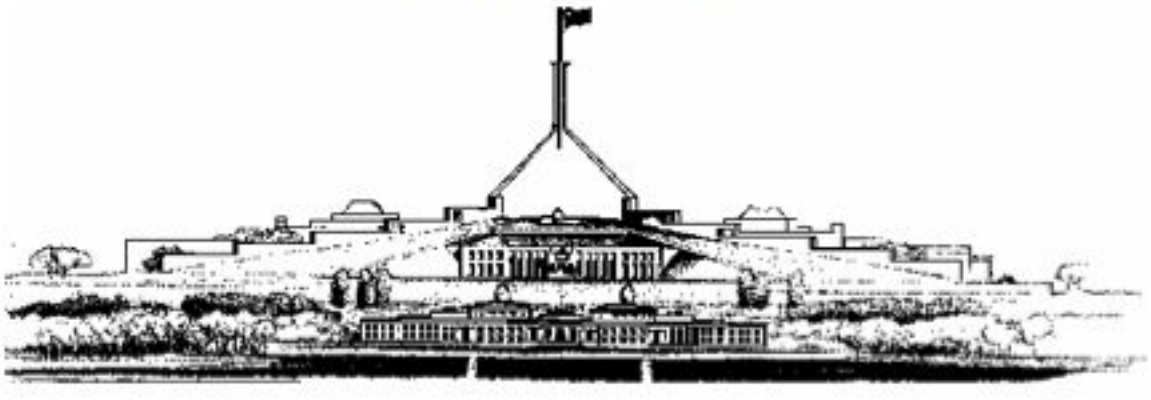
COMMONWEALTH OF AUSTRALIA

PARLIAMENTARY DEBATES



THE SENATE

COMMITTEES

Rural and Regional Affairs and Transport References Committee

Report

SPEECH

Thursday, 20 June 2013

BY AUTHORITY OF THE SENATE

SPEECH

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Questioner		**Responder**	
Speaker	Fawcett, Sen David	**Question No.**	

Senator FAWCETT (South Australia) (18:09): I move:

That the Senate take note of the report.

The final report of the Rural and Regional Affairs and Transport References Committee into aviation accident investigations was tabled in May this year. It followed a long period of investigation into the inquiry by the ATSB into the accident in which a Pel-Air aircraft ditched off Norfolk Island in 2009. The Senate report highlighted that the performance of the two government agencies that were primarily involved, the Australian Transport Safety Bureau and the Civil Aviation Safety Authority, came far short of the expectations that the Australian taxpayer, this parliament and the aviation community should have.

In 2010 a review was done into the operations of those two agencies. Of the eight desired outcomes of that review, the committee found that actions by ATSB and CASA failed to deliver against six of the main areas. I will list them and then talk in more detail about them. They failed to maximise the beneficial aviation safety outcomes that could have been derived from the investigation into this incident. They failed to enhance public confidence in aviation safety. I think we saw that in the controversy in the aviation industry and the media around the report when it was finally released. They failed to support the adoption of a systemic approach to aviation safety. They failed to promote and conduct ATSB independent no-blame safety investigations and CASA regulatory activities in a manner that assured a clear and publicly perceived distinction between each agency's complementary safety related objectives, as well as CASA's specialised enforcement related obligations; they also failed to avoid to the extent practicable any impediments in the performance of each other's functions. They also failed to acknowledge errors and to be committed in practice to seeking constant improvement. The committee made 26 recommendations to address a number of systemic deficiencies that were identified in both the investigative and regulatory processes but also in funding and reporting.

Safety outcomes is one area that I would like to touch on. Accident investigations are an opportunity for an informed and expert body to sit back and take a considered look at why an incident occurred. That body may be expert but they are not necessarily the best judges of how the lessons from that incident may be applied to other sectors of the aviation industry. The committee found that for various reasons and over time the ATSB processes have got to the point where much evidence can be excluded if it does not fall into the categories that they consider will impact on high-risk future operations. So we have a situation where they are making an arbitrary decision to exclude evidence, and without evidence they are not then investigating or reporting on what actually occurred. That means that other aviation operations are not the beneficiaries of an explanation of occurrences and failures in a system safety approach and what defences failed such that the accident occurred. It has been the traditional approach to identify each of those factors and let the stakeholders make their own assessment. But the safety outcomes are no longer optimised because of this approach of trying to make that arbitrary decision at the front. That is a significant flaw in the current approach which the committee has recommended be revisited.

The report and CASA's statements in name supported the concept of a systemic approach to aviation safety. But what we found very clearly was that the investigation focused very quickly on the pilot in command on the night, as opposed to looking at the raft of other factors. Looking at the James Reason model of system safety, one sees that there are a number of defences which are in place, which include the operating company, the regulator and a raft of things —training et cetera—as well as the pilot. But many of those factors were given, at best, lip-service. They were mentioned in the report so a box could be ticked to say that they were considered, without a detailed consideration of them. For that reason, the report was quite flawed.

What made the matter worse was that, having required both CASA and ATSB to produce documents for the inquiry, which initially they were reluctant to do, we spent some considerable time going through literally boxes and boxes of documents to find information, emails, reports and things that were relevant to the report and, having seen a report that said that the company was applying all of its regulatory requirements and CASA was auditing it and so there were no organisational factors to consider, we found that CASA in fact had done a special audit. Not only had they done a special audit that found a range of

problems within the company; they had done their own internal report about CASA's performance of their oversight of the company and found that, in their own words, that was deficient.

So we have a situation where CASA—who have an obligation, under the memorandum of understanding, to disclose to the ATSB when they are aware of or hold, information relevant to an accident investigation—withheld the information of the Chambers report, which is their internal document, and when, as a directly interested party, they were given a draft of the report and the opportunity to say, 'No, this is not correct; there are organisational factors both with the company and the regulator that you should be aware of,' they chose not to do that. That comes very close to breaching, if it does not actually breach, the transport safety act. It certainly does nothing to boost public confidence and it does nothing to enhance the safety outcomes that could have been achieved through this investigation.

It is telling that there were many organisational and systemic measures put in place by the company in order to resume operations. That says that, in their assessment and in the assessment of those people who were auditing the company, clearly the pilot alone was not at fault for the original accident or there would be nothing else they had to change. So the ATSB, in its approach to its report, and CASA, by withholding that information, have done the aviation industry in Australia a great disservice. The aviation industry relies on open, transparent and accurate reporting from the regulator and from the safety investigation agency to make sure that the organisations concerned can be ongoing learning organisations that maximise the safety outcomes for the travelling public and for people operating aircraft.

The regulatory reform process is another thing that came through from this. The air ambulance operation, like the RFDS operation—which also has some emergency aspect to it, certainly for the helicopter emergency services—highlights that we have a category of operation here which has traditionally been put into the air work category, and that is clearly not adequate for all operations in terms of either their planning requirements or the aircraft equipment. To put them into a higher category such as regular public transport or even charter would unnecessarily, in fact prohibitively, restrict their ability to respond and operate in emergency situations to unprepared airfields. There is a very clear case here for industry to have a voice and a role to work with the regulator to establish a new category of operation that provides the guidance required around equipment standards and configuration of the aircraft but also provides the flexibility the operators need to perform their mission in a structured manner.

The last point I would raise is that the Chambers report indicated that CASA felt they were underresourced and their people, in many cases, did not have the requisite insight and, in some cases, skills, knowledge or background to do the auditing. From subsequent discussions, I would argue that, in some cases, they did not have the background to be writing the regulations or standards in the first place. I believe there is a strong requirement to look at the regulatory reform process and the role that industry should have, not just with token consultation but with a powerful voice, even to the point of veto, where they can work with the regulator to highlight what is industry best practice, and that should form the basis of regulation unless there is a very clear safety case to not go down that path. Australia's travelling public and our aviation industries deserve better. I look forward to the reforms that either this government or the next will bring. I seek leave to continue my remarks later.

Leave granted; debate adjourned.