Senate Inquiry Submission

As a passenger on this flight I have an interest in ensuring that the reasons such an incident occurred are thoroughly investigated and reported openly, honestly and fairly. My wife and I were led to believe that a final report would take some 12 months to complete. Instead we endured a wait of almost three years for a final report by the ATSB that, when it was finally published, was found to be factually incorrect and omitted crucial information. Following the inept performance of the senior representatives of CASA and the ATSB on the recent 4 Corners program I have become convinced that the investigative process is fundamentally flawed, open to abuse by vested interests and is serving the Australian flying public poorly.

The ABC's program highlighted many such deficiencies. The premise of the program was that the pilot has been unfairly blamed by both the investigative body, the ATSB, and the regulatory body, CASA. These bodies, purportedly representing the best interests of the public, appear to have colluded to ensure that the final report sheets the blame home to the pilot while deliberately minimising or completely ignoring the glaring inadequacies with their own role in air safety.

As a layman my understanding of some of the more technically complex issues may be flawed and so I have relied upon a number of sources in preparing this submission. These include the various published documents such as the ATSB reports and press announcements; the 4 Corners videos and documents found on their website and the comments of various aviation commentators. My work experience includes management in a manufacturing environment, working within international quality standards, following safety procedures and investigating industrial accidents. I have been trained in auditing skills and have also been audited on the compliance with these policies and procedures. Such experience has led me to the conclusion that the report has been deliberately and wilfully slanted to deflect attention from the root causes of the accident and on to the final link in the causal chain, the actions of the pilot.

I believe a number of factors are pertinent to the investigation and the circumstances surrounding the crash.

1. This was the third crash of a Pel Air aircraft, the other two in 1985 and 1995 each causing fatalities. It could be expected that such a record would require stricter supervision by the regulator but there is no evidence of this.

2. Audits of Pel Air by CASA prior to this crash found no evidence of problems. This reflects extremely poorly on the performance of CASA a point that is confirmed by an audit of CASA conducted by the international regulator, ICAO and the American regulator, the FAA. (see point12.)

3. A special audit of Pel Air by CASA, conducted immediately after the crash, found 31 safety and regulatory breaches. These included systemic issues with flight planning, fuelling, fatigue management and training.

4. The details of the special audit report were to be kept from the public. A point apparently designed to maintain the commercial interests of Pel Air, at that time vying for a lucrative Air Ambulance contract. It would be difficult to imagine any organisation inviting such tenders would even consider Pel Air if these failures were known. Pel Air was subsequently awarded the Air Ambulance contract in Victoria, on Christmas Eve, only 6 weeks after a near fatal crash.

5. Pel Air was allowed to rectify their defects without public scrutiny. The public has a right to make informed decisions about their travel arrangements. Had I been aware of the poor safety record of Pel Air and of the risk involved in taking that flight given the poor state of the regulatory framework, then it is possible that I would have selected a safer option.

6. At least one of the defects uncovered was found by the ATSB to be a "critical safety issue," that carried an intolerable risk to safety. This involved poor regulatory guidance by CASA and, in a video conference between representatives of the two bodies, CASA appears to have agreed, at that time, that this was indeed a critical issue.

7. The ATSB's final report downgraded the significance of this critical issue to one of only minor importance with the Chief Commissioner of the ATSB, Martin Dolan, claiming that the issue was immaterial to the cause of the crash.

8. The ATSB did not properly report the findings of the special audit. It is simply incomprehensible that a publicly funded body such as the ATSB, charged with investigating the most serious of accidents, would almost totally ignore the results of a special audit conducted immediately after the loss of a jet aircraft.

9. The ATSB did not believe that the 31 identified regulatory and safety breaches contributed in any way to the crash. This is the most damning reflection on the performance of the ATSB and of Martin Dolan in particular. I believe it would be almost impossible to find any impartial observer who would accept that none of the defects found with Pel Air's or CASA's regulations, policies or procedures had any impact upon the circumstances of that flight. Martin Dolan repeated this ad nauseum on the 4 Corners video interview and could offer no satisfactory, rational explanation.

10. CASA too could not accept the findings of their own special audit, ignoring their own identified inadequacies and preferring to blame the pilot. John McCormick, the Director of Safety at CASA could find no problem with the poor state of Pel Air's flight planning procedures and the fact that each pilot performed the complex fuel calculations in a different way. Instead, he claimed that as a pilot himself with 40 years experience a pilot is solely responsible for this. His own auditors took an opposing view, and reported that non-standardised flight planning is deficient and issued a Request for Corrective Action.

11. CASA approved the Operations Manual of Pel Air, issuing an Airworthiness Certificate. This is an implicit acceptance of the flaws with flight and fuel planning subsequently found by the special audit and illustrates the systemic problems at CASA.

12. ICAO found numerous problems with the operation of CASA in the months leading up to the crash. This was confirmed by the FAA in an audit of CASA conducted just weeks after the crash.

13 The public was informed of neither of these important findings.

14. As pointed out on the 4 Corners program the ATSB's final report was flawed, causing it to be quietly withdrawn some 24 hours after publication. The report was then reissued with no form of version control. I now have two versions of the final report and do not know which to believe.

15. The report omitted crucial information on the issue of Reduced Vertical Separation Minima (RVSM). This issue, together with apparent deficiencies of the Operations Manual severely limited the pilot's ability to plan the flight effectively. This apparently deliberate omission ensured that the blame for poor flight and fuel planning was pinned on the pilot despite the constraints that each of the above placed upon him.

16. There is no attempt by the ATSB to undertake root cause analysis of the issues raised in their final report. This was exemplified by the issue of Threat and Error Management (TEM), a procedure to improve flight safety by identifying potential threats and errors. According to the report ICAO regulations require training in TEM, though not for this category of flight. CASA regulations however do not require training in TEM. The logical outcome of these points would be to analyse the reasons why there is no such training requirement in Australia and why this flight was in this particular category. If such training is required, or does help prevent accidents and the flight was found to be in an inappropriate category for this type of operation then CASA could be held accountable for this. Instead, the report simply omitted analysis of these issues.

17. Despite the requirement in the Operations Manual neither of the crew had undertaken training in Crew Resource Management (or in TEM). The ATSB's investigation went further; in a survey of both trainee and experienced pilots the report found inconsistencies in their approach to the legal requirement to divert to an alternate because this is not part of the syllabus for a trainee pilot. Despite these findings the ATSB declined to offer any recommendations that may improve this clearly unsatisfactory situation.

18. Despite all of these findings no adverse comment was made about the lack of CASA regulation regarding training and nomination of an appropriate flight category. No recommendations regarding flight crew training were made neither was there any mention of corrective action in the form of regular audits of Pel Air to ensure that such oversights are not repeated.

19. We were invited by the ATSB to make submissions regarding the draft final report before publication. I made suggestions regarding the wearing of lifejackets during over water operations, the adequacy of emergency locator beacons and the use of audits to ensure compliance. Most of these were ignored and gave the impression that the ATSB was committed to its own agenda and was unwilling to consider simple improvements to practices that would have a tangible impact upon survivability.

The ATSB final report did, in a rather unemotional manner, attempt to reflect our experience of that night. However, it could not accurately convey the true horror of each of us confronting the very real fear that we were about to die on no less than 3 occasions. I fully expected to die upon impact and, despite having no visibility of the surface, the pilot did extremely well to help us survive this phase.

In the second survival phase, evacuation of the aircraft, the report noted that the crew benefitted from HUET training. My wife was also fortunate to be ably assisted by the doctor and nurse who undid the straps to her stretcher and with sea water rapidly filling the cabin they managed to get her and themselves out of a tiny emergency exit.

I had no such assistance, nor the benefit of HUET training. Instead, pinned to my seat by a torrent of water bursting in through the forward hatch I was unable to release my seat belt until the cabin was almost full of water. Once again I was convinced that I was about to die but, having repeatedly inhaled water, I somehow found my way to the exit and swam up to the surface as the cabin began to sink.

On the surface I struggled to breathe and was being continually battered by the waves. The doctor assisted me to inflate my lifejacket and instructed me to help support my wife, who had no life jacket. After being smashed against the rear of fuselage we decided it was safer to attempt to swim towards a faint light on the horizon that we assumed was Norfolk Island. After 90 minutes of effort we were less than a third of the way towards the light. I was exhausted by the effort of trying to breath, support my wife and swim in the freezing waters. I was very much aware that I was cut and bleeding from being slammed into the torn wreckage and had no doubt that we were swimming in shark infested waters. Fearing that I would never see my two most recently born granddaughters, I became despondent and believed that we were unlikely to make it to the island. We huddled together to rest for what I took to be the final time, having had our hopes of rescue raised and dashed a number of times by spurious reflections on the water. The rescue boat arrived almost on cue, as I did not believe that I would have been able to last much longer.

The effect upon our lives since then has been profound. My wife is suffering from severe Post Traumatic Stress Disorder. She has been admitted to a hospital / care facility some nine times in the past two years and is quite unable to work or properly care for herself.

I have included this description not to elicit sympathy but to illustrate the comprehensive way in which the very systems, regulations, policies and procedures apparently designed to prevent such an accident let us down on that night. It was only through sheer luck, our own efforts and those of the heroes of Norfolk Island that we survived.

I believe that it is utterly shameful that Pel Air, the ATSB and CASA can each act in a manner that compromises flight safety. After three fatal or near fatal accidents Pel Air is clearly unfit, and has been for some time, to hold an airworthiness certificate. CASA has demonstrated that it is incapable of regulating properly and enforcing such regulations while John McCormick has demonstrated on prime time television that he lacks a basic understanding of modern safety practices. The ATSB's credibility as an apparently independent investigative body has been terminally undermined, not only by the manifestly inadequate final report but also by the time taken to produce it.

The self serving attitude displayed by both Martin Dolan and John McCormick, on the 4 Corners program, illustrate that neither man is a fit and proper person to be responsible for flight safety in Australia. It is my hope that this inquiry will establish the multiple causes of the crash and determine why both CASA and the ATSB have deliberately failed to do so.

Gary Currall

12 October 2012