New Zealand reform process and outcomes, including industry acceptance.

**Recommendation 13**

**6.58 The committee recommends that a short inquiry be conducted by the Senate Standing Committee on Rural and Regional Affairs and Transport into the current status of aviation regulatory reform to assess the direction, progress and resources expended to date to ensure greater visibility of the processes.**

55 See www.casa.gov.au/scripts/nc.dll?WCMS:STANDARD::pc=PC_92098 ; www.casa.gov.au/scripts/nc.dll?WCMS:STANDARD::pc=PC_92107; Steve Creedy, 'Civil Aviation Safety Authority close on reform of rules', *The Australian*, 4 November 2011. The article notes that the new regulations may not be in place before the end of 2014; Emma Kelly, InFocus, 'Australia closes in on regulatory reform', 19 February 2013. www.flightglobal.com/news/articles/in-focus-australia-closes-in-on-regulatory-reform-382027/; Paul Phelan, 'To hell with the rules', 6 April 2013, Pro Aviation http://proaviation.com.au/?p=639 accessed (19 April 2013).

56 AMROBA, *Submission 15*, p. 1; Civil Aviation Authority of New Zealand, *Strategic Direction, October 2011*.