

# Additional Comments by Senator Nick Xenophon

## Who guards the guards themselves?

1.1 I would like to acknowledge the many submitters to this inquiry, and in particular the individuals who were involved in the incident itself. Their information and testimonies were invaluable to the committee and I appreciate their contributions, particularly in light of how distressing it was for them to relive the accident.

1.2 As the committee states, this inquiry was not an attempt to re-examine the circumstances of the ditching of Pel-Air VH-NGA, or to conduct an aviation accident investigation. Instead, it focussed on the reporting standards and activities of the ATSB and CASA in relation to the ditching, and general governance, transparency and accountability issues.

1.3 However, what is clear from this inquiry is that, while the pilot of the flight did make some erroneous decisions, he essentially became a scapegoat for serious regulatory failures on the part of CASA and the ATSB.

1.4 I strongly endorse the comments made by the committee in its report. The evidence given by Mr McCormick of CASA and Mr Dolan of the ATSB was both shocking and disturbing.

1.5 What at first seemed a fairly straightforward inquiry, instead turned up evidence of withheld documents, poor reporting standards, institutional blindness and what appears to be CASA's undue and potentially dangerous influence over the ATSB and its investigation processes. It is clear to me that both agencies have been allowed to operate to a sub-par standard with little knowledge or intervention for too long.

1.6 The details of the ditching and subsequent report are complex and technical. However, the core of the issue is that the ATSB produced a report into the ditching over 33 months after the incident that, contrary to world's best practice and the ATSB's own standards, did not even touch on the systemic or regulatory environment in which the pilot was operating. Instead, it focussed primarily on the pilot's actions. It did not examine the organisation for which the pilot was working, or the systems, procedures or environment in that organisation. This is despite the fact that a CASA Special Audit of Pel-Air after the ditching discovered serious regulatory breaches, and an internal CASA report (the Chambers Report) found significant failures in CASA's oversight of the operator. While neither of these documents were provided to the ATSB in a timely manner (the Chambers report was not released to them until after the inquiry had commenced), the ATSB's investigation should have discovered these problems. That there was no indication of this in the report is a serious concern.

1.7 Further, among the many documents provided to the committee by the ATSB and CASA, the committee discovered the following email, from an ATSB officer to Mr Dolan and Mr Sangston. It reads (bold emphasis added):

We were discussing the potential to reflect the intent of our new MoU that describes the 2 agencies as 'independent but complementary'. We discussed **the hole CASA might have got itself into by its interventions since the**

**ditching, and how you might have identified an optimum path that will maximise the safety outcome without either agency planting egg on the other agency's face.**

Right now, I suspect that CASA is entrenching itself into a position that would be hard to support. **If we were to contemplate an exit strategy, or an 'out', then CASA would need to recognise that it is 'in' something in the first place.** This is my take on how I see their position at the moment.

When the aircraft ditched, both the flight crew and the operator stopped their Westwind Aeromedical operations. **CASA coached and guided the operator very well as they collaborated to develop a much safer process to avoid a repetition of this accident.** This has happened, and Pel-Air are now operating again. **The same thing hasn't happened to the flight crew.** While they may not have been the 'Aces of the base' **they were following the relevant procedure provided by both CASA and the operator.** This is an opportunity for CASA to follow the same approach with the flight crew as they have done with the operator.

...

As we discussed yesterday, following the ditching, everything went (metaphorically) 'up in the air'. CASA has done a good job in realigning Pel-Air while it was still in the air so that it returning to earth with a much better take on how to manage this risk. **Unfortunately, they took action on the flight crew without first contemplating their end-game. If they re-frame their pre-emptive action with the flight crew to show that they had managed all the levels of safety management simply by putting the pilots' permissions to fly on hold until they had found the problem and remedied it, then they would look far better than if they tried to prosecute the probably indefensible and hardly relevant.**

**We will be telling this story in our final report (if not earlier;)** so why not make the most of this opportunity for both agencies to publicly work harmoniously, in a parallel direction?<sup>1</sup>

1.8 It is important to note that 'this story' never made it into the final report, or into any other arena. This email clearly indicates there was a belief inside the ATSB that CASA had 'got itself into a hole', and that the ATSB's priority was avoiding conflict between the two agencies, rather than holding CASA to account. Indeed, the ATSB's report makes no mention of the officer's concerns, and does not even hint at the whole 'story' outlined in the email.

1.9 It also makes it clear that, at least initially, the focus of the investigation was on systemic issues, and that the ATSB officer believed CASA's actions against the pilots were premature and unnecessary. Why the emphasis of the report changed is open to conjecture.

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1 Internal ATSB email regarding the ATSB and CASA's approach to the Pel-Air investigation (dated 9 February 2010), Additional Information 12, received 10 October 2012.

1.10 The report itself is of such a poor standard that many believe it could be considered a breach of Australia's international obligations under the International Civil Aviation Organisation's Annex 13 guidelines for accident investigation reporting.

1.11 Without distracting from the excellent work of the committee's report, I believe it is important to draw attention to two issues that the committee, due to time restraints, was not able to examine more closely.

1.12 Firstly, I believe relationship between CASA's Bankstown Office (responsible for the oversight of Pel-Air and run at the time in an acting capacity by the author of the "Chambers Report") and Pel-Air's management in terms of probity, transparency and impartiality deserves further scrutiny.

1.13 Secondly, I believe it would have been beneficial to publicly examine whether the "demonstrably safety-related" actions taken by CASA against the pilot by CASA were appropriate, reasonable and consistent with other such enforcement. I believe these two issues deserve further consideration.

1.14 Both of these issues could have cast some light on why the ATSB's focus shifted from systemic and human factors to the behaviour of the pilot.

1.15 Beyond the ATSB report itself, the committee also considered the regulatory environment in which such flights operate. As discussed in the committee report, there are significant industry concerns about the low safety standards for aeromedical operations, which come under the category of 'aerial work'. This category includes activities such as crop dusting and aerial surveys.

1.16 One of the significant issues in relation to the ditching was whether or not the pilot should have chosen to divert to an alternate destination due to the weather at Norfolk Island. The committee report discusses Mr McCormick's response to whether CASA should provide guidance in these circumstances, and whether the drafting of a new Civil Aviation Safety Regulation would address this.

1.17 The committee report stated that CASA has drafted Civil Aviation Safety Regulation (CASR) Part 135, which may assist in dealing with this issue. However, CASA's website information on CASR 135 states:

A passenger transport operation is a transport operation in an aircraft involving the carriage of passengers, whether or not cargo is carried on the aircraft. A passenger transport operation does not include, cost sharing operations, aerial work operations or an operation for the carriage of passengers in an aircraft with a certificate of airworthiness other than a standard certificate of airworthiness.<sup>2</sup>

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2 Information available from: [www.casa.gov.au/scripts/nc.dll?WCMS:PWA::pc=PARTS135](http://www.casa.gov.au/scripts/nc.dll?WCMS:PWA::pc=PARTS135) (accessed 7 May 2013).

1.18 Further, the CASA website on CASR 136 indicates that Emergency and Medical Services Operations will remain under the category of aerial work.<sup>3</sup> Therefore, it seems that even though CASA has drafted the guidance under CASR 135, it would not have applied to this flight then or indeed in the future. Further, the guidance only states that alternates need to be provided for, not under what circumstances pilots must choose to travel to those alternates.

1.19 It is also important to note the committee's discussion of the ATSB's Canley Vale report. This incident (also a medical flight) tragically resulted in the deaths of both the pilot and the nurse onboard. The ATSB's response to this accident was similar to its report into the Pel-Air ditching. The ATSB also made it very clear in its report that it did not consider CASA's failure to oversee the operator appropriately as relevant. The validity of that view is, I believe, a direct parallel to that exposed by this inquiry for the Pel-Air ditching and equally alarming.

1.20 The committee also recommended the establishment of an expert independent panel to oversee the ATSB's investigations and reporting. Given the circumstances raised in this report, I believe there is merit in expanding the role of this panel to oversee the performance of both CASA and the ATSB as a whole. There is currently no system to measure the activities of these agencies in an objective manner, and the need for expert oversight and monitoring has been made abundantly clear.

1.21 It is my view that the panel should instead take the form of an Inspector-General of Aviation Safety. Such a body would have the appropriate resources, expertise and powers to oversee the ATSB and CASA to a greater degree. The current Inspector-General of Taxation would be an excellent model to follow as an independent office aimed at conducting systemic reviews and providing recommendations to government.

### **Recommendation 1**

**That the Government establish, as a matter of urgency, the role of Inspector-General of Aviation Safety, with the necessary powers, resources and expertise to oversee and independently review the activities of CASA, the ATSB and other relevant organisations to an appropriate level.**

1.22 Ultimately, this inquiry has exposed serious and significant flaws in Australia's aviation safety systems. The general industry attitude towards both the ATSB and CASA is incredibly concerning; it is a mixture of fear, suspicion, disappointment and derision.

1.23 It is my view that CASA, under Mr McCormick, has become a regulatory bully that appears to take any action available to ensure its own shortcomings are not made public. This poses great risks to aviation safety, and the safety of the travelling public. Equally, the ATSB—which should fearlessly expose any shortcomings on the part of CASA and other organisations to improve aviation safety—has become institutionally timid and appears to lack the strength to perform its role adequately.

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3 Information available from: [www.casa.gov.au/scripts/nc.dll?WCMS:PWA::pc=PARTS136](http://www.casa.gov.au/scripts/nc.dll?WCMS:PWA::pc=PARTS136) (accessed 7 May 2013).

Both agencies require a complete overhaul, and I believe it is only luck that their ineptness has not resulted in further deaths so far. There is an urgent need for an Inspector-General of Aviation Safety, entirely independent of the Minister and his department, to be a watchdog for these agencies.

1.24 In the end, this report raises many questions. But if we wish to bring about change and improve aviation safety, we will clearly need to look beyond our inept regulators and ask: who will guard the guards themselves?

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