Australian Government

Civil Aviation Safety Authority

OFFICE OF THE DIRECTOR OF AVIATION SAFETY

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Senator the Hon Bill Heffernan
Chair
Senate References Committee on Rural and
Regional Affairs and Transport
Parliament House
CANBERRA ACT 2600

Dear Senator Heffernan

CASA Second Supplementary Submission

I refer to the Senate References Committee on Rural and Regional Affairs and Transport Inquiry into Aviation Accidents Investigations (Pel-Air) and the hearing on 15 February 2013 where CASA agreed to provide the Committee with a second supplementary submission.

This submission is attached for the Committee's consideration.

Yours sincerely

John F. McCormick
Director of Aviation Safety

Second Supplementary 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 this second supplementary submission, with a particular view to addressing some of the issues that arose in the course of the Committee's hearing on 15 February 2013, amongst other related matters.

1.2 CASA is committed to the maintenance and improvement of aviation safety, and earnestly endeavours to perform its functions with the achievement of that objective governing the thinking and actions of management and staff at all times. CASA's approach to the accident involving VH-NGA on 18 November 2009, and to the matters to which that tragic event gave rise, has been and continues to be entirely in keeping with that commitment. We recognise that the Committee's concerns with these issues reflect a corresponding commitment.

1.3 The Committee's acceptance, at the commencement of the hearing on 15 February 2013, of CASA's contentions in relation to the responsibility of the pilot-in-command of VH-NGA at the time of the accident is acknowledged. CASA stands by its evidence and submissions in connection with this important consideration (and more generally), and will not pursue that particular aspect further in this submission, except to reiterate that the actions CASA took in respect of Mr James, like the actions CASA took in relation to Pel-Air Aviation Pty Ltd (Pel-Air), were reasonable, appropriate, fair and calculated to best serve the interests of safety.

1.4 CASA has never challenged the view that there were and had been deficiencies in Pel-Air's systems and practices, and that CASA's approach to its audit and surveillance functions in the years preceding the accident involving VH-NGA was in need of improvement. Indeed, it was CASA that identified these shortcomings in both areas, and initiated meaningful and effective action to address and rectify them shortly after the accident occurred.

1.5 As maintained in CASA's earlier evidence and submissions, CASA does not concur with the view that such shortcomings and deficiencies as may have existed in the operator's systems, policies and practices, or in CASA's auditing and surveillance of the operator in the period leading up to the accident, are properly regarded as causal factors in so far as the accident involving VH-NGA is concerned.

1.6 The view has been put during the course of this Inquiry that, on one hand, the nature and import of CASA's exchanges with the Australian Transport Safety Bureau (ATSB) were inappropriate and even 'collusive', and on the other hand, that, in allegedly failing to inform the ATSB that CASA had information bearing relevantly on matters that fell within the purview of the ATSB's investigative activities, CASA had breached a protocol requiring the provision of such information to the ATSB. On the basis of the facts and circumstances outlined in this second supplementary submission, and consistent with the evidence CASA has previously given in connection with this Inquiry, CASA rejects both of these contentions.

1.7 Similarly CASA does not accept that there have been any attempts to divert any scrutiny of both its own and the operator's shortcomings, by unfairly focusing on and 'blaming' the pilot, or otherwise.

1.8 Having particular regard to suggestions made during the hearing of 15 February 2013, that CASA had 'breached' its obligation under paragraph 4.4.6 of the Memorandum of Understanding between it and the ATSB, the Committee's attention is drawn to paragraphs 4.8 to 4.10 of this supplementary submission.

2. The Relevant CASA Reports

2.1 In the interests of clarity, it will be useful at the outset to summarise briefly the nature, purpose and import of the relevant reports CASA prepared attendant upon the accident involving VH-NGA on 18 November 2009.

AVIATION SAFETY AUDIT REPORT: PEL-AIR AVIATION PTY LTD THE *PEL-AIR SPECIAL AUDIT* (8 JANUARY 2010)

2.2 Following the ditching of VH-NGA, CASA initiated a Special Audit of the operator between 26 November and 15 December 2009.

2.3 A number of findings were made by the audit team relating to Pel-Air's fuel policy and practice, obstacle clearance protocols, maintenance control and defect reporting, operational control processes, training, fatigue management and aspects of the operator's drug and alcohol management program.

2.4 CASA accepted a phased management action plan (MAP) developed by the operator, addressing the shortcomings and deficiencies identified in the course of the Special Audit. Conditions were placed on Pel-Air's Air Operator's Certificate (AOC) requiring Pel-Air to acquit the items specified in the MAP before the conditions on their AOC would be lifted. When Pel-Air satisfied those requirements, the conditions on its AOC were ultimately removed on 22 December 2010.

2.5 The Pel-Air Special Audit described above was conducted by a multi-disciplinary team of CASA officers with subject-matter expertise in the various areas to be assessed in the course of the audit. In addition to the Audit Coordinator and the Lead Auditor, the team included four Flying Operations Inspectors, five Airworthiness Inspectors, one Drug & Alcohol Inspector, one Accident Investigation expert, one Air Transport Inspector[1] and two Human Factors experts.

2.6 The two Human Factors experts contributing to the work of the Special Audit team were Mr Ben Cook, then Manager of CASA's Human Factors Section, and Mr Malcolm Christie, another CASA Human Factors Specialist. Like other members of the Special Audit team, their role was to examine and analyse those aspects of Pel-Air's operations in respect of which they had particular expertise, and to provide input into the final audit report on that basis.

2.7 Individual members of CASA audit teams are not normally expected or authorised to produce separate, discrete, independent 'reports'. Rather, their assessments and findings are meant to inform and, as appropriate, to form part, of the overall audit report. The ultimate responsibility for the composition, organisation, consolidated content and authoritative preparation of this audit report rests with the Audit Coordinator.

2.8 In this case, the so-called 'Cook Report' was a subordinate contributory piece of evaluative work from which the Coordinator of the Pel-Air Special Audit team, Mr Roger Chambers, then Area Manager of CASA's Bankstown Office, could, (and did) draw on, in his preparation of the final authoritative Pel-Air Special Audit Report.

2.9 As he quite properly did with the submissions of all members of the Audit Team, Mr Chambers included in the final Pel-Air Special Audit Report those elements of Mr Cook's assessment that were germane to the audit. Material was excluded only on that basis and in accordance with generally applicable audit protocols. Accordingly, relevant FRMS-related findings in Mr Cook's assessment appear consistently in the corresponding sections of the Special Audit Report.

2.10 Similarly in accordance with CASA's generally applicable protocols, all members of the Special Audit team, including Mr Cook and Mr Christie, were given the opportunity to comment on and correct elements of the final Special Audit Report before it was finalised. Mr Chambers received no comments or suggested amendments either from Mr Cook or Mr Christie.

[1] Currently designated Safety Systems Inspector.

2.11 CASA's Accident Liaison and Investigation Unit (ALIU) is responsible for, amongst other things, conducting accident and incident investigations for CASA's purposes. Very shortly after the Australian Transport Safety Bureau (ATSB) advised CASA that they would be conducting an investigation into the accident, CASA's ALIU undertook to conduct a 'parallel investigation' for CASA's purposes, and advised the ATSB accordingly on 23 November 2009.[2]

2.12 Under the direction of the manager of the ALIU, Mr Richard White, four CASA officers participated in the investigation. The Parallel Accident Investigation produced a comprehensive report, dated 21 July 2010, concentrating on operational aspects of the flight and identifying several 'causal factors' that were seen to have contributed to the accident.[3]

2.13 CASA's Parallel Accident Investigation team made a number of findings and summarised the safety actions taken by CASA in relation to the pilot and the operator, and by the operator itself, to address the issues found to have contributed directly and indirectly to the accident.[4]

OVERSIGHT DEFICIENCIES—PEL-AIR AND BEYOND THE *CHAMBERS REPORT* (2 AUGUST 2010)

2.14 Mindful of the findings in the Pel-Air Special Audit Report, and the potential implications of those findings for CASA's oversight processes more generally, CASA initiated an internal review of CASA's relevant oversight policies and practices, the effectiveness of CASA's audit and surveillance tools and the adequacy of available resources. Mr Roger Chambers, who had led the team responsible for producing the Pel-Air Special Audit, was assigned this task.

2.15 While the catalyst for this review was the accident involving VH-NGA and the findings and observations arising from the Pel-Air Special Audit, the purpose of the review was to identify broader areas for improvement in CASA's organisational approach to its audit and surveillance functions more generally.

2.16 In CASA's view, there is nothing in the Chambers Report that would have provided the ATSB with critical new information about the operator or the conduct of the accident flight, which was not either already included in the CASA accident investigation report and the Special Audit Report of Pel-Air, or which the ATSB could not have readily obtained through the section 32 process.

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[2] See *Memorandum of Understanding between the Australian Transport Safety Bureau and the Civil Aviation Safety Authority* (the MoU), para. 4.1.2.

[3] *Parallel Accident Investigation Report*, para. 2.3, p. 33.

[4] *Parallel Accident Investigation Report*, secs 3 and 4, pp. 33-37.

3. CASA's Relationship with the ATSB

3.1 CASA and the ATSB have different, but decidedly complementary safety-related roles. The *Civil Aviation Act 1988* expressly provides that CASA has the function of 'cooperating with the Australian Transport Safety Bureau in relation to investigations under the *Transport Safety Investigation Act 2003* that relate to aircraft',[5] and in corresponding terms, the Transport Safety Investigation Act provides that the ATSB has the function of 'cooperating with any agency of the Commonwealth . . . that has functions or powers relating to transport safety or functions affected by the ATSB's function of improving transport safety.'[6]

3.2 The International Civil Aviation Organization (ICAO) recognises that cooperative relations amongst and between all government agencies with aviation safety-related functions is a critical feature of a viable State Safety Program.[7]

3.3 Interagency communication and coordination are integral to the success of any State Safety Program, and both processes form essential elements in Australia's State Aviation Safety Program.[8]

3.4 Consistent with each agency's legislative mandate, in keeping with best international practice and as specified in Australia's State Aviation Safety Program, CASA and the ATSB have developed, and faithfully operate in accordance with, a *Memorandum of Understanding between the Australian Transport Safety Bureau and the Civil Aviation Safety Authority* (MoU), which specifies sound protocols governing inter-agency communications.

3.5 CASA rejects any suggestion that the maintenance and utilisation of communication channels between CASA and the ATSB of the kind contemplated by the interagency MoU is in any way inappropriate.

3.6 Subject to important legislative protections, the exchange of information between CASA and the ATSB pursuant to the terms of the MoU—especially in connection with, but by no means limited to, each agency's evaluation of the facts and circumstances pertinent to an aircraft accident—is crucial to a shared commitment to minimising the likelihood of a recurrence.

3.7 On this basis, CASA does not accept suggestions that there was anything, sinister, collusive or in any other way inappropriate in the cooperative exchanges between CASA and the ATSB attendant on the accident involving VH-NGA.

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[5] Civil Aviation Act, para. 9(3)(a).

[6] Transportation Safety Investigation Act, subpara. 12AA(2)(a)(i)

[7] ICAO *Safety Management Manual*, Third Edition, Doc. 9859 (2012)

[8] See *Australia's State Aviation Safety Program* (April 2012), pp. 6, 18, and 19 (http://www.infrastructure.gov.au/aviation/safety/ssp/index.aspx).

4. Disposition of the *Chambers Report* and the Operation of Paragraph 4.4.6 of the Memorandum of Understanding

4.1 A concern first raised with CASA during the hearing on 15 February 2013 involved the supposed failure, on CASA's part, to provide the ATSB with a copy of the *Chambers Report*, in accordance with the applicable provisions of the MoU.

4.2 The allegation was made that, consistent with the terms of paragraph 4.4.6 of the MoU, the *Chambers Report* constituted 'information that could assist the ATSB in the performance of its investigative functions' that was 'known' to CASA, and of the existence of which CASA was bound to 'undertake to advise the ATSB'.

4.3 Nothing in paragraph 4.4.6 requires CASA to provide such information to the ATSB. Rather, having been advised of the existence of such information, it would then be for the ATSB to request that it be provided, pursuant to paragraph 4.4.4 of the MoU and normally on the basis of a notice under section 32 of the Transport Safety Investigation Act.

4.4 In his testimony before the Committee at the hearing on 15 February 2013, the Director of Aviation Safety, Mr John McCormick, maintained, on the basis of the information available to him at the time, and his unaided recollection of such exchanges between CASA and the ATSB during the relevant period of which he was aware, that he did not consider the Chambers Report to constitute information of the kind contemplated by paragraph 4.4.6 of the MoU.

4.5 CASA's position in relation to this issue, when it was raised on 15 February 2013, reflected a reasonable understanding of the scope of the kind of 'information' contemplated by paragraph 4.4.6 of the MoU, as limited to 'information' germane to the relevant investigation, namely, in this case, the investigation of the accident involving VH-NGA.

4.6 As Mr McCormick explained in his testimony, CASA did not consider the Chambers Report necessarily fell squarely within the scope of paragraph 4.4.6 of the MoU. The review on which the Report was based was initiated *after* CASA had conducted its Special Audit of Pel-Air, and it was concluded *after* CASA had completed its Parallel Accident Investigation into the accident. Both reports were provided to the ATSB pursuant to requests under section 32 of the Transport Safety Investigation Act. The Chambers Report, was not, and was not considered to be, an 'investigation' into or specifically related to the accident itself.[9]

4.7 At the same time, and as CASA acknowledged in its evidence before the Committee on 15 February 2013, it was conceivable that, on a broad and liberal reading, information of the kind reflected in the Chambers Report could

[9] The heading of the section of the MoU in which both paras 4.4.6 and 4.4.4 appear is 'Disclosure of information relating to investigations' (sec. 4.4, p. 6).

arguably be regarded as falling within the scope of paragraph 4.4.6. Without conceding the position CASA had advanced on the matter, this was a point Mr McCormick advised the Committee that he would 'take away and consider'.[10]

4.8 Having now had the opportunity to refresh his recollection of matters related to the Chambers Report, Mr McCormick has ascertained that, in the context of a regular meeting with the Chief Commissioner of the ATSB, Mr Martin Dolan, on 26 May 2010 (convened pursuant to paragraph 3.3.1 of the MoU), he did, in fact, expressly advise the Chief Commissioner that, in the wake of the accident involving VH-NGA, CASA would be undertaking a review of its audit and surveillance processes.

4.9 Of course, at the time there was no 'Chambers Report' to which Mr McCormick might have referred. However, having advised the Chief Commissioner of CASA's intentions, the existence of *information*—and the likelihood that there would be further information of a kind that could be said to fall within the broad scope of paragraph 4.4.6 of the MoU—was conveyed to the ATSB on 26 May 2010.

4.10 Had the ATSB considered that further details about the matter might be required for their investigative purposes, or that any report arising from the review they had been advised CASA was undertaking might properly be obtained by the ATSB for such purposes, it was the ATSB's prerogative to request that information at any time.

5. Pel-Air's Fuel Policy

5.1 During the hearing on 15 February 2013, some members of the Committee maintained that CASA had ignored issues related to Pel-Air's operational management, including what was advanced as a fact that Pel-Air did not even have an appropriate fuel policy, preferring to focus on the pilot, rather than the systemic issues that led to the ditching of the aircraft off Norfolk Island.

5.2 This contention was firmly rejected by Mr McCormick in his testimony. CASA took immediate and appropriate action in relation to both Pel-Air and Mr James on the basis of the Special Audit. More to the point, however, while Pel-Air's fuel policy for the Westwind aircraft required amendment in a number of areas, it should be noted that Mr James did not follow the fuel planning and enroute monitoring requirements specified in the company's Operations Manual that existed at the time of the accident.

5.3 As discussed in CASA's first supplementary submission,[11] CASA 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 for refuel with only four arriving without sufficient fuel on-board to allow for a diversion to Noumea (Tontouta). As it happens, Mr

[10] *Hansard* (Proof), Friday, 15 February 2013, p. 3.

[11] See paras 5.3.8-5.3.9.

James was the pilot-in-command on two of these four occasions, including the flight which resulted in the ditching of VH-NGA.

5.4 Three of the 78 flights mentioned above departed Apia, and the only pilot-in-command who did not fully fuel the aircraft before departing was Mr James, on the night of 18 November 2009, the night of the accident.

6. Concluding Remarks

6.1 In conclusion, CASA wishes to reiterate certain salient points which came to the fore in the course of the hearing on 15 February 2013, with a view to clarifying and confirming our position on the critical issues with which the Committee is concerned

6.2 CASA's relationship with the ATSB, and the processes by which interagency communications are managed and coordinated, are critical to the maintenance and improvement of aviation safety. Consistent with ICAO principles, and faithful to principles integral to Australia's State Aviation Safety Program, CASA is committed to the maintenance of this vitally important relationship.

6.3 Nothing in CASA's intentions or actions related to the accident involving VH-NGA involved other than the earnest, honest and competent efforts of CASA management and staff to fulfil the main objective of the Civil Aviation Act, namely, to maintain, enhance and promote the safety of civil aviation, with a particular emphasis on preventing aviation accidents and incidents.[12]

6.4 In all aspects of its regulatory dealings with Pel-Air and Dominic James in the wake of the accident on 18 November 2009, CASA has consistently acted fairly, responsibly and in the demonstrable interests of safety. Appropriate constraints and restrictions were necessarily imposed on both the operator's AOC and Mr James's licence—pending a satisfactory demonstration of compliance and proficiency.

6.5 CASA recognises that there is, and will always be, room for improvement in the management and administration of its own operational affairs, as well as those of the organisations and individuals whose aviation-related activities CASA regulates. CASA embraces every opportunity to learn, and encourages all active participants in the Australian aviation community to do likewise.

6.6 We thank the Committee for the opportunity to present this second supplementary submission.

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[12] Civil Aviation Act, sec. 3A.