Australian Government

Civil Aviation Safety Authority

LEGAL SERVICES DIVISION

File Ref: GI12/224

30 May 2012

Mr Mark Roberts
Coroner's Registrar
Coroner's Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Mr Roberts

I refer to your letter of 29 February 2012 forwarding a recommendation made by the Victorian Coroner in respect of the inquest into the death of Mr Robert How. The Coroner's recommendation was that a review of the current safety reporting requirements on aeroclubs should be undertaken by the Civil Aviation Safety Authority (CASA) and the Australian Transport Safety Bureau (ATSB), with a view to re-assessing whether the current arrangements allow for the timely and effective reporting and investigation of complaints of air safety breaches.

CASA recognises that mandatory and voluntary reporting schemes provide important sources of information about accidents, incidents and safety concerns that usefully identify hazards and risks to aviation safety, and can effectively serve to reduce the likelihood of their recurrence generally, and in particular instances. Cognisant too of the different purposes for which such information may properly be used by CASA, as the aviation safety regulator, and the ATSB, as the 'no blame' accident and incident investigation agency, both organisations have been working together for some time to develop complementary regulatory regimes designed to enhance and, in so far as practicable, to coordinate effective and timely reporting processes. The application of appropriate reporting obligations on aeroclubs, amongst other bodies, is contemplated by these developments.

Having regard to this particular accident, the Coroner's findings were considered by CASA's Accident Investigation Review Committee and a case study will be developed highlighting the lessons to be learnt for publication in CASA's *Flight Safety Australia.*

I trust this information is of assistance.

Yours sincerely

Joe Rule
Manager
Legal Branch

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