ANGEL FLIGHT SUBMISSION TO THE RRAT COMMITTEE – GENERAL AVIATION INQUIRY

Angel Flight is a charity organisation that provide non-emergency medical transport for people living in rural and regional areas.

Angel Flight fills an extremely important gap in healthcare systems across Australia. Our service improves access to health care, a basic human right, for many rural and regional Australians. Angel Flight's purpose and underpinning reason for this submission, is to be able to continue to help rural and outback Australians get the care they need, at no cost to them, without the costly, unnecessary, burdensome and ineffective regulations imposed by CASA.

The COVID situation has made life even more difficult, and Angel Flight has enabled many families to be reunited with their young children; patients to return home to their loved ones to pass away at home; and to transport returning Australians to hospital across the country to farewell terminally ill relatives: no other service can provide this to the Australian people, and nor were they able to achieve these results because of a ban on using commercial flights or driving between States. State Health Services are now referring these cases directly to Angel Flight. The charity has facilitated transport, through the generosity of volunteers and donors, since 2003. As an overview of the value of the service to rural Australians, Angel Flight has

- facilitated transport for more than 100,000 patients and carers free of charge.
- enabled transport totalling than 20 million km since 2003.
- arranged more than 50,0694 flights.
- provided volunteer services to more than 3,000 rural and remote destinations.
- 3,500 volunteer pilots registered.
- 4,700 volunteer drivers registered.
- 4,500 volunteer health professionals registered to assess and refer patients for travel in light aircraft.
- Enabled flight and drive assistance for all ages : the youngest passenger being 10 days old and the oldest 93 years, accompanied by carers or guardians.
- saved governments and patients in excess of $65 million in travel costs.
- not asked for nor received Government funding and is unique in this aspect – it is financially responsible and in the ACNC 'tick of approval' category.
- Angel Flight is the largest single contributor to General Aviation in Australia. The only other provider of a similar service (with a completely different model), has two aircraft and operates out of one State, and has required government funding to continue its operation.
- Angel Flight's aviation safety record (independently assessed) clearly shows it is as safe as any equivalent general aviation flying in Australia and safer than many categories.

<u>Operation and effectiveness of CASA: Inquiry Terms of Reference</u>

a. the legislative and regulatory framework underpinning CASA's aviation safety management functions, including: i whether the legislation is fit for purpose; ii. the safety and economic impacts, and relative risks, of CASA's aviation safety frameworks; and iii. the engagement of CASA with other relevant Australian Government agencies;

THE FACTS:

- Based on recent ATSB data, the latest accident rates per million flying hours for selected private and general aviation flying are approximately:
  - Recreational/sport sector 360;
  - business/personal transport and pleasure 142;
  - Angel Flight 42.

- ATSB investigated a community benefit flight accident in 2011, as did the Victorian Coroner. Neither body (nor any other court or agency) found any fault with AF, which was completely exonerated. A further investigation was undertaken in relation to a 2017 accident. No court, agency or other body found AF to be responsible/liable. The only recommendation made was that AF 'consider' using airline transport. That had always been done, and RPT flights used when appropriate. That continues. There was no recommendation directed to the cause of the accident, being pilot error/weather-related.
- ATSB used data since acknowledged to be inaccurate (using only 50% of actual flights, and basing the analysis on there only having been 47 aircraft engaged in community benefit flights over the previous three years – in circumstances where during any single year, there were approximately 240 aircraft flying for AF alone.)
- CASA's senior director, Monahan, who was the instigator of the CSF regulations, initially stated that the AF accident rate was 16 times higher than GA; then later claimed it was 9 times higher; then in court documents reduced that to 5 times: CASA has since acknowledged its own data is inaccurate. **See Note 1.** The BITRE data that CASA rely on is collected in a manner that means it is inevitably grossly inaccurate and it is inconceivable that ATSB and CASA staff did not recognise the deficiencies – from the outset, the data was never collected from pilots, and there was no definition as to what constituted a CSF (as that term was only struck in 2019 by CASA).
- For example, the BITRE data for the years 2014 - 2018 reported 45 – 50 aircraft involved in CSFs whereas Angel Flight alone used more than 240 aircraft each year. Furthermore, data has been collected only since 2014 but Angel Flight has operated since early 2003. Moreover, there was no defined "CSF" category during that period. However, prior to implementing the regulations, CASA had access to both AF's data, and that of the independent statisticians: it chose to ignore both. The statisticians' reports were not challenged by CASA. Two of Australia's most senior statisticians effectively concluded there was no difference in the accident rates between the GA category generally, and Angel Flight. **See Note 1.** *Monahan's misleading and incorrect statements caused financial damage to AF, public uncertainty, and significantly, onerous insurance requirements for the aircraft owners and pilots. He did not publicly withdraw any of those damaging statements, which were only revealed during cross-examination of Monahan in the Federal Court.*
- The ATSB also acknowledged that "as there was only one fatal accident involving an aircraft conducting community service flights between 2014 and 2018 there is a high level of statistical uncertainty associated with this rate". Similarly, CASA acknowledged that the accident was due to pilot error: during the **Federal Court hearing it also (through Monahan) admitted that there was no data or analysis to support the regulations, and nor would any of them have prevented the accident .** *This is in direct contrast to the evidence of both Monahan and then deputy DAS of CASA, Crawford, during the 2019 Senate RRAT Committee (ATSB and CASA).**See Table 1.***
- On several occasions the 2019 Inquiry was assured by both Monahan and Crawford that there was data to support their safety case: court proceedings revealed that there was, and never had been, a safety case undertaken by CASA, nor a risk analysis of any kind, and no information which would support the contention that CSF flights were different from private flights. **See Note 1.** This is in accord with the contentions of Angel Flight, which had requested the safety case from Monahan many times over the 18 month period prior to the Instrument being tabled. The affidavit material accepted by CASA in the Federal Court evidencing these matters was not challenged and nor was the deponent, AF CEO Pagani, required for cross-examination by CASA. **See Note 2.**
- It is not possible to draw any valid statistical conclusions from two events in 18 years, a fact recognised but ignored by CASA in preparing the Legislative Instrument CASA 09/19. The Senate RRAT Committee recommended CASA amend the Instrument after making negative

comments about its processes and conclusions. CASA chose not to follow the Senate Committee recommendations. Nor did it ever provide to the Committee the promised [now known to be non-existent] data/safety case to support its conclusions or the Instrument.

- Monahan has confirmed that it was very likely that the mishap was not related to any charity flight aspect but a choice by the pilot. **See Note 3.**
- CASA also admitted in court, that in the case of the 2017 accident, it was not related to Angel Flight's activity.
- Independent professional analysis conducted for Angel Flight at that time showed conclusively that our safety record was no different from other general aviation flying
- CASA has conceded, both to Angel Flight and to the Federal Court, that none of the provisions of the Instrument were relevant to any CSF accident, and nor would they have prevented or lessened the risk of any accident. And CASA also admitted that there was no evidence nor root cause analysis conducted by or on behalf of CASA to support any clause in the Instrument **See Note 4.** The premises upon which it was based, included, amongst other things, 'pressure' on pilots (but not a single pilot was asked); landing at unfamiliar aerodromes (but not a pilot nor Angel Flight was asked), uninformed passengers (but not a passenger was asked, and CASA was provided with all Angel Flight documentation, videos and protocols for passengers). **And as late as December 2021 CASA continues to publish misinformation about the AF operations, in that it claims CSF pilots 'often' fly to unfamiliar locations – it has still never asked the pilots nor Angel Flight, and AF's own data is to the contrary.**
- The court found, in summary, that the Civil Aviation Act allows CASA to make any rule in aviation without any genuine data if they considered it a safety matter.
- None of Angel Flight's admitted sworn evidence was challenged by CASA, although it was in direct conflict with the evidence given by their senior national aviation director.
- CASA's Executive Manager National Operations and Standards has little or no general aviation experience and fewer flying hours than the average Angel Flight pilot (Note 6 - Paragraph 2 of Monahan's affidavit). It was admitted in court by Monahan that the relevant staff in CASA had no experience whatsoever in the CSF sector.
- Nor was there any evidence to support increased maintenance requirements, takeoff and landing requirements which are three times greater than other aviation sectors, reduced passenger numbers, restrictions on pilots carrying assistants or relatives, nor in the requirement for 400 hours TT (Angel Flight had always required 250 PIC which it maintains, and which is a more relevant safety factor than training hours). **See Table 1, Note 4.**
- No Coroner, Court, Insurer or Regulator has found Angel Flight to be responsible for any accident. After careful examination, following three years of compliance with the instrument, we are unable to find any positive outcomes. Costs of additional maintenance and T/O/Landing requirements, inconvenience, reduction of safety in not allowing anyone on board to assist the pilot (as lookout or on the ground), and passenger limitations have all been reported to AF, and in addition, pilots and owners not undertaking volunteer flights (nor allowing their aircraft to be used for those flights) have also been reported due to the extra maintenance requirements of the CSF.

b. the immediate and long-term social and economic impacts of CASA decisions on small businesses, agricultural operations and individuals across regional, rural and remote Australia;

- Continuing unnecessary regulation of the Community Service Flight sector only results in rural and regional Australian's missing out on vital medical treatment where there is no demonstrated increased safety risk.
- Angel Flight pilots have ceased flying due to the increased costs and regulatory burden. None of the Instrument conditions improve aviation safety in the CSF sector, and none have been related to any accident (admitted by CASA). Pilots report that the increased cost of

maintenance (they now have to comply with commercial aerial work requirements, rather than private category) has caused them to stop flying for up to three months at a time, for CSF flight. Other pilots report an increased cost in maintenance of up to $10,000 pa if they continue to fly as a volunteer for AF.

- Pilots report anger and frustration at being summonsed, on threat of prosecution, to produce their log books for both aircraft and flight, particularly when the summonses include demands for information not required to be recorded or held by pilots or owners.
- Safety has decreased and caused frustration amongst pilots, in that they are not permitted to have a helper on board – helpers assist in the 'look out' environment of a busy traffic area, and on the ground to carry equipment and escort passengers, allowing the pilot to concentrate of refueling, checks etc. Pilots are also disappointed that they can no longer take family members on a flight – for example, for a stay in the destination town, awaiting a return flight, or simply having a break.
- Families are at times forced to be split because of the passenger limit. AF has volunteer pilot/owners with a range of larger aircraft, including Citation jets, Cheyenne, B200, PC12 and a Falcon jet. None of these are permitted to carry more than 5 passengers. There is no logic nor safety case in relation to this (and other) rules.
- There is an increased cost to pilots/owners by having to undertake a take-off and landing within 30 days preceding the flight. In all other commercial, private, airline circumstances, both in Australia and throughout the world, the period is 90 days. CASA advises the pilots they 'can' interpret this as meaning a flight on the same day (even then requiring unnecessary circuits), however, the legislation is clear. Pilots are not prepared to accept Monahan's implied assurances that if they break the rule and comply on the day of the flight, they will be protected from liability and insurance cover. Monahan has not offered an indemnity to them if they adopt his interpretation rather than the law. Most pilots live in capital cities. This means a trip from home to the airport, preflight, removing the aircraft from the hangar, various clearances having to be obtained, and then the reverse after the flight, at times after a 1-2 hour drive each way from the field, just in order to comply with the requirements. There is no evidence in Australia, nor in the other major country providing similar services (USA) that 30 day TO/L has any impact on safety: it was certainly not a relevant factor in the two weather-related en route accidents which occurred in Australia between 2003-2019.

c. CASA's processes and functions, including: i. its maintenance of an efficient and sustainable Australian aviation industry, including viable general aviation and training sectors; ii. the efficacy of its engagement with the aviation sector, including via public consultation; and iii. its ability to broaden accessibility to regional aviation across Australia, considering the associated benefits of an expanded aviation sector

- Angel Flight has a documented safety management system and an active safety committee. We have stringent safety procedures that are more demanding than some commercial charter operators and our pilots have experience far in excess of CASA requirements. For example, 75% of our active pilots are instrument rated; almost 50% have either commercial or airline licences; and the average flying experience is 3,400 hours.
- All Angel Flight pilots, regardless of qualifications, must have 250 hours as pilot-in-command whereas CASA allows pilots with as few as 170 hours (less than 100 hours in command) to act as pilot in command with paying passengers. Angel Flight pilots, irrespective of experience, are required to complete two on-line safety courses and participate in at least two mentoring flights before undertaking their first missions. Prior to each flight, all pilot

licences, medicals, recency requirements, renewals, reviews and time-on-type are checked, and post flight reports are obtained from pilots, drivers, passengers and health professionals

- When the discussion paper was issued in late December 2018, Angel Flight and CASA community engagement staff were in the final stages of a completing a MOU to ensure the highest safety levels were continued This process had been approved by former DAS Carmody. CASA senior staff working on the MOU have said they were "blind-sided", as was Angel Flight, by the Instrument as not a single item in it had been the subject of discussions between CASA and Angel Flight.
- A senate inquiry into ATSB and CASA recommended CASA amend the Instrument. CASA ignored the finding.
- CASA has subsequently admitted in court that there is no data to show that any aspect of the Instrument would have prevented either of the two accidents; likewise they had no data to demonstrate a connection between the additional requirements imposed by the Instrument and the safety of Angel Flight activities.
- The Civil Aviation Act allows CASA to make the rules, administer the rules and prosecute, and to impose regulations on general aviation aircraft and pilots with no evidentiary justification. There is widespread industry dissatisfaction with CASA's dual roles of creating regulations, policing and prosecuting those regulations. *Judgement of Anderson J in AFA v CASA 2021 FCA 469 at paragraph 355 - The court found that it is not necessary for CASA to demonstrate by some statistical or empirical analysis that a risk factor exists to justify the validity of a condition in an Instrument*
- CASA admitted it ignored its own protocols.
- There is no effective oversight of this Government organisation.
- ATSB can knowingly publish flawed and contradictory data without having to justify its findings, and there is no judicial appeal or review process against the ATSB, which has historically been found seriously wanting and in error. ***During the 2019 inquiry into Operation of the Australian Transport Safety Bureau Senator PATRICK said "with the Pel-Air flight that you're talking about the ATSB was found negligent by the committee".***
- The Instrument expires in March 2022 and should not be reinstated because there is and was, no data or analysis to support it and CASA has admitted there is no connection between the instrument and any accidents. Angel Flight is and always has been, willing to enter into a mutually agreed MOU or Code of Practice as an alternative to any regulation.
- Regrettably, despite the automatic repeal of the Instrument being imminent, CASA has again failed to undertake any type of risk analysis/safety case in respect of its consideration of imposing a further Instrument on the CSF sector. Instead, it has released a survey (under the guise of a consultation for an Instrument), dealing only with the queries of positive and negative effects of the Instrument since enactment. It has nowhere embarked, nor does it intend to embark, upon its required protocols relating to a general risk analysis or safety case.
- Significantly, CASA at no time contacted Angel Flight in order to consult with AF, nor to advise of its intentions to impose another Instrument. Last month, after there being no effort whatsoever from CASA to engage with Angel Flight, AF contacted the current DAS to request a meeting. This is notwithstanding that CASA had been gathering information from as early as July/August 2020 in relation to the Instrument: In August last year CASA issued a demand to pilots and aircraft owners to provide information about the CSFs undertaken. This required access to aircraft log books and other documentation. The summonses asked questions about information which was never required by law, including the Instrument. Monahan advised the pilots and owners it was for the purpose of data collection. Monahan advised AF that it was for the purpose of compliance. Pilots were directly threatened with prosecution, notwithstanding they were not required under the legislation to provide all of the information demanded, and that many were in a lock-down situation (particularly in Victoria) and that their aircraft and log books could not be accessed, being in different towns from their residences.

Only after intervention by AF were the pilots and owners given more time, in the circumstances of their lockdown status.

- At the meeting arranged by Angel Flight in November (with the parliamentary and public service Christmas breaks pending), Angel Flight requested the status of investigations/risk analyses/safety cases being examined by CASA, and of the status of the formerly proposed MOU/CAAP (given the Best Practice Guidelines require CASA to implement legislation as a last resort, and not as a default situation). There had clearly been no intention at all to contact AF at this time. At the meeting AF learned that a survey had already been prepared, and was to be published forthwith. AF had never been consulted about the survey, which, in its form presented to AF, was inappropriate (for example, including former patients and doctors etc as a respondent group through the CASA website – these people no doubt would not be those who used the service in 2018, and nor would they read the CASA website not be familiar with any legislation). It also included all CSF pilots as one cohort, notwithstanding the only other provider operates in only one State, with two owned aircraft, and rosters its pilots on scheduled services with no financial/aircraft/asset contribution from the pilots.
- At the meeting Monahan and current DAS Spence advised they would 'allow' AF to see the survey, but with only 24 hours (over a weekend) to assess and comment on the document. This was the history of November 2018 repeating itself, when Monahan presented to the AF Office with a hand-scribbled set of rules, advising there would be an Instrument and it would be implemented within two weeks. This notwithstanding the MOU/CAAP was being worked on that very week with CASA's Community Engagement Team, who were unaware of the proposed Instrument. On this current November occasion, it was only through insistence and perseverance by AF that CASA extended the period within which we could look at the document to three working days.
- Since that date, AF has again been proactive and requested a meeting with the Community Engagement Team to canvass the updated MOU/CAAP proposed by AF, a copy of which had been sent to the DAS, and the entirety of which had been implemented by AF as safety improvements, given the irrelevance of the Instrument to safety outcomes. CASA agreed to the meeting, but did not instigate the process – that, again, was left to Angel Flight.
- It is clear that CASA, again, does not intend to conduct a proper safety case nor risk analysis in respect of its intended replacement Instrument.

<u>Recommendations</u>

- The Minister should commission an independent audit of the performance of both the ATSB and CASA in relation to their independence, quality, analysis and research and the relationship between ATSB, CASA, and the aviation industry.
- The Civil Aviation Safety Act and Regs must be urgently amended to ensure:
  - CASA must use valid empirical valid data for determinations and rule-making, and publish the data and analyses used to justify those determinations and rules.
  - CASA's protocols must be mandatory and adhered to, not optional as at present.
  - CASA must be reviewed regularly to ensure the present poor culture, evident from many of the submissions to the current Senate inquiry into general aviation, does not continue.
  - CASA should not be empowered to make arbitrary decisions which affect the aviation industry financially, and which have an adverse impact on rural and regional Australians without an open and properly conducted safety case.
  - CASA cannot continue to mislead the Minister, the Parliament and the general public with inadequate, incomplete and unjustifiable reasons for its actions. Note: In the various RAAT inquiries, CASA stated repeatedly that it had a safety case, but failed to present it. The court proceedings show that no safety case existed.

NOTES

Note 1 –* ***Monahan conceded that CASA had many statistics that, depending on how you frame the question, can result in a very damning ratio e.g 9x the rate, and that CASA knew that with some data sets one incident can skew the numbers significantly. CASA used a combination of rates and comparisons to similar countries, concluding that the 'mishap' rate required modest mitigators or controls. He made these concessions in internal CASA emails. Notwithstanding this, CASA published the alleged 9x rate until the court case itself, where Monahan dropped that rate to 5***

- ***Further, at para 51 of Monahan's affidavit he states "At page 6 of the September 2017 SFR, it states that "[a]lthough the number of AF accidents is a statistically small sample and therefore may not be able to form the basis of a statistically valid comparison."***

- ***Despite this, the comparisons were used as a basis for the Instrument. CASA also decided not to publish its safety analysis on the grounds that it "did not want the public consultation to descend into an argument about the statistics or calculation methods" Note 4 - Paragraph 93(a) of Monahan's affidavit.***

- ***Court Case Question to Monahan "material that you had available, none of it informed you about the operation in those two fatal accidents of any conditions which you have generalised as being supposedly peculiar to CSF's compared to ordinary private flights, correct?"***
  Answer "correct"

Note 2 – In answer to a question from Senator Patrick during the 2019 inquiry into Operation of the Australian Transport Safety Bureau, Dr Godley of ATSB said "Senator, we've outlined this in the report. We didn't speak to any pilots about whether they've experienced perceived pressure." Both ATSB and CASA failed to interview any Angel Flight pilots, passengers or health professionals to gather evidence to support claims made in their reports, which was a significant omission given that the Instrument was in part, premised on Monahan's 'findings' that AF pilots were 'under pressure'.

Note 3 – Email from Monahan to Watson Tuesday 4 July 2017 11:48 AM
"it is very likely that the mishap was not related to any charity flight aspect but a choice by the pilot"

Note 4 – ***Anderson J in AFA v CASA 2021 FCA 469 at paragraphs 91, 93 and 94 said: "Mr Monahan accepted that he did not have data differentiating between CSFs and ordinary private flights in respect to the requirement concerning the completion of a minimum amount of flight time or justifying differential maintenance requirements. He accepted he had no empirical support for the condition in the instrument relating to passengers numbers."***

Mr Monahan accepted that there was no "root cause analysis" undertaken by CASA into the two relevant fatal accidents (one in 2011 and one in 2017) which led to any of the recommendations contained in the Instrument. Mr Monahan accepted that there was no "root cause analysis" leading to any recommended content of the Instrument because there was no such "root cause analysis" consideration by Mr Monahan or his colleagues

TABLE 1

Angel Flight Australia v CASA

CASA Instrument 09/19 - Instrument imposing restrictions on flight crew licences for Community Service Flights

	Source RRAT Committee Hearing 4 September 2019	Details	Source Federal Court Hearing, 16 and 17 March 2021	Details
1	Evidence of Mr Crawford RRAT Committee Inquiry into the ATSB transcript at page 25	**Senator Patrick Q:** Would you agree that, rather than having us go through all of this, all of the provisions in the instrument, had they been in place in 2011, would not have prevented these accidents? **Mr Crawford:** It was a night VFR. The instrument addresses that. If we had introduced that instrument prior to that accident, we might have avoided it. It still relies on pilot decision-making. In reality though, when we see two fatal accidents, whilst we consider what specifically happened in those two accidents, we also consider whether there is something in the pressure that pilots potentially feel, depending on their experience. And we felt it was necessary to address that situation.	Cross Examination Christopher Monahan - Transcript of Proceedings 16 March 2021 Ref: P38 lines 30 to 40	**Q: And so by deduction, you accept, don't you, that the one and only paragraph containing the most detailed reference to that accident in August 2011 finds no reflection in the instrument; correct?---**For the first paragraph, correct. It's the only paragraph, isn't it, about that accident?---Well, the second paragraph as well. The second paragraph is not about that accident at all, is it. Mr Monahan, you've been at some pains to say it wasn't night?---That's so. That second paragraph has nothing to do with that accident, does it?---**A: Okay. All right. Correct.**
2			Cross Examination Christopher Monahan - Transcript of Proceedings 16 March 2021 Ref: P38 at line 45 and P39 at line 1	**Q:** Thank you. **Is anything else** contained in what you swore in your affidavits, or you have annexed, having sworn that this was material, **to which you and your colleagues had regard before the instrument was made which sets out details of either of the two fatal accidents for the purposes of informing the content of a proposed instrument?** **A:** Nothing additional.
3			Cross Examination	**Q:** Perhaps you could attend to my questions. **There is no reference to any**

	Source RRAT Committee Hearing 4 September 2019	Details	Source Federal Court Hearing, 16 and 17 March 2021	Details
			Christopher Monahan - Transcript of Proceedings 16 March 2021 Ref: P39 at lines 30 to 35	**root cause analysis leading to any recommended content of the instrument because there was no such consideration by you and your colleagues to the best of your knowledge, correct?** **A:** Correct.
4			Cross Examination Christopher Monahan - Transcript of Proceedings 16 March 2021 Ref: P41 at lines 25 and 30	**Q:** Please. But having taking them into account, I suggest, **those who looked at the 2011 accident before you and** you looking at it **after you** took over this topic **did not consider that it provided that accident, its root causes**, had you known them, that it **provided justification for any particular condition to be imposed on CSFs specifically. Do you agree?** **A: By itself, correct.** **Q:** Thank you. And, perhaps, this can be done a bit more rapidly with the second accident. **All of this is also true of the second accident**, that it **provided**, as to any root causes, had you ever come to know of any of them, **no justification for any particular condition to be imposed on CSFs specifically; correct?** **A: Not to a specific provision, correct.**
5			Cross Examination Christopher Monahan - Transcript of Proceedings 16 March 2021 Ref: P42 at line 10	**Q:** What I want to ask you about is this: do you agree that **there is nothing concerning the circumstances of either of the fatal accidents as to root cause, as to training experience of the pilots, as to conduct of passengers, as to particular routes or mission that informed to any degree the making of the instrument. Do you agree with that?** **A: Correct.**
6	Evidence of Mr Crawford, Mr Monahan, and Dr Aleck RRAT	**Senator PATRICK:** But bar the difference of the pressure, which the ATSB has talked about, we are talking about CASA licensed pilots in private aircraft that are otherwise considered safe in any other operation, and you're	Cross Examination Christopher Monahan - Transcript of Proceedings	**Q:** Now, both **being community service flights involves**, according to your affidavits, **some generalisations about conditions supposedly peculiar to CSF flights as opposed to** what you've just called other **ordinary private flights; is that right?**

	Source RRAT Committee Hearing 4 September 2019	Details	Source Federal Court Hearing, 16 and 17 March 2021	Details
	Committee Inquiry into the ATSB transcript at page 29 and 30	imposing an additional requirement on community service flights. **Dr Aleck:** But, similarly, it's recognised in the federal aviation policy on this that a private pilot license is an entry-level requirement and that community service flying is different. **Senator RENNICK:** Would these additional requirements have prevented the accidents from occurring? **Mr Crawford:** Those two specific accidents? **Senator RENNICK:** Yes. **Mr Crawford:** No, but they may prevent an accident from happening in the future. **Senator RENNICK:** 'May'. Yes.	16 March 2021 Ref: P42 at line 25 to 40	**A: Correct.** **Q:** But **you had no information as to whether any of those** supposedly generalised **differences operated in either of those fatal accidents**. Do you agree? **A: Correct.** **Q**: On any view of then, then, you would almost have understood that there was no empirical support of any kind supplied by those two accidents for the idea that there are conditions peculiar to CSFs justifying the imposition of conditions specifically on CSFs. Do you agree? **A:** Apologise. Can you – can I – you're asking me to reference an accident report or what was available to me. I want to make sure - - - All of the - - -?--- - - - I don't do that **Q: material that you had available, none of it informed you about the operation in those two fatal accidents of any of the conditions which you have generalised as being supposedly peculiar to CSFs compared to ordinary private flights, correct?** **A: Correct.**
7			Cross Examination Christopher Monahan - Transcript of Proceedings 16 March 2021 Ref: P47 at lines 35 to 40	**Q:** In other words, consistently with what you told his Honour earlier this morning, **nothing concerned the facts or root cause analysis of the second fatal accident played any part in justifying the imposition of conditions specifically on CSFs; is that right?** **A: Mmm.** **Q:** Because you can't point to it. **You didn't look at it**?---In terms of the report? **The particular root cause analysis and explanation of that second fatal accident as it relates to matters supposedly peculiar to these flights?** **A: And the actual root cause of that; correct. You're – you're correct.**

	Source RRAT Committee Hearing 4 September 2019	Details	Source Federal Court Hearing, 16 and 17 March 2021	Details
8			Cross Examination Christopher Monahan - Transcript of Proceedings 16 March 2021 Ref: P48 at line 1	**Q:** And you have had the opportunity to review and study the affidavit of Dr Crees himself sworn on 15 June 2020? **A:** I reviewed it.
9			Cross Examination Christopher Monahan - Transcript of Proceedings 16 March 2021 Ref: P48 at line 15 to 35	**Q:** So, first of all, upon study of his material you understood that he was raising serious points - - -? **A:** Correct. **Q:** - - - concerning the reliability of basic data, it might be called the denominator - - -? **A:** Yes. **Q:** - - - datum - - -? **A:** Correct. **Q:** Namely, millions of flight hours; is that correct? **A:** Correct. **Q:** And you have not thought it appropriate to draw to his Honour's attention by any affidavit any disagreement by you with that, have you? **A:** My affidavit went to what I thought were the germane points of the case - - - **Q:** Well, probably easier - - -?--- - - - **A:** and at that time I didn't think - - - **Q:** just to answer my question?--- **Q:** You haven't thought it necessary to draw to attention any disagreement you have with any of that, have you? **A:** I have not – I have not lodged a disagreement, correct.

	Source RRAT Committee Hearing 4 September 2019	Details	Source Federal Court Hearing, 16 and 17 March 2021	Details
10			Cross Examination Christopher Monahan - Transcript of Proceedings 16 March 2021 Ref: P52 at lines 30 to 40	**Q:** Unless you know the number of passengers, you've got no idea whether you are looking at a group that carries passengers – or more passengers – more often than the other group; correct? **A:** I – with the limited data we have, correct. I – yes. You had no data on that, did you?---That's because it's – it's currently not reported, until now. **Q:** I'm saying you had no data; correct? **A:** I – I did not have the number of passengers on each one of those flights, correct. **Q:** And now, let me make it clear, I am criticising? **A:** Okay. **Q: I suggest to you that the desirable support of empirical justification for the imposition of conditions concerning passengers on CSFs positively required you to obtain such data or to accept that you had no empirical support for such a condition; correct?** **A: Correct.**
11	Evidence of Mr Crawford and Mr Monahan RRAT Committee Inquiry into the ATSB transcript at page 25	**Senator PATRICK Q:** You place an extra maintenance requirement on an Angel Flight aircraft that in neither of those accidents had any part to play and has no part to play in pressure, which is one of the issues which have been raised in the ATSB. **Mr Crawford:** When we wrote our instrument, as you recognise, we were setting a minimum standard. At the end of the day it's a system of safety, and we felt that we also had to look at maintenance and consider that in the safety system.	Cross Examination Christopher Monahan - Transcript of Proceedings 16 March 2021 Ref: P57 at lines 40 to 45	**Q:** Nothing like that was true according to investigation and consideration for the making of the instrument for CSFs, was it?---In that the - - Q: Nothing special about the flights imposed differential stresses and strains justifying differential maintenance requirements; is that correct? A: Correct. **Q:** Indeed, **nothing was ever collected by way of data or analysed during consideration for the making of this instrument suggesting that there was anything about CSFs that informed a particular need** – a peculiar need – **for aeroplane maintenance requirements**

	Source RRAT Committee Hearing 4 September 2019	Details	Source Federal Court Hearing, 16 and 17 March 2021	Details
		Senator PATRICK: Is there a safety case that you've generated for that? **Mr Crawford: …**we believe that what we've proposed, or introduced, isn't too onerous, because it's 100 hours or 12 months… **Senator PATRICK:** Can you provide a safety analysis that got you to the point of imposing this particular new criterion? I know Dr Crees has pulled out of flying because of that particular requirement. Where's the analysis that got you to that point? Can you please table that analysis. You must have done some. How did you pick that? **Mr Monahan:** When you look at the average number of flight hours by private pilots in Australia, it's roughly 40 to 45. **Senator PATRICK**: So you have this laid out in a safety case? **Mr Monahan:** Yes. We'll provide that. **Senator PATRICK:** A very simple question: can you provide that to the committee? **Mr Monahan:** Yes.		such as in clause 11 for CSFs; that's correct, isn't it? **A: Correct.**
12			Judgement of J Anderson in AFA v CASA 2021 FCA 469 Ref: P25 at paragraph 91	Mr Monahan accepted that the conditions imposed by the Instrument found no reflection in the two paragraphs of the ATSB report which stated what the ATSB found in respect to the 15 August 2011 accident. Mr Monahan accepted that there was no

	Source RRAT Committee Hearing 4 September 2019	Details	Source Federal Court Hearing, 16 and 17 March 2021	Details
				"root cause analysis" undertaken by CASA into the two relevant fatal accidents (one in 2011 and one in 2017) which led to any of the recommendations contained in the Instrument. **Mr Monahan accepted that there was no "root cause analysis" leading to any recommended content of the Instrument because there was no such "root cause analysis" consideration by Mr Monahan or his colleagues.**
13			Judgement of J Anderson in AFA v CASA 2021 FCA 469 Ref: P26 at paragraph 93	Mr Monahan accepted that those persons at CASA who had looked at the 15 August 2011 accident before Mr Monahan commenced at CASA did not consider that the 15 August 2011 accident provided justification for any particular condition to be imposed on CSFs. Mr Monahan also accepted that a second fatal accident in 2017 did not provide any root causes to justify any particular condition to be imposed on CSFs. Mr Monahan said that the conditions under which CSFs are conducted are different from a normal private flight. Mr Monahan accepted that there was nothing concerning the circumstances of either of the fatal accidents that informed to any degree the making of the Instrument. For example, there was nothing as to the root cause, as to the training or experience of the pilots, as to the conduct of passengers, or as to the particulars routes or mission.
14			Judgement of J Anderson in AFA v CASA 2021 FCA 469 Ref: P26 at paragraph 94	Mr Monahan said that there were conditions peculiar to CSFs as opposed to ordinary private flights. **However, Mr Monahan accepted that, in respect of the two fatal accidents, he had no information as to whether any generalised differences between CSFs and ordinary private flights were in operation in the two fatal accidents.**
15			Judgement of J Anderson in AFA v CASA 2021 FCA 469	Mr Monahan accepted that he knew nothing about any of the accidents or incidents so as to attribute their occurrence to anything which is peculiar to CSFs. **Mr Monahan accepted that**

	Source RRAT Committee Hearing 4 September 2019	Details	Source Federal Court Hearing, 16 and 17 March 2021	Details
			Ref: P26 at paragraph 96	**there was nothing in the facts or "root cause analysis" of the second fatal accident which, on their own, justified the imposition of the conditions on CSFs.** Mr Monahan accepted that he did not, in his affidavits, raise any disagreement with the data analysis set out in Mr Crees's affidavit
16			Judgement of J Anderson in AFA v CASA 2021 FCA 469 Ref: P27 at Paragraph 97	Mr Monahan accepted that his affidavits in this proceeding did not include any justification for how the comparator group was formulated, and, in particular, why it included (what were referred to in cross-examination as) "country aerodrome joy flights". **Mr Monahan also agreed that his evidence did not set out an analysis of any relation between accidents and numbers of passengers.**
17			Judgement of J Anderson in AFA v CASA 2021 FCA 469 Ref: P27 at paragraph 99	Mr Monahan accepted that he did not have data concerning the passenger numbers carried by CSFs. **Mr Monahan accepted that the desirable support of empirical justification, for the imposition of conditions concerning the number of passengers on CSFs,** positively required him to obtain such data or to accept that he had no empirical support for such a condition.
18			Judgement of J Anderson in AFA v CASA 2021 FCA 469 Ref: P27 at paragraph 100	Mr Monahan accepted that he did not have data differentiating between CSFs and ordinary private flights in respect to the requirement concerning the completion of a minimum amount of flight time. The data he had was provided by BITRE and studies reviewed of other comparative nations.
19	Evidence of Mr Crawford and Mr Monahan RRAT Committee Inquiry into the ATSB transcript at page 25	**CHAIR:** But you have previously asked for the basis of the maintenance report and it's not been forthcoming. **Senator PATRICK:** Yes, I understand. I have actually. I think that was taken on notice. Thank you, Chair, for helping me there. In your analysis, have you	Judgement of J Anderson in AFA v CASA 2021 FCA 469 Ref: P28 at paragraph 103	Mr Monahan was referred to cl 11 of the Instrument, which is titled "Aeroplane maintenance requirements. Mr Monahan said that maintenance of aircraft was a matter obviously germane to safety regardless of the type of flight being undertaken. Mr Monahan accepted that there was nothing special about CSFs which imposed differential stresses or strains justifying differential maintenance

	Source RRAT Committee Hearing 4 September 2019	Details	Source Federal Court Hearing, 16 and 17 March 2021	Details
		looked at the cost aspects of this? **Mr Monahan:** Yes. **Senator PATRICK:** So, when we get that safety report, we'll get to see what the cost implication on the user would be with respect to these. **Mr Crawford:** We're very confident we have taken a pragmatic and proportionate approach on this instrument.		requirements. **There was no data collected or analysed during consideration of the making of the Instrument that suggested that there was anything about CSFs that informed a particular need for aeroplane maintenance requirements such as is found in cl 11 of the Instrument.**