



# Responding to coronial recommendations

THE CIVIL AVIATION SAFETY AUTHORITY'S REGULATION OF  
GENERAL AVIATION

April 2015

**Report by the Commonwealth Ombudsman,  
Colin Neave, under the *Ombudsman Act 1976***

**REPORT NO. 02|2015**

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## EXECUTIVE SUMMARY

Between 2009 and 2013 (the period considered in this report), 153 people died in 120 accidents involving general aviation aircraft. Many of these deaths were the subject of coronial inquests, which perform an important function in publicly examining the causes of such accidents, and what can be done to minimise the risk of similar accidents and deaths in the future. As result of such inquiries, coroners regularly make findings and recommendations addressed to the Civil Aviation Safety Authority, which has primary responsibility for the maintenance, enhancement and promotion of the safety of civil aviation in Australia.

This investigation looked at how CASA considers, responds to, and implements coronial recommendations, including its internal records for tracking decisions and progress against the recommendations. We considered the reasonableness of CASA's general arrangements for handling coronial recommendations, and the specific actions it has taken in response to each of the coronial inquests within the scope of this investigation. However, given the high level of technical detail and expertise involved in aviation matters, we did not seek to form a view on the soundness of CASA's acceptance or refusal of any particular finding or recommendation.

Our investigation identified opportunities for improvement in relation to a range of matters, including:

- CASA's awareness of coronial inquiries and recommendations
- CASA's approach to assessing coronial recommendations, particularly those suggesting increased enforcement of existing regulations, or the introduction of new regulations
- CASA reporting publicly both on its assessment of coronial recommendations, and its progress in implementing those recommendations it has accepted, and
- CASA's capacity to ensure that Recreational Aviation Administration Organisations (RAAOs) implement recommendations that are relevant to their membership.

We made eight recommendations to CASA, focusing particularly on the transparency of CASA's assessment of coronial recommendations, and its public accountability for implementing recommendations to which it has agreed. The recommendations include that CASA:

- takes steps to improve its working relationships with all State and Territory coroners' offices, and ensures that a representative attends all coronial inquests into general aviation fatalities
- responds publicly to all coronial recommendations, clearly explaining its reasons for accepting or refusing each recommendation, and what it has done or will do to implement accepted recommendations

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- reviews its record keeping arrangements for tracking its assessment and implementation of coronial recommendations
- develops a mechanism by which it can ensure that RAOs implement coronial recommendations within their respective regulatory responsibility
- commits to reporting publicly, at least annually, on its progress in implementing coronial recommendations.

Broadly speaking, CASA has accepted all of our recommendations. Its detailed response to each recommendation is incorporated into the body of this the report.

## PART 1—INTRODUCTION

1.1 This report explores issues arising from the Ombudsman’s analysis of findings and recommendations directed to the Civil Aviation Safety Authority (CASA) by State and Territory coroners.

1.2 Aviation accidents are often widely reported in the media as matters of public interest. When fatalities occur and the possibility of human error, mechanical failure or regulatory failure is identified, the public is entitled to question what is being done, and what can be done, to minimise the chance of similar accidents in the future. Coronial inquests perform an important function in publicly examining these questions, and making recommendations for improvements to aviation safety.

1.3 Going into this investigation, our office was aware of a number of instances in which coroners investigating aviation deaths had made findings and recommendations to CASA. However, it appeared to us that the lack of public response or visible action by CASA made it difficult for the public (including other coroners considering similar matters) to establish whether CASA had considered or acted on those comments.

1.4 The Ombudsman decided to investigate CASA’s handling of coronial inquest findings about matters relevant to the regulation of general aviation. ‘General aviation’ commonly refers to all civil aviation operations other than scheduled air services and non-scheduled air transport operations for remuneration or hire. It includes, but is not limited to aviation for recreational purposes, as well as for some commercial purposes including joy flights, aerial mustering and flight training.<sup>1</sup>

1.5 During the period under investigation, 2009 to 2013, 153 people died in 120 accidents involving general aviation aircraft. Our investigation considered all coronial inquest reports relating to these general aviation fatalities that were released during this period, and in which coroners made recommendations to CASA. In total, there were 94 recommendations<sup>2</sup> made in 13 inquest reports<sup>3</sup> by coroners in New South Wales, Queensland, Victoria and Western Australia.<sup>4</sup>

1.6 As part of our investigation, we sought information from CASA about its past and current approach to considering, responding to, and implementing coronial recommendations, including its internal records for tracking decisions and progress against the recommendations.

1.7 Our investigation focused on examining CASA’s arrangements for:

- identifying coronial inquests that are relevant to its work, and assessing whether its participation (or representation) in those inquests is appropriate (discussed in Part 3 of this report)
- internally considering coronial findings and recommendations with a view to assessing whether some action is required on its part (Part 4 of this report)

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<sup>1</sup> <http://www.infrastructure.gov.au/aviation/general/>.

<sup>2</sup> A further six (6) recommendations were made directly to Recreational Aviation Administration Organisations.

<sup>3</sup> Fifteen (15) reports were issued by coroners during the relevant period, including two (2) matters where separate reports were generated for each deceased person.

<sup>4</sup> A list of all in-scope inquests can be found in Appendix 1.

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- publicly responding to coronial findings and recommendations (Part 5 of this report)
- implementing accepted coronial recommendations (Part 6 of this report).

1.8 In conducting this investigation, we considered the reasonableness of CASA's general arrangements for handling coronial recommendations, as well as its specific actions in response to each of the coronial inquests identified. However, given the high level of technical detail and expertise involved in aviation matters, we did not seek to form a view regarding:

- the validity of the findings of the coroners involved, or the evidence on which those findings were based
- the soundness of CASA's acceptance or refusal of any particular finding or recommendation.

1.9 Rather, this report outlines our conclusions with respect to CASA's responsiveness to coronial inquests and makes some recommendations for improvement. These recommendations focus particularly on the transparency of CASA's assessments of, and decisions about coronial recommendations as well as its accountability for the outcomes of recommendations to which it has agreed.

## **PART 2—BACKGROUND**

### **Coroners' Courts**

2.1 Under State and Territory legislation, the death of a person may be referred to the relevant coroner for investigation. That investigation may consider a number of issues including the deceased's identity, the time, place and circumstances of their death, and the medical cause of death.

2.2 In the course of their investigation, the coroner may decide to conduct a public inquest, particularly when they consider the facts surrounding a death are unclear or raise an issue of public importance. An inquest allows the coroner to hear evidence on oath from parties who may have information about the deceased person or the circumstances of their death. At the conclusion of the inquest, the coroner may make findings about those matters, as well as recommendations aimed at preventing similar deaths in the future.

2.3 Most deaths occurring in the course of general aviation activities are referred to the relevant State or Territory coroner by investigating police. Inquests into such deaths often result in comments, findings and recommendations being made to CASA and/or the Australian Transport Safety Bureau (ATSB) regarding areas for review or improvement. These recommendations may include actions such as increased compliance, new or revised regulations, and public or industry information campaigns.

### **Government agencies**

#### ***Civil Aviation Safety Authority (CASA)***

2.4 CASA was established in 1995 as an independent statutory authority, whose primary function is to conduct the safety regulation of civil air operations in Australia

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and the operation of Australian aircraft overseas. Its functions also include providing comprehensive safety education and training programmes, cooperating with the ATSB, and administering certain features of Part IVA of the *Civil Aviation (Carriers' Liability) Act 1959*.

2.5 The *Civil Aviation Regulations 1988* and the *Civil Aviation Safety Regulations 1998*, made under the *Civil Aviation Act 1988* (the Act), provide for general regulatory controls for the safety of air navigation.

2.6 The Act and Regulations empower CASA to issue Civil Aviation Orders on detailed matters of regulation, and to issue Manuals of Standards that support those regulations by providing detailed technical material.

2.7 Generally speaking, all aircraft pilots and other aircrew must be licenced by CASA in accordance with this regulatory framework. Similarly, all aircraft must be registered and maintained in accordance with this regulatory framework. CASA has appropriate surveillance, investigation and enforcement powers to ensure that the regulatory requirements are met.

### **Recreational Aviation Administration Organisations**

2.8 Through Civil Aviation Orders, CASA has exempted certain recreational pilots and recreational aircraft from otherwise applicable requirements to be licenced and registered by CASA, on the condition that the recreational pilots are members of one of nine Recreational Aviation Administration Organisations (RAAOs).<sup>5</sup> Each of the RAAOs has a particular area of expertise in the recreational aviation sector.

2.9 Individual members of each RAAO must undertake to comply with the RAAO's rules and procedures, which are promulgated subject to CASA's approval. CASA has entered into Deeds of Agreement with each RAAO, which outline the expectation that RAAOs will have rules and procedures dealing with:

- Issuing recreational pilot authorisations
- registration and maintenance of recreational aircraft
- training of participants in the relevant sport or recreational aviation activity.

2.10 The individual RAAOs are responsible for the day-to-day enforcement of technical and operational safety standards, in accordance with their CASA-approved rules and procedures. CASA audits each RAAO's performance at least annually.

### ***Australian Transport Safety Bureau (ATSB)***

2.11 The ATSB is an operationally independent bureau within the Department of Infrastructure and Regional Development. It is Australia's prime agency for the independent investigation of civil aviation, rail and maritime accidents, incidents and safety deficiencies.

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<sup>5</sup> The Australian Ballooning Federation, the Australian Parachute Federation, the Gliding Federation of Australia, the Hang Gliding Federation of Australia, the Model Aircraft Association of Australia, the Australian Sport Rotorcraft Association, Recreational Aviation Australia, the Sport Aircraft Association of Australia, and Australian Warbirds Association Limited.



2.12 The ATSB's website<sup>6</sup> publicly outlines its priorities when deciding whether to investigate a particular transport safety matter. Its primary focus is on improving safety for fee-paying passengers, particularly in matters that may present a serious threat to public safety and are of broad public interest. This means that recreational aviation incidents are a low priority, and are not routinely investigated by the ATSB.

2.13 Where the ATSB does investigate a matter, it may publish its findings and make recommendation for authorities (including CASA) and other parties to address in the interest of improving safety.

### ***Interaction of responsibilities***

2.14 Along with Airservices Australia – which has responsibility for managing air traffic operations – CASA and the ATSB form a tripartite structure for aviation safety in Australia. Each has a separate and distinct function, but all are expected to work closely together as an integrated system.

2.15 CASA and the ATSB have signed a Memorandum of Understanding (MoU) that sets out safety objectives and underlying values to guide the ongoing relationship between the two organisations. The MoU is aimed at maximising aviation safety outcomes and enhancing public confidence in aviation safety. The recent Report of the Aviation Safety Regulation Review<sup>7</sup> recommended that CASA and the ATSB amend the MoU “to make it more definitive about interaction, coordination, and cooperation”. The Australian Government accepted this recommendation and a new MoU is expected to be signed in March 2015.

## **PART 3—AWARENESS OF INQUESTS AND OUTCOMES**

3.1 As the national regulator of the general aviation industry, it is vital that CASA is alert to events and public commentary relevant to that role. Aviation fatalities and the coronial inquests that often follow provide CASA with important information about areas where changes to regulation and compliance activities may be warranted.

3.2 This Part of the report examines CASA's current arrangements for identifying relevant coronial inquests, and for attending and participating in the inquest process.

### **Awareness of inquests and recommendations**

3.3 CASA may become aware of a recreational aviation fatality in a number of ways, including notification from the relevant RAAO, the ATSB or the police, or (most commonly in the first instance) from media reports. However, it is not necessarily involved in every accident investigation, or coronial inquiry.

3.4 In its initial response to our investigation, CASA expressed frustration that on occasion coronial inquests into aviation fatalities have been held and completed without notice to CASA. It explained that this means CASA loses the opportunity to participate in the proceedings and provide the hearing with important information about its role and functions and existing regulatory arrangements, which it asserts are often misunderstood. CASA advised that, in such instances, the resulting coronial findings and recommendations may be ‘less than well-informed’.

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<sup>6</sup> Australian Transport Safety Bureau (2014) *Deciding whether to investigate* [www.atsb.gov.au/about\\_atsb/investigation-procedures.aspx](http://www.atsb.gov.au/about_atsb/investigation-procedures.aspx).

<sup>7</sup> <http://www.infrastructure.gov.au/aviation/asrr/>.

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3.5 When called as a witness to an inquest, CASA is represented by its legal department. However, CASA does not routinely send representatives to attend inquests involving general aviation accidents where its participation as a witness is not required. Given the concerns CASA expressed to this office about the quality of the recommendations sometimes made by coroners in general aviation matters, CASA should consider adopting a policy of attending and contributing to all inquests into aviation fatalities of which it is aware.

### Awareness of recommendations

3.6 A review of the websites of the various State and Territory coroners reveals that coroners' courts generally forward a copy of the inquest findings and recommendations to those witnesses who gave evidence to the inquest. Coroners may apply discretion to also provide a copy of their findings to other 'interested parties', such as the family of the deceased person(s), agencies or organisations that are referred to in the hearings or may have an interest in the findings, and public officers such as the Attorney-General and the Police Commissioner.

3.7 CASA's initial response to our investigation indicates that, even where it has not given evidence at a particular inquest (or possibly even been aware of it), the coroner will generally identify CASA (as well as the ATSB and relevant RAAO) as an interested party and provide it with a copy of their findings.

3.8 However, in a particular case in 2012 CASA was not called as a witness to an inquest into a recreational aviation fatality. Further, CASA was not aware that an inquest had been held until the day the findings were handed down. The relevant RAAO, which had appeared as a witness, provided CASA with a copy of the coroner's findings at that time. The recommendations in that inquest report were directed specifically to the RAAO, rather than to CASA, although it is not clear if that was the reason why the coroner's report was not provided directly to CASA.

3.9 In any event, the fact that CASA was not aware of the inquest is of particular concern, especially given that the recommendations made in that matter included one to the effect that the RAAO should promote a culture of promptly reporting accidents and inappropriate behaviour to responsible bodies, such as CASA or the ATSB. A similar recommendation was also made directly to CASA just three months later by another coroner.

3.10 It is not clear whether CASA also proactively monitors the progress and completion of relevant inquests, to identify the making of recommendations relevant to its role.

#### **RECOMMENDATION 1**

That CASA takes steps to establish effective working relationships with all State and Territory coroners' offices, with a view to ensuring that:

- a) CASA is notified of, and invited to participate in all coronial inquests relating to general aviation
- b) CASA is notified by coroners of the outcome of all coronial inquests relating to general aviation
- c) coroners have access to relevant and up-to-date information about CASA's roles, functions and current programs of regulation and compliance, as well as the roles and functions of RAAOs.

**RECOMMENDATION 2**

That CASA ensures a suitable CASA representative attends all coronial inquests into general aviation fatalities, regardless of whether CASA has been expressly requested to participate as a witness.

**RECOMMENDATION 3**

That CASA implements arrangements to proactively monitor the commencement, progress and completion of coronial inquests regarding general aviation fatalities.

## **PART 4—ASSESSING CORONIAL RECOMMENDATIONS**

4.1 At the conclusion of each inquest, the coroner releases a report outlining their findings in the matter and, where appropriate, making recommendations about how to prevent similar fatalities in the future. This Part of the report examines the standard and reasonableness of CASA's current arrangements for assessing coronial recommendations directed to it.

### **Accident Investigation Review Committee**

4.2 In 2009 CASA established an Accident Investigation Review Committee (AIRC). The AIRC is responsible for:

- reviewing the safety recommendations made to CASA in coronial hearings and ATSB investigation reports, assigning these to a Division/s for action, tracking the progress of the assigned actions, and closing the actions
- on CASA's behalf responding to the ATSB, coroner and other relevant external recommendations
- when appropriate, initiating internal review or studies in relation to matters associated with safety recommendations made to CASA by relevant external parties.

4.3 The AIRC is tasked with maintaining records of all safety recommendations made to CASA by external parties, including State and Territory coroners. These records also reflect CASA's views on:

- whether it agrees with the recommendation(s)
- what (if any) response it has provided to the recommending body
- what, if any, action it has taken (or intends to take) in respect of the recommendation(s).

4.4 The AIRC reports to CASA's Aviation Safety Review Committee (ASRC), which is chaired by the Director of Aviation Safety (CASA's chief executive officer). The ASRC must endorse the AIRC's recommended actions, which then become the responsibility of the relevant line area within CASA to implement.

### **Record-keeping**

4.5 We obtained copies of CASA's records of its consideration of all coronial inquest reports relating to general aviation fatalities between 2009 and 2013. The relevant records in fact went further back in time, and covered all coronial recommendations

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and comments made to CASA since 2003. The records, in varying degrees of detail, summarised CASA's internal assessment of each recommendation, and any action taken in response.

4.6 Our assessment of CASA's earlier records, between 2010 and November 2013, was that in many cases those records were not particularly helpful in understanding CASA's assessment of the recommendation or any action taken as a result. Those documents also appear to only be relevant to the time at which they were prepared; that is, they do not necessarily reference past actions or decisions that might be relevant to understanding the current status.

4.7 We were pleased to note that CASA significantly improved its record keeping and tracking arrangements in about November 2013. The current 'inquest report summary' document details each of the recommendations that remain active in respect of a particular inquest at the time of preparation, and provides space for free text commentary about the status of the recommendation and any proposed next steps.

4.8 However, while the current format is certainly an improvement, the information contained in the records themselves appears to still be a fairly superficial explanation of the reasons for accepting or rejecting a recommendation, or for deciding a particular course of action by way of implementation. Indeed, it was difficult in many instances for this office to assess whether the decisions and actions outlined in the 'inquest summary' documents were reasonable, because there was insufficient information to explain the process via which the reported conclusions were reached.

4.9 In its initial response to our investigation CASA acknowledged that it would be useful for specific details of its considerations, decisions and actions in respect of coronial recommendations to be formally and explicitly recorded. It undertook to consider amendments to its standardised record keeping arrangements to ensure this greater level of detail was included.

4.10 The AIRC, in conjunction with the relevant line areas within CASA, presumably assesses coronial recommendations by reference to a variety of information, including legislation, regulations, policy, procedure, and accident and compliance data. We suggest that it would be relatively easy to include reference to these materials, including excerpts where appropriate, in the case summary document for each inquest, in support of CASA's conclusions. This level of detail would make it much easier for others who might have need to consider the matter – internally and externally – to understand the basis of the decisions and actions that were taken in a particular matter.

4.11 Further analysis of CASA's record keeping arrangements is provided in *Part 6 – Implementing coronial recommendations*, along with some recommendations for improvement.

### **Approach to assessing recommendations**

4.12 In the course of examining CASA's response to coronial recommendations, this office identified some particular issues regarding CASA's general approach to recommendations calling for increased enforcement.

#### ***Recommendations for increased enforcement***

4.13 In many of the inquest findings considered in our investigation, the coroner concluded there had been poor compliance by the pilot with existing regulations. We

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identified at least nine specific recommendations that CASA more effectively enforce compliance with aviation regulations. A further inquest identified non-compliance with fundamental regulatory requirements (pilot uncertified, aircraft unregistered) as a key contributing factor to the fatality examined, without making specific recommendations about enforcement.

4.14 CASA's responses to these recommendations, both in its internal assessment and its correspondence to the relevant coroners, make it clear that CASA considers the key to preventing deaths in such cases is the pilot's personal responsibility in adhering to regulations, rather than increased compliance and enforcement activities by CASA and RAOs.

4.15 For example, in Mull,<sup>8</sup> Coroner White concluded that the circumstances of Mr Mull's death indicated that specific regulation regarding the building and maintenance of kit build helicopters<sup>9</sup> was warranted. The coroner recommended that CASA consider the introduction of such regulation for all kit build helicopters, and also review the building and maintenance permissions for the specific type of helicopter involved in Mr Mull's death.

4.16 In response, CASA suggested that the existing regulatory framework was sound, and that the real issue was the willingness of individuals to comply with the framework. CASA also indicated that individuals should avail themselves of the support of the relevant RAO in order to acquire the 'necessary knowledge and skills to enable (them) to avoid the conditions that resulted in the accident'. It also said that it could not be expected to police each and every individual given its operational constraints.

4.17 We acknowledge that it would not be reasonable to expect CASA to ensure compliance with every regulation in every case. CASA regulates a large and diverse aviation industry with significant but not unlimited resources. Particularly with respect to recreational flyers who operate from a wide variety of official and unofficial flight facilities, it is simply not possible for CASA to be present everywhere, making sure that every pilot is doing the right thing. Nor would it be reasonable to expect CASA to reinvest large amounts of resources that are currently devoted to safeguarding large numbers of people, into trying to safeguard a few.

4.18 Nevertheless, compliance is a significant element of CASA's core business, and it is reasonable to expect that its decisions about where to focus its compliance activities will be made in a transparent and defensible way. To this end, we suggest that, where CASA considers that a coronial recommendation for increased compliance does not warrant implementation because that compliance activity is a low priority, then it should explicitly underpin this conclusion with a clear and defensible method for assessing and prioritising risks.

### ***The need for new regulation where participants 'have accepted the risk'***

4.19 In the coronial reports we considered, coroners had made at least 54 recommendations for new regulations to be introduced, or for existing regulations to be strengthened. Based on the available information, it appears that CASA rejected almost all of these recommendations as either unnecessary or unworkable.

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<sup>8</sup> 2009, Victoria, Coroner White.

<sup>9</sup> Separate from the general regulation of 'experimental' aircraft, in which kit build helicopters are included.

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4.20 It is not our intention to second-guess CASA's assessment of the need for, or workability of, any particular recommended regulation. However, we did identify a common theme in CASA's assessment of these recommendations, to the effect that it considers that no regulatory action is required because it would only be addressing a known risk that the participants in the activity can be taken to have accepted.

4.21 Put simply, we do not accept that this is, in and of itself, an adequate basis on which to dismiss a considered recommendation from a coroner.

4.22 We do accept, of course, that there are inherent risks in recreational flying, but governments can and often do regulate 'risky' activities. Operating and travelling in motor vehicles is a prime example. It has long been understood that wearing seatbelts significantly reduces the risk of death and injury in motor vehicle accidents. The decisions of State and Territory governments requiring that seat belts be used were driven by the social costs of preventable deaths and injuries, notwithstanding that car users could be taken to have accepted the risk of not using them.

4.23 We do not mean to suggest that CASA should regulate to address every known risk, nor that it should accept every coronial recommendation. Rather, if CASA concludes that new or strengthened regulation to address a particular risk is not necessary or is not a priority, it is reasonable to expect to see that decision framed in more considered and compelling terms.

4.24 As with recommendations regarding compliance measures, we suggest that CASA details its consideration of recommendations for new regulations in a more transparent way. Ideally, such considerations would include an assessment of the costs, benefits and risks of the proposal, balanced (where appropriate) against the opportunity to use those resources in other, higher-risk areas that may save more lives.

### **Risk to others**

4.25 In our view, CASA's approach to recommendations addressing 'accepted risks' also does not adequately account for the potential social costs arising from the risks posed to others, in the air or on the ground, by the actions of the 'informed' person. Many of the accidents the coroners investigated could easily have also killed or injured non-participants, and passengers are in a particularly vulnerable position.

4.26 In the Hender inquest,<sup>10</sup> a father took his ten-year-old son as a passenger on a flight in a modified and uncertified aircraft. The coroner recommended that CASA prohibit persons under the age of 17 flying in modified experimental aircraft. CASA's response to the coroner advised that it did not consider there was any basis in safety for it to impose such a prohibition and that, in any event, to do so would be inconsistent with the ability of those aged 15 and above to undertake flight training. CASA also expressed the view that, in the absence of any compelling safety data that would justify restrictions being imposed, it considered it was the parents' responsibility to manage the risks to minors of participating in the activity.

4.27 While we acknowledge CASA's reservations about the specific recommendation in that case (discussed further below under 'Reasonableness of recommendation'), we do not consider 'parental responsibility' is itself a sufficient basis for dismissing the need for greater regulation of activities involving a serious risk to uninformed passengers. While parents certainly have a part to play in managing the risks for their own children (assuming they are aware of those risks),

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<sup>10</sup> 2013, Victoria, Coroner Hendtlass.

this approach fails to consider the risks posed to minors other than pilots' own children, or to adults who may be unaware or misinformed of the risks of the proposed activity. In our view, CASA has a heightened responsibility to safeguard minors and other parties who may not be well informed (or at all) of the risks of the activity in which they are participating. In light of this, we suggest that CASA's assessment of coronial recommendations more clearly distinguishes risks to others from risks that participants may be taken to know and accept, and bases its conclusions on a clear and defensible method for assessing and prioritising such risks.

#### **Unknown risks**

4.28 Putting aside the risks that CASA asserts participants in certain activities accept, we suggest CASA's approach fails to acknowledge that there are also many instances in which the 'informed' person is exposed to risk they have not accepted, and may not even be aware of.

4.29 In Scholl,<sup>11</sup> the deceased was undertaking flight training and had purchased a used aircraft. By all accounts he was meticulous about safety and understood he had taken all necessary precautions with respect to the condition of his aircraft. However, the coroner concluded that the circumstances of his death demonstrated Mr Scholl may not have been provided with sufficient training and, in his relative inexperience, may have been misled about the true condition of his aircraft. In that matter, the coroner made at least 12 recommendations relating to the need for new or improved regulation of the ultralight industry to prevent future deaths. Unfortunately the records provided to our investigation by CASA were not sufficiently detailed to allow us to identify whether CASA agreed with, or implemented each of those recommendations.

#### ***Reasonableness of recommendations***

4.30 In many instances where coroners have recommended increased enforcement or regulation, CASA's assessment indicates a view that such measures are unnecessary. Most of these determinations appear to be made on two main grounds, being either that the matter has already been addressed (whether in the specific way suggested by the coroner or by some other method), or the action proposed is unreasonable or impractical.

4.31 Where CASA considers that a recommendation is misguided or is not something it can, or otherwise should implement, it is reasonable to expect that it would clearly articulate the reasons for that view. In doing so, CASA should bear in mind that coroners make their recommendations on the basis of the evidence before them and may not always have the benefit of a full and current understanding of the regulatory framework in which CASA operates, or of the options that are (or are not) available to CASA in addressing problems of compliance.

4.32 While it may be that CASA has good reasons for concluding that the specific recommendation put forward by the coroner is not workable, we suggest it would be uncommon for a coroner to make such recommendations in the absence of serious concerns about how the fatality in question came about. In turn, we would suggest that, in assessing a coronial recommendation, CASA places greater focus on the underlying intention of the recommendation rather than the specific detail of the recommendation itself in deciding whether the recommended action – or another action consistent with the spirit of that recommendation – should be implemented.

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<sup>11</sup> 2009, Queensland, Coroner Braes.

4.33 The recommendations in the Hender<sup>12</sup> inquest regarding the carriage of minors as passengers are a good example of where this kind of approach could be applied. Coroner Hendtlass recommended that CASA prohibit persons under the age of 17 flying in modified experimental aircraft. CASA's response to the coroner indicated that it did not intend to implement this recommendation because (among other things) it would be inconsistent with the ability of persons aged 15 and above to participate in pilot training. In forming this view, it is not clear whether CASA considered imposing an alternative course of action – such as instead applying restrictions on carrying passengers aged 14 and under – might be appropriate to address the recommendation.

4.34 We were pleased to note CASA had applied this principle in respect of one of the recommendations in Scholl,<sup>13</sup> where Coroner Braes identified a possible gap between the actual and expected levels of expertise expected of pilots in maintaining their own aircraft. He recommended that CASA should review its arrangements whereby a 'Level One maintenance authority' was regarded as competent to carry out personal aircraft maintenance. As we understand it, this recommendation was aimed at encouraging CASA to require that maintenance of personal aircraft be conducted by people with a higher level of technical skill than could be assumed of a Level One maintenance authority. While it is not clear whether CASA considered accepting and implementing the recommendation in its original form, its internal records indicate CASA concluded that a workable solution would be to negotiate the provision of additional training for Level One maintenance authorities by the RAAO to address the potential gap in knowledge identified by the coroner. It proceeded to negotiate the provision of that training by the RAAO, Recreational Aviation Australia. While CASA's approach to that recommendation was admirable unfortunately, within the same case, we saw many more instances where CASA's only response to recommendations was that it did not consider any action was required because the current arrangements were sufficient.

4.35 In such cases, an explanation of CASA's assessment of the original recommendation, in tandem with an explanation of its subsequent decision to reject the recommendation entirely or to implement some alternative course of action, would enable the coroner and the public to understand the reasons for CASA's approach, and to appreciate that – while CASA takes coronial recommendations seriously – it is not always able to implement them precisely as envisaged by the coroner.

#### **RECOMMENDATION 4**

That, in assessing recommendations by coroners, CASA ensures that:

- a) it makes decisions with reference to the costs, benefits and risks of the proposal, in order to form a view about its relative merit against other planned activities
- b) where it concludes that a particular recommendation cannot, or should not be implemented in the form proposed by the coroner – it considers whether another course of action could be more readily implemented to satisfy the intention of the original recommendation
- c) it clearly articulates those assessments in its public response to the recommendation.

<sup>12</sup> 2013, Victoria, Coroner Hendtlass.

<sup>13</sup> 2009, Queensland, Coroner Braes.



## PART 5—RESPONDING PUBLICLY TO CORONIAL RECOMMENDATIONS

5.1 With the (arguable) exception of coroners in Victoria,<sup>14</sup> CASA is not required to – and therefore generally does not – respond to coronial recommendations, either directly to the relevant coroner or publicly.

5.2 While it is true that, in most instances, CASA is not required to respond to coronial recommendations, in our view it should do so as a matter of course. Coronial findings are made public<sup>15</sup> precisely because they relate to matters of public interest and public safety. It is reasonable then, as a matter of good public administration, to expect that the agencies to whom those concerns regarding public safety are directed would respond publicly about if and how it intends to address those recommendations.

5.3 As well as satisfying the interests of transparency and accountability, we consider there would be a number of additional benefits to CASA in publicly reporting its response to coronial recommendations.

### Education

5.4 In its comments at the commencement of this investigation CASA pointed our office to the ‘less than fully informed understanding’ of CASA’s role, functions and resources demonstrated by some coroners in making their recommendations. This suggests that there may be value in CASA taking steps to improve its relationship and interaction with the various state and territory coroners to ensure that:

- CASA is invited to attend and, if necessary, participate in all coronial inquests regarding general aviation fatalities
- CASA is well placed to better inform coroners about its role, functions and resources, and thereby educate coroners on how they might frame their recommendations to ensure they are matters within CASA’s responsibility and operational capability.

5.5 It is likely that many members of the public also do not fully understand the role and responsibilities of CASA. By reporting publicly against coronial recommendations – and, where appropriate to the matter, providing an explanation of its functions – CASA might use this forum to better educate the public about its role in promoting aviation safety.

### Improvement of recommendations

5.6 By committing to providing a response to each recommendation made by state and territory coroners within a set timeframe CASA will be better placed to

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<sup>14</sup> Subsections 72(3)-(5) of the *Coroners Act 2008* (VIC) require that “public statutory authorities” must provide a written response to the recommendations, specifying any action/s that has, is or will be taken, within three months. The Coroner must publish these responses on the internet. It is arguable, but not certain, that the Victorian Act applies to Commonwealth statutory authorities including CASA: see *Re Residential Tenancies Tribunal of NSW; ex parte Defence Housing Authority* (1997) 190 CLR 410. That case held that while State laws cannot alter or limit a Commonwealth statutory authority’s powers, State laws of general application can regulate how those powers are exercised.

<sup>15</sup> Although the report itself may be de-identified for reasons of privacy or sensitivity.

publicly articulate its views regarding those recommendations, including where it considers that a recommendation is misdirected, misguided or unworkable. In doing so, it is reasonable to expect that coroners would use that feedback in framing future recommendations to CASA.

5.7 Publishing its responses to coronial recommendations would also help CASA to address its concern that coroners often make recommendations that echo (or even explicitly repeat) comments made by coroners in previous matters. Indeed, if CASA was to provide records of its responses to past recommendations in a suitably accessible (and even searchable) manner, coroners may even be able to identify the existence, and status of similar recommendations in other matters before issuing their own.

#### **RECOMMENDATION 5**

That, as a matter of course, CASA responds publicly to all coronial recommendations by providing written advice of:

- a) its decision to refuse or accept each recommendation
- b) reasons for its decision to refuse or accept each recommendation
- c) the steps it has taken, or intends to take to implement the recommendation, including where it has decided to institute an alternative course of action to that proposed by the coroner.

## **PART 6—IMPLEMENTING CORONIAL RECOMMENDATIONS**

6.1 Coronial recommendations, and their acceptance by CASA, will have little or no practical impact if CASA does not implement the recommendations effectively. This section of the report examines CASA's effectiveness in tracking progress in implementing those recommendations it has accepted.

6.2 Based on the information CASA provided in the course of our investigation, we found it difficult to reach conclusions about the effectiveness of CASA's implementation of any particular recommendations. In most cases, the information in CASA's internal records was not sufficiently detailed to allow us to know what specific implementation action it proposed to take, nor to be able to tell whether it had actually taken that action.

6.3 Given our difficulties in following the sequence of events, it would not be surprising if CASA itself experiences similar difficulties in assuring itself that its implementation of coronial recommendations was appropriate and timely.

### **Issues impacting implementation**

#### ***Recording keeping and tracking***

6.4 Coronial recommendations are made by coroners in each State and Territory under different laws, in differing formats, and with varying time delays from the when the events under investigation occurred. This in itself makes it challenging for national agencies such as CASA to effectively keep track of them.

6.5 In order to ensure that recommendations are appropriately noted, considered and acted upon, it is vital that CASA has a robust tracking mechanism. An overview

## **Commonwealth Ombudsman—CASA: Responding to coronial recommendations**

of CASA's record keeping arrangements is included in *Part 4 – Assessing coronial recommendations*.

6.6 At the time of this report, CASA's approach is to detail the relevant recommendations from each inquest into a separate summary document. This individualised approach enables the AIRC to view the details of the recommendations as well as their current status within the organisation. As we understand it, a new version of this summary is created for each AIRC meeting, to provide members with the necessary background for discussion. However the summary includes only those recommendations that remain active at the time of the relevant meeting. It does not contain any details of recommendations from the same matter that have been previously considered or actioned. While sensible in terms of keeping the AIRC's records relevant and concise, the removal of inactive recommendations over time would seem to create complexities in terms of ensuring that the details, decisions and outcomes for all finalised recommendations have been suitably recorded in one place. Someone hoping to get a full understanding of CASA's complete response to all recommendations from a particular inquest would seemingly have to locate copies of all summaries for each AIRC meeting that considered that set of recommendations, and then piece them together.

6.7 In order to assess the ease of obtaining a full view of the progress of recommendations in a particular matter, our office considered the three different versions of records CASA had maintained in the 51 recommendations made to it in the Scholl<sup>16</sup> matter. Over the course of three years, CASA's records of that inquest went from listing every recommendation separately (with little or no detail), to grouping the recommendations for a bulk comment, to including only one remaining recommendation. There was no clear path by which we could understand the decisions or outcomes of the remaining recommendations, and it is not clear to us that CASA could easily track these matters either.

6.8 In examining the AIRC's procedures, it seems that when it accepts a recommendation, it necessarily delegates responsibility for implementation to the relevant line area. However, once this delegation has occurred, it is not clear whether the AIRC actively monitors the progress of implementation between meetings, or prompts action where implementation is not progressing in a reasonable timeframe. We suggest that such action would assist the AIRC to ensure CASA is implementing agreed recommendations in a timely manner.

6.9 With a monitoring focus in mind, we note that the AIRC does not appear to maintain a central record of the status of all current coronial recommendations. This sort of overview, if coupled with data about expected timeframes for implementation, might assist the AIRC to identify recommendations where agreed action has not been taken or has been delayed, and to act accordingly.

### ***Responsibility of RAOs in implementing recommendations***

6.10 As outlined earlier, the nine RAOs are responsible for the day-to-day enforcement of safety standards and operational rules, in accordance with their CASA-approved rules and procedures.

6.11 In many instances, coroners make recommendations to CASA (or, in some cases, directly to the RAO) regarding recreational aviation matters for which an RAO has direct responsibility under this arrangement. Where CASA or the relevant RAO accepts such a recommendation, CASA then relies on the RAO to take the

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<sup>16</sup> 2009, Queensland, Coroner Braes.

necessary action. However, difficulties may arise where the RAAO is unwilling or slow to implement the recommendation, or is concerned about the cost of implementation.

### **Unwillingness or slowness to implement**

6.12 Although the Deeds of Agreement with RAAOs require that they take steps to comply with the recommendations of coronial (and other) investigations, where an RAAO does not do so CASA has limited options via which to prompt it to act.

6.13 With the exception of one RAAO,<sup>17</sup> CASA does not have a direct regulatory relationship with RAAOs such as it has with other organisations or persons approved or authorised by CASA to perform functions on its behalf. This means its sole recourse for non-compliance is to threaten the RAAO with the removal of, or substantial variations to, the exemptions given to its members under the Regulations. However, given that CASA has granted these exemptions precisely because it is not resourced to conduct the functions fully itself, it seems unlikely that it would be able to act on such an ultimatum.

6.14 We are aware that CASA anticipates amendments to the Safety Regulations that would address this issue. Our office does not have a view about the specific method that should be used, but agrees that an appropriate mechanism should be built into the delegations to ensure that CASA has adequate mechanisms available to ensure that RAAOs act on coronial recommendations, whether directed to their organisation or to CASA, in a reasonable and timely way.

### **Accountability for implementation**

6.15 Further to our view that CASA should publicly report on its assessment of coronial recommendations, we consider that CASA should similarly report on its progress in implementing those recommendation to which it has agreed. In our initial contact with CASA on this investigation, we pointed to the section of the Queensland Government's Annual Report dealing with coronial recommendations as an example of how CASA might report on its own actions. CASA's response indicated that it would consider publishing this information along these lines.

#### **RECOMMENDATION 6**

That CASA reviews the effectiveness of its current tracking arrangements, with a view to assessing:

a) whether it would be appropriate to create a central database of all recommendations made by coroners, along with details of:

- CASA's acceptance or refusal decision
- reasons for the acceptance or refusal decision
- action taken, or underway to implement the decision

b) whether greater oversight by the AIRC is required to ensure appropriate progress is made on recommendations between AIRC meetings.

#### **RECOMMENDATION 7**

With respect to RAAOs, that CASA identifies and applies a suitable mechanism to ensure RAAOs implement coronial recommendations within their respective regulatory responsibility in a reasonable and timely fashion.

<sup>17</sup> Australian Warbirds Association Ltd.

**RECOMMENDATION 8**

If it has not already done so, that CASA commit to reporting publicly, at least annually, on its progress in implementing coronial recommendations.

**PART 7—CONCLUSION**

7.1 CASA deserves credit for its open and constructive response to our investigation and to our recommendations. It has given a number of undertakings that we are confident will improve the transparency and accountability of its responses to coronial recommendations.

7.2 This office will continue to work with CASA to monitor its progress in implementing our recommendations. We will also disseminate the outcome of our investigation to State and Territory coroners.

## PART 8—AGENCY RESPONSE



**Australian Government**  
**Civil Aviation Safety Authority**

OFFICE OF THE DIRECTOR OF AVIATION SAFETY

Trim Ref: G115/188

23 March 2015

Mr Colin Neave  
Commonwealth Ombudsman  
GPO Box 442  
Canberra ACT 2601

Dear Mr Neave

**Response to Investigation Report — *Responding to Coronial Investigations:  
The Civil Aviation Safety Authority's Regulation of General Aviation***

Thank you for your letter of 19 February 2015, and for the opportunity to comment on the accompanying draft report of your office's investigation into the Civil Aviation Safety Authority's (CASA) handling of coronial inquest findings relevant to the regulation of general aviation.

As you know, there has been significant constructive communication between senior representatives of your office and CASA in the course of this investigation. I am pleased to see that your report reflects important elements of the input CASA was able to provide in those exchanges.

In response to your request, comments on each of the 8 recommendations in your report are provided below.

**RECOMMENDATION 1**

That CASA takes steps to establish effective working relationships with all State and Territory coroners' offices, with a view to ensuring that:

- a) CASA is notified of, and invited to participate in all coronial inquests relating to general aviation
- b) CASA is notified by coroners of the outcome of all coronial inquests relating to general aviation
- c) coroners have access to relevant and up-to-date information about CASA's roles, functions and current programs of regulation and compliance, as well as the roles and functions of RAAOs.

**CASA agrees with this recommendation, with minor qualifications.**

**In respect of (a)** — CASA has sought to establish relationships of this kind on various occasions in the past. Your office will be aware, however, of the challenges posed by the

fact that the administration and management of coronial processes in Australia (i) vary considerably amongst the States and Territories; (ii) may change without notice within individual States and Territories; and (iii) are not formally overseen by a single national body providing an authorised single-point of contact for State and Territory coroners.

With these considerations in mind, CASA will re-initiate efforts to formally establish and maintain up to date contacts with the coroners in all State and Territories. Where contact can be established, CASA will take such steps as we are able to take to ensure CASA is notified of all coronial inquests relating to general aviation. In such cases, where CASA has not been invited by the coroner to participate in a forthcoming inquest, and it appears to CASA that there may be some utility in doing so, CASA will ask to be represented at, and to participate in, those proceedings.

**In respect of (b)** — On the basis of such contact as CASA is able to establish and maintain with individual State and Territory coroners, CASA will expressly request that notification be provided to CASA, directly and in a timely way, of the outcome of all coronial inquests relating to general aviation.

**In respect of (c)** — CASA will take such steps as can practicably be managed to ensure that all State and Territory coroners have access to relevant and up-to-date information about CASA's roles, functions and current programmes of regulation and compliance. Whilst much of this information is publicly available on CASA's website, CASA will ensure that relevant information and website details are provided to each State and Territory coroner once the contact mentioned above has been made.

In anticipation of certain regulatory changes involving CASA's relationship with what are currently recognised as Recreational Aviation Administration Organisations (RAAOs), as a result of which changes those organisations would become Approved Self-Administering Aviation Organisations, under Part 149 of the *Civil Aviation Safety Regulations 1998*, CASA will provide all State and Territory coroners with general information about each RAAO. Here too, CASA's ability to do so effectively will require that appropriate points of contact are established with individual State and Territory coroners.

Membership and participation in the activities of the *Asia-Pacific Coroners Society* is not mandatory. However, the Society's annual conference organisers actively solicit the attendance and participation of all Australian State and Territory coroners (amongst others) at those conferences, and it would appear that representatives of many, if not all, Australian State and Territory coroners, do attend. CASA will pursue the possibility of securing a regular slot as a speaker at these annual conferences, with a view to using that forum as an opportunity to help ensure coroners have access to current information of the kind mentioned above.

**RECOMMENDATION 2**

That CASA ensures a suitable CASA representative attends all coronial inquests into general aviation fatalities, regardless of whether CASA has been expressly requested to participate as a witness.

**CASA agrees with this recommendation, in principle.**

Subject to operational priorities, the costs involved and other relevant considerations, CASA will take reasonable steps to ensure that a suitable CASA representative is available to attend all coronial inquests into general aviation fatalities, and we will endeavour, in all cases, to ensure CASA is in a position to participate as a witness in coronial proceedings where CASA has been invited to do so.

As your office will be aware, CASA is often invited to provide subject matter expertise on various technical and operational aspects of matters under scrutiny in coronial proceedings, even where the coroner him, or herself, does not consider it necessary for CASA to appear or participate on the basis of its position as the safety regulatory authority. CASA routinely complies with these requests, and has readily made technical and operational personnel available to assist coroners, counsel assisting coroners and police authorities conducting investigations on behalf of coroners.

**RECOMMENDATION 3**

That CASA implements arrangements to proactively monitor the commencement, progress and completion of coronial inquests regarding general aviation fatalities.

**CASA agrees with this recommendation.**

As recognised in your report, CASA is continually monitoring the field, with a view to ensuring early awareness of events involving general aviation fatalities.

In conjunction with these processes, and in light of the matters discussed in CASA's response to Recommendation 1, CASA will implement appropriate arrangements to proactively monitor the commencement, progress and completion of coronial inquests involving general aviation fatalities. Naturally, such action will be implicit in any coronial inquest in which CASA is otherwise involved.

**RECOMMENDATION 4**

That, in assessing recommendations by coroners, CASA ensures that:

- a) it makes decisions with reference to the costs, benefits and risks of the proposal, in order to form a view about its relative merit against other planned activities
- b) where it concludes that a particular recommendation cannot, or should not be implemented in the form proposed by the coroner – it considers whether another course of action could be more readily implemented to satisfy the intention of the original recommendation
- c) it clearly articulates those assessments in its public response to the recommendation.

**CASA agrees with this recommendation.**

**In respect of (a) and (b)** — CASA already proceeds along the lines described in these elements of this recommendation. As acknowledged in your report, CASA's actions in support of these efforts are more apparent in the documentation reflecting current practices than they appear to have been in the past. In the circumstances, CASA considers the primary import of this recommendation is reflected in (c), below.

**In respect of (c)** — CASA will earnestly endeavour to articulate more clearly its assessments, of the kind mentioned in (a) and (b), on the relevant records of the Accident Investigation Review Committee and the Aviation Safety Review Committee. Steps will also be taken to ensure CASA's assessments are clearly articulated in its public response to coronial recommendations (see CASA's response to recommendation 5).



**RECOMMENDATION 5**

That, as a matter of course, CASA responds publicly to all coronial recommendations by providing written advice of:

- a) its decision to refuse or accept each recommendation
- b) reasons for its decision to refuse or accept each recommendation
- c) the steps it has taken, or intends to take to implement the recommendation, including where it has decided to institute an alternative course of action to that proposed by the coroner.

**CASA agrees with this recommendation.**

CASA recognises the importance of ensuring its position on all coronial recommendations directed to CASA is clear and transparent. Such an approach is entirely consistent with the principles and supportive practices that have been announced by the Director of Aviation Safety, and are likewise reflected in the Government's Response to the Aviation Safety Regulation Review.

On this basis, CASA readily agrees to initiate action to ensure that, once a decision to accept or reject a coronial recommendation *directed to CASA* has been authoritatively taken:

- CASA's decision to accept or reject such a recommendation will be notified to the coroner who made that recommendation, and publicly announced in an appropriate form, manner and place;
- the reasons for CASA's decision to accept or reject such a recommendation will be included in the notification CASA provides to the coroner and in the public notification mentioned above; and
- CASA will notify the coroner, and include in a public announcement of the kind mentioned above, the steps CASA has taken, or intends to take, to implement a recommendation it has accepted (in whole or in part), as well as any alternative course of action CASA has taken, or intends to take, to that proposed by the coroner, whether the coroner's recommendation is accepted or rejected.

**RECOMMENDATION 6**

That CASA reviews the effectiveness of its current tracking arrangements, with a view to assessing:

- a) whether it would be appropriate to create a central database of all recommendations made by coroners, along with details of:
  - CASA's acceptance or refusal decision
    - reasons for the acceptance or refusal decision
    - action taken, or underway to implement the decision
- b) whether greater oversight by the AIRC is required to ensure appropriate progress is made on recommendations between AIRC meetings.

**CASA agrees with this recommendation.**

Consistent with CASA's discussion of these issues with representatives of your office, CASA notes the Ombudsman's acknowledgement of the marked improvement in recent years in CASA's approach to and management of the recording of decisions in relation to coroners' recommendations, and the tracking of the actions taken by CASA on the basis of those decisions.

At the same time, CASA acknowledges that, in the interests of greater clarity and transparency, there is room for improvement in aspects of these processes, and in the oversight and administration of CASA's actions pursuant to those decisions.

On that basis, CASA will review current arrangements for tracking its decisions in relation to the disposition of coroners' recommendations, with a view to assessing, amongst other things, the matters mentioned in this recommendation.

**RECOMMENDATION 7**

With respect to RAAOs, that CASA identifies and applies a suitable mechanism to ensure RAAOs implement coronial recommendations within their respective regulatory responsibility in a reasonable and timely fashion.

**CASA agrees with this recommendation.**

As mentioned above, and as discussed at some length with your office, it is anticipated that today's RAAOs, with which CASA has no direct regulatory relationship, will transition to the status of Approved Self-Administering Aviation Organisations (ASAOs), under proposed Part 149 of the *Civil Aviation Safety Regulations 1998* (CASR). It is expected that Part 149 will be made in 2015.

As a consequence of this regulatory advancement, in addition to the formal recognition and flexibility qualifying ASAOs will come to enjoy, those organisations will also be assuming a range of duties and obligations *under the regulations*.

Aspects of these obligations exist under the current RAAO regime, even in the absence of explicit regulatory requirements directly governing the safety-related actions of RAAOs. In certain cases, it is clear that an RAAO's response to a coroner's recommendation, and the actions an RAAO might take (or fail to take) in implementing such a recommendation, bear on the safety-assurance considerations CASA looks to in assessing the overall integrity of the basis on which aviation activities take place under the auspices of an RAAO.

The introduction of CASR Part 149 should provide a suitable mechanism of the kind contemplated by this recommendation.

**RECOMMENDATION 8**

If it has not already done so, that CASA commit to reporting publicly, at least annually, on its progress in implementing coronial recommendations.

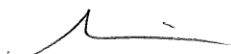
**CASA agrees with this recommendation.**

Consistent with our responses to recommendations 4 and 5, CASA readily commits to making appropriate arrangements whereby it will report publicly, at least annually, on the progress in implementing coronial recommendations that have been direct to, and accepted by, CASA.

In keeping with the constructive nature of CASA's engagement with your office from the outset of this investigation, I trust you will find our responses to your recommendations appropriate and helpful. We have certainly found your office's observations to be instructive, and we look forward to moving forward on that basis.

If you have any questions about CASA's responses, or the undertakings we have given in relation to a number of your recommendations, please do not hesitate to contact me, or my Associate Director of Aviation Safety, Dr Jonathan Aleck

Yours sincerely



Mark Skidmore AM  
Director of Aviation Safety

## APPENDIX 1

Inquest name	Report released	Jurisdiction	Total recommendations	Recommendations to CASA
Beresford	2013	QLD	10	4
Hempel & Lovell	2013	QLD	5	4
Hender, J Hender, S	2013	VIC	9	7
O'Keefe & Hainaut	2012	NSW	2	9 (2 to RAAO)
O'Donoghue Costin	2012	NSW	10	6 (4 to RAAO)
How	2012	VIC	1	1
Reid	2012	NSW	1	1
Catargiu, Cousins, Pinney & Thomas	2011	WA	1	1
Johnson	2010	NSW	2	2
James & Chambers	2010	WA	5	4
Helicopter crash near Gunpowder	2009	QLD	3	2
Scholl	2009	QLD	58	51
Mull	2009	VIC	3	2
<b>TOTAL</b>				<b>94 (6 to RAAOs)</b>