THE SENATE

RURAL AND REGIONAL AFFAIRS AND TRANSPORT

REFERENCES COMMITTEE

PEL-AIR SUBMISSION ON

AVIATION ACCIDENT INVESTIGATIONS

EXECUTIVE SUMMARY

ATSB INVESTIGATION INTO THE DITCHING OF VH-NGA ON 18 NOVEMBER 2009.

Pelair agrees with the conclusion of the investigation that:

- The aircraft carried enough fuel at departure for normal operations as required under the regulations;

- The essential cause of the ditching was the change of the weather enroute;

- Timely notification of the change of weather by ATC would have averted the accident;

Pelair feels that the role of ATC could be examined in this respect to see if any systemic improvements can be made to provide an additional layer of safety buffer.

TERMS OF REFERENCE

(A) The findings of the Australian Transport Safety Bureau into the ditching of VH-NGA Westwind II, operated by Pel-Air Aviation Pty Ltd, in the ocean near Norfolk Island airport on 18 November 2009.

Pel-Air offers the following comments in relation to the findings of ATSB report AO-2009-072.

FINDINGS

At the time of flight planning, there were no weather or other requirements that required the nomination of an alternate aerodrome, or the carriage of additional fuel to reach an alternate.

Pel-Air agrees with this finding.

The aircraft carried sufficient fuel for the flight in the case of normal operations.

Pel-Air agrees with this finding.

The flight crew did not source the most recent Norfolk Island Airport forecast, or seek and apply other relevant weather and other information at the most relevant stage of the flight to fully inform their decision of whether to continue the flight to the island, or to divert to another destination.

The crew did request actual weather reports (either METARs or SPECIs).

WEATHER PROVIDED BY NADI:
The PIC requested a METAR from Nadi for Norfolk at 0756 and at 0801 was provided with an 0800 SPECI which indicated overcast (OVC) cloud at 1100 feet. This was the first indication to the crew that the weather at Norfolk Island was becoming marginal.

WEATHER PROVIDED BY AUCKLAND:
The aircraft transferred to Auckland at 0839 but did not request the latest Norfolk weather until 0904 when they were given the 0902 SPECI which showed broken (BKN) cloud at 1100 feet and OVC cloud at 1500 feet. This finally alerted them to the situation at Norfolk Island. However a much more severe SPECI was issued earlier at 0830 showing a marked deterioration of the weather with cloud BKN at 300 ft and OVC at 900 ft. This was well below the landing minima and **if it had been passed to the aircraft on first contact with Auckland would have alerted the crew to the true situation with time enough to divert**. **At 0839 the aircraft was still around 32 min away from the last diversion point to Tontouta** as shown in the timeline in the report. Additionally, if the Nadi controller had passed the 0830 SPECI to the aircraft when it was issued there would have been even more time for the crew to assimilate the changing weather and take appropriate action. As it was the critical 0830 SPECI was never passed to the crew.

While the obtaining of up to date weather information is ultimately the responsibility of the PIC, controllers are in a position to see weather changes as they happen and should always alert the crew to any new reports they see as significant. The report does not address the question as to whether the controllers could or should have passed on the 0830 SPECI to the crew other than to say they were not required to do so by international agreement.

The flight crew's delayed awareness of the deteriorating weather at Norfolk Island combined with their incomplete flight planning to influence their decision to continue to the island, rather than divert to a suitable alternate.

Pel-Air agrees with the first part of the finding on delayed awareness but disagrees with the second part. As explained in the preceding section, the accident would have been averted if weather information was obtained in a timely manner as there was more than enough time and fuel to divert had the up-to-date information been communicated.

The flight crew's advice to Norfolk Island Unicom of the intention to ditch did not include the intended location, resulting in the rescue services initially proceeding to an incorrect search datum and potentially delaying the recovery of any survivors.

Pel-Air agrees that the crew did not make a proper mayday call as per the regulations. While this may be understandable in the circumstances, the failure to even provide the approximate ditching location meant additional delay to the rescue.

The operator's procedures and flight planning guidance managed risk consistent with regulatory provisions but did not effectively minimise the risks associated with aeromedical operations to remote islands.

Pel-Air disagrees with the second part of this finding and maintains that its procedures, compliant with CASA regulations at the time, are effective for minimising risks for remote island operations. Pel-Air supports the proposed rule changes by CASA to bring passenger carrying aerial work operations in line with regular public transport operations to remote islands including the requirement to always carry an alternate.

The available guidance on fuel planning and on seeking and applying en route weather updates was too general and increased the risk of inconsistent in-flight fuel management and decisions to divert.

Pel-Air agrees that more information can be provided in this area and notes that CASA is proposing a review of CAAP 234-1 and the relevant regulations to take into account amendments to ICAO Annex 6 with new Standards and Recommended Practices (SARPs) regarding to fuel planning, in-flight fuel management and the selection of alternates becoming effective in November 2012. Pel-Air has also instituted a range of improvements to provide more guidance to pilots in this respect.

That having been said, by the nature of their profession the pilot-in-command is trained to exercise the ultimate authority with regard to the safety of their aircraft and the conduct of their flight .

(B) The nature of, and protocols involved in, communications between agencies and directly interested parties in an aviation accident investigation and the reporting process.

Pel-Air feels that the independence of the Safety Investigator must be retained at all times and that the principle of not apportioning blame or liability must be adhered to. It is concerned that information shared too freely by the ATSB with directly interested parties such as CASA will have the potential to hinder safety reporting and investigation.

The current MoU between CASA and the ATSB outlines the separation of responsibilities between the two organisations and these need to be maintained.

(C) The mechanisms in place to ensure recommendations from aviation accident investigations are implemented in a timely manner.

Pel-Air feels that current law under section 25A of the Transport Safety Investigation Act is an adequate mechanism to ensure that ATSB recommendations are responded to in a timely manner.

Not all ATSB recommendations are automatically implemented and the review process under section 25A allows for an examination of recommendations by the responsible and relevant parties. In the case of CASA, this requirement is also reflected in the MoU between CASA and the ATSB.