IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 5773/08

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of ROBERT ALAN HOW

Delivered On:	February 28, 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne 3000
Hearing Dates:	February 23 and 24, 2011 at Wonthaggi Magistrates' Court Watt Street, Wonthaggi, Victoria 3995
Findings of:	JUDGE JENNIFER COATE
Representation:	Ms Gretchen Bennett on behalf of Civil Aviation Safety Authority
Police Coronial Support Unit:	Senior Constable Kelly Ramsay

I, JUDGE JENNIFER COATE, State Coroner having investigated the death of ROBERT HOW

AND having held an inquest in relation to this death on February 23 and 24, 2011
at Wonthaggi Magistrates' Court

find that the identity of the deceased was ROBERT ALAN HOW

and the death occurred on 25 December 2008

at Kernot, Victoria 3979

from:
1a. MULTIPLE INJURIES AND EFFECTS OF FIRE[1] IN THE WAKE OF AN AEROPLANE CRASH

in the following circumstances:

Summary

1. Mr Robert Alan How ("Mr How") was the owner pilot of a Cessna aeroplane ("the plane"). He had a landing strip on his property. At about 8.45am on the morning of 25 December 2008 Mr How, flying solo in his plane, was observed to be flying very low over a neighbouring property approximately 3 km from his own. Shortly after the initial observation of low flying, his plane struck power lines about 600 m from the residence on the property he was flying over. The power lines were estimated to be about 25 m or 86 feet above ground. The plane fell to the ground and ignited with Mr How remaining in the pilot's seat and dying as a result of his injuries and the effects of fire.

2. Mr How was 62 years old at the time of his death. He was married to Helga How and they lived on a nearby property at 295 St Hellier Road, The Gurdies.

Background

3. Mr How held a Private Pilot (Aeroplane) Licence that was issued on September 3, 2003 and was endorsed for Visual Flight Rules (VFR) flights. Mr How had a valid Class 2 medical certificate.

4. Mr How had an estimated 600 hours total flight time, but did not have any low flying qualifications or ratings.

5. The Hows had a private airstrip on their property. On the morning of 25 December 2008, Mr How flew from his private air strip to Tyabb airport to refuel. He then flew back towards his home. About 3 kilometres from his property, he flew over a house located on a property at 120 Edden Road in Kernot.

[1] Autopsy report of Dr Sarah Parsons

6. At the house on that property were members of the Gill family gathered together for Christmas. At about 8.45am Mr David Gill stated that he heard the loud sound of a plane flying over the house. He looked out the window and saw the undercarriage of the plane. Mr Gill estimated that the plane was only about 50 feet off the roof of the house.[2]

7. Mr Gill stated that about 5 seconds after he saw the plane, his phone went dead.

8. He stated that his teenage daughter told him the plane they had just seen had landed in their paddock.

9. Mr Gill and his father got on motor bikes and traveled immediately to the site of where the plane had come down on their property in the hope that they could remove the pilot to safety. The evidence is that within seconds of the plane hitting the ground it was on fire. Mr Gill stated that it was obvious upon approaching the plane that the pilot had already received fatal injuries from the fire.

10. Mr Gill stated that Mr How used to do a "flyover" of their property at Christmas time. Mr Gill's teenage daughter also made a statement confirming this and included that she had sometimes seen that same plane flying "over the paddocks and doing somersaults."[3]

11. The evidence from the examination of the site of the crash was that the plane Mr How was flying clipped a power line, which was about 86 feet above the ground and came down in the paddocks under those power lines and then burst into flames.

12. The power lines were not marked. However, they were not required to be marked according to the Australian Standards[4] as they were under 90 metres or 295 feet from the ground.

13. Examination of the wreckage of the plane was performed by Barry Foster, a Licensed Aircraft Maintenance Engineer. He found no mechanical failure that may have caused or contributed to the accident.[5]

14. The Australian Transport Safety Bureau ("ATSB") investigation into the circumstances surrounding this accident produced a report.[6]

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2 Statement of Mr David Gill 25.12.2008
3 Statement of Kelsie Gill 25.12.2008
4 The Report prepared by Australian Transport Safety Bureau May 2009 noted that the Australian Standards for marking powerlines and their supporting structures have been discussed in the number of Australian Transport Safety Bureau of investigation reports.
5 Statement of Barry Foster: 27.12.2008
6 Contained in the Inquest Brief: Aviation Occurrence Investigation AO-2008_082 Published ATSB Safety Report May 2009

15. That investigation found no operational reason such as adverse weather or takeoff or landing for Mr How to be below the required 500 feet at the time of the accident.[7] Further, the report found no evidence of any flight control failure prior to Mr How's plane striking the wire.

16. The ATSB investigation gathered a picture of a considerable history of low flying incidents ascribed to Mr How. That report pointed out the prevalence and dangers of low flying for pilots who have not been trained for such activity.

17. The ATSB report noted that power lines are notoriously difficult to see, especially when unmarked and "reinforces the inherently hazardous nature of low flying." The evidence is that Mr How was familiar with the area and had previously flown low over this same residence. The ATSB investigation also concluded that *"although the pilot probably knew about the power line, it is apparent that he did not see it in enough time to avoid the wire strike. Powerlines are inherently difficult to see, especially when unmarked as they were in this case. Compounding the problem can be factors such as sun glare and windscreen visibility. However, given the position of the sun at the time of the accident and the pilot's southerly track, it was unlikely that sun glare was a factor. Windscreen visibility was unable to be established."* [8]

18. The above factual circumstances were not contentious at inquest.

19. It should be noted that despite some material being included in the course of the investigation about the possibility of Mr How suffering from a mental illness, not only was there no evidence of this, a statement from his treating GP dated October 1, 2009 noted that she had been treating him for 2 years and she had a history from his previous GP and that during all of her assessments, "there was no sign of any cognitive disturbance, thought disorder, altered affect or response to internal stimuli".[9]

Issues identified:

20. At the Directions Hearing held on 31 August 2010, the following issues were identified for further investigation at inquest: (a) The adequacy of the response by CASA to the complaints it had received about Mr How's low flying and (b) whether or not there should be mandatory reporting obligations on flying clubs to report breaches of safety or unsafe conduct by pilots.

21. The Civil Aviation Safety Authority was given leave to appear as an interested party at the directions hearing in this inquest. Mrs How was advised of the directions hearing and inquest. Although she did not attend either, I was advised by the investigating member that Mrs How was kept informed of the proceedings.

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[7] Unless a specific permit for low flying is granted, 500 feet was the minimum legal height for Mr How unless landing or taking off or some adverse weather condition required it. Mr How did not have such a permit. The Civil Aviation Regulations 1988 Regulation 157 states that a pilot in command of an aircraft must not fly the aircraft in any area at a height lower than 500 feet.

[8] ATSB report p.4

[9] Report of Dr Aylen dated 1.10.09

22. To address both issues 1 and 2 above, it is necessary to set out a summary of the evidence of complaints of low flying made against Mr How and when and by whom and to whom they were made and in what circumstances and what response was received.

History of low flying complaints

23. The evidence was somewhat difficult to put together with respect to the history of complaints of low flying. A major reason for this was the lack of adequate records from CASA. Doing the best I can from the statements of the complainants and the records produced including copies of emails produced,[10] the evidence leads me to conclude that there were a number of complaints of low flying made against Mr How over the couple of years preceding his death. Some examples are set out below.

24. **January 2006:** A complaint was made to the Civil Aviation Safety Authority ("CASA") by a neighbour of Mr How who lived on a nearby property about 100 metres from the How's airstrip. Ms Nola Kim made a complaint of "reckless flying" which she asserted was constituted by Mr How flying so low that according to Ms Kim, he was almost level with the windows in her house. This complaint was taken by Peter Phillips of CASA. Ms Kim's evidence was that she believed that Mr Phillips had made contact with Mr How and that this caused Mr How to repeat this conduct after he had been spoken to about Ms Kim's complaint.

25. **September 2006:** A complaint in the form of a telephone call was made by another neighbour of Mr How, a Mrs Tiki Charlton. Mrs Charlton stated that she left a message on a CASA answering machine about Mr How's flying but she did not hear back from CASA.[11]

26. **February 13 2007:** A further complaint was made by Ms Kim about Mr How's reckless flying. This was constituted by Ms Kim's assessment that a plane took off from the airstrip and "turned sharply back" towards her property and was flying only about 40 to 50 metres over her head. She went on to describe the plane "*banking so sharply that the wings were up and down, that is vertical to the ground. It then flew back directly over my house roof and again was only about 50 metres off the house. ....It was extremely noisy, frightening and it was very dangerous*". [12]

27. Ms Kim provided a description and number for the plane. Ms Kim received a visit from Mr Stephen Priest from CASA who advised Ms Kim that he would speak to Mr How about his conduct. The CASA record contains an email dated March 1 2007 from a Mr Rob Collins stating he would forward the complaint to the Southern Australia Regional Manager for action.

28. On March 3 2007, Mr McAllister from CASA emailed Ms Kim and told her that Flying Operations Inspector Stephen Priest had filed a report and CASA are now looking at what options are available to address the "unnecessary low flying over your property".

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10 See exhibits 1, 3, 4, 5 and "records of conversation" supplied by CASA after the close of the evidence, at the time of providing closing submissions dated July 27 2011

11 Statement of Mrs Charlton 24.8.2010

12 Exhibit 3

29. **February 15 2007:** Mrs Charlton rang CASA and spoke to Stephen Priest and complained about Mr How's low flying and an occasion when he was constantly landing and taking off from his landing strip on his property. Mr Priest called back at some undefined time (not recorded in his CASA notes) and asked if Mr How was still landing and taking off as he had been doing and Mrs Tiki Charlton answered that is was not occurring regularly at that time but as at September 2006 it was occurring regularly.

30. **December 8 2007:** Leigh Charlton, husband of Mrs Charlton, made a complaint to CASA about low flying by Mr How. Mr Charlton had put this complaint into a statutory declaration as requested by CASA. He gave a time and a description of the plane he stated was low flying and the visible letters and noted that the plane could not be taking off or landing as it was at right angles to the landing strip. Mr Charlton's evidence was that by this time, Mrs Charlton had made a number of phone calls and stated she "felt a bit frustrated with CASA" as she felt she was not being believed and didn't think anything had been done about her complaint.[13]

31. **January 8 2008:** Mr Charlton gave evidence that he sent an email to Stewart McAllister on January 8 2008. He set out two complaints of low flying with a description of how such flying could not be consistent with any requirements of "take off or landing" as the flying was perpendicular to the landing strip. Mr Charlton gave evidence at the inquest that he got the impression that CASA believed what was going on was "a tiff between neighbours."[14] Mr Charlton gave evidence that his wife had told him she no longer liked living at their home as she believed it was only a matter of time before something would happen and she feared that Mr How would crash into their house.

32. **January 10 2008:** Ms Kim sends another complaint to CASA in an email to Stewart McAllister detailing four further incidents of unnecessary and dangerous low flying and indicating that she only wants Mr How to "take off properly" and then there would be no bother. On January 10 2008 Mr McAllister sends back an email telling Mrs Kim that CASA are very short of Flying Operations Inspectors and asked her to provide a statutory declaration containing her complaints so that "with your help we will try to take some positive action against Mr How". Mr McAllister also asked Ms Kim to get a statutory declaration from her visitor as well.

33. **March 3 2008:** A further complaint by Ms Kim to Mr McAllister complaining of several instances in some detail of Mr How's low flying behaviour. Ms Kim was asked to provide photos. Ms Kim did provide the photos as requested.[15] Ominously Ms Kim wrote on March 3 2008 "I hope I don't have to wait until there is a newspaper report of a tragedy in the Gurdies or elsewhere because he has misjudged one of his flying tricks and crashed into a house, or caused a bush fire."

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13 Ibid

14 Transcript p 23

15 Mr Richards gave evidence about how notoriously unhelpful photos are to make assessments about low flying. However, this is what CASA asked Ms Kim to do and she did. When questioned about what would have been helpful, Mr Richards explained that CASA once got a video from a complainant who was a qualified wing commander and that was effective. However, there was no evidence that CASA gave anybody any assistance or guidance in how to compile information that would assist CASA to take action.

34. **Tooradin Airport:** Mr Gary Morrison was and still is the owner of the Tooradin Airport. He gave evidence at the inquest that the Tooradin Airport is a private facility owned and operated by him since about 2001. He gave evidence that when he, Mr Morrison, first took over the airport about 10 years ago, Mr How had been a user of his airstrip in that he used to land and park his plane there from time to time and use it as a landing and re-fuelling facility. Mr Morrison gave evidence that after a couple of years of near misses and various incidents with Mr How, he finally banned Mr How from bringing his plane into the Tooradin Airport. Mr Morrison estimated that the "banning" was probably about a couple of years before Mr How's death. The effect of Mr Morrsion's evidence was that he had banned Mr How for his lack of judgment and safety and airmanship. He stated he had spoken to him several times about this behaviour but that Mr How had not maintained compliance with his requests to adjust his behaviour. Mr Morrison gave some examples of the sorts of complaints he was getting about Mr How and they were consistent with what the neighbours had also been complaining about. He stated he was getting these complaints from other pilots.[16] However, the incident that was the catalyst for Mr Morrison's action was an incident where Mr How overshot the runway and "ditched" his plane resulting in the propeller being stuck in the mud and then Mr How refused to have his plane properly checked before taking off again.

35. Mr Morrison was questioned about whether or not he had reported his concerns to CASA. He gave evidence that he had not but that "maybe he should have". Mr Morrison's evidence was that he thought that banning him from the airport was punishment enough and was going to "teach him a lesson".[17] Mr Morrison stated in evidence that Mr How might lose his licence if he reported him to CASA and Mr Morrison obviously felt uncomfortable about being responsible for that and felt that his actions would teach him the lesson he needed and the banning would be the punishment.

36. **Peninsula Aero Club:** This club operates out of the Tyabb Airport. It would appear that Mr How went to Tyabb Airport after being banned from Tooradin Airport. Mr Alexander Robinson, the Chief Flying Instructor at Peninsula Aero Club made a statement and attended the inquest to give evidence. Mr Robinson is a pilot of some 40 years' experience and has held his position at the Peninsula Club for the past 10 years. Mr Robinson had been an instructor for 30 years. He is a proof test officer with CASA.

37. Mr Robinson gave some evidence about how one becomes a member at the Peninsula Aero Club. His evidence was that a prospective member is nominated by a current member. The nomination goes to a committee which asks the question about whether there is any knowledge that would make the person an unsuitable member. Mr Robinson's answer indicated that to the best of his knowledge no-one had been rejected from membership on this basis in his 10 years with the club.

38. In his statement, Mr Robinson[18] stated that the club kept a complaints book about a range of issues. He stated that Mr How had accumulated some incidents recorded in the complaints register which were generally about low flying. He also stated that whilst Mr How was a very good flyer he

16 Transcript p.115
17 Transcript p.113
18 Exhibit 6

would "push boundaries", especially when it came to landing. He stated that Mr How would "brag about how he could land in a short distance .... People were just not willing to go with him".[19]

39. At the time at which Mr Robinson attended to give evidence at the inquest, the file belonging to Peninsula Aero Club could not be located but Mr Robinson described it with respect to complaints about Mr How as "quite large". Mr Robinson stated that they had warned Mr How a couple of times and put him on notice that if he did not change his behaviour he would be banned. Mr Robinson stated that he was aware that Mr How had been banned from Tooradin but that he knew this through the "internal pilot network", not through any formal record or procedure or document.

40. Mr Robinson gave evidence about an incident he personally witnessed wherein Mr How misjudged his landing and instead of landing down the middle of the runway he clipped a white tyre marking the edge of the runway. Mr Robinson stated that instead of stopping when that happened, Mr How took off again which in Mr Robinson's view, should not have happened as such an incident required his plane to be checked by an engineer before flying again.

41. As to the reporting of that incident to CASA, Mr Robinson said that "Technically I guess we should have possibly put in a report to CASA, but we didn't." When asked whether or not there was a mandatory reporting requirement, Mr Robinson's evidence was that if the aircraft was damaged that would require a mandatory report.[20]

42. On the second day of the inquest, after Mr Robinson had been excused, the records that had been obtained from Peninsula Aero Club for the investigation were produced. Those records contained reports about Mr How from May 23 2005 (safety issue), November 27 2006 and January 9 2007 (low flying over houses) resulting in Mr How receiving advice from Peninsula that he was required to have a "check flight" with the Chief Flying Pilot to demonstrate that he had a reasonable knowledge of the visual flight rules and the club's "Fly Neighbourly" policy. There is a note on the file from Mr Robinson that on January 25 2007 Mr How participated in the required tasks and demonstrated his understanding of what was required of him. By November 30 2007, the file reveals a further complaint about Mr How again taking his approach to the airstrip too short. It is noted that this was observed by several club members.

43. Mr Robinson also gave evidence that he was not aware of any obligation on a flying club that banned a member to make that ban known to any other club. Further, he gave evidence that there was no obligation on the club to make enquiries of a prospective member's safety history.[21] When asked what his opinion was about the lack of requirement to notify any other club of the banning for safety breaches, Mr Robinson stated that he thought people deserved a second chance and that it was quite possible "that a person maybe has made a mess in a certain spot, that they are really reluctant to not give a second chance" at the club.[22]

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19 Exhibit 6 p.2
20 Transcript p.34
21 Transcript p.40
22 Transcript p.41

44. When pressed a bit further, Mr Robinson thought clubs would be too busy to make such enquiries. Further, he did not see why one airfield would notify another one and finally, a receiving club could make its own enquiries.

45. Mr Robinson gave evidence that if a person is not flying well that would normally show up in their "flight reviews".

46. Mr Robinson stated that an accident is an immediately notifiable matter, or if someone is dead or the plane is significantly damaged. For a minor incident such as a bird strike with some minor damage with no one hurt, CASA should be advised, but if it is something minor and there is absolutely no damage, then CASA does not need to be notified.[23]

47. When asked about whether persistent low flying was something that should be reported, Mr Robinson agreed that should be reported. Mr Robinson gave evidence that to the best of his recollection his club did make reports to CASA of Mr How's low flying but that he personally did not.[24] His reasoning for not making the reports was as follows: *"had had no way to substantiate that and therefore I could not report it, other than it is hearsay but there was an awful lot of hearsay."*[25] Mr Robinson confirmed that he believed that his obligation was that if he had a "substantiated" report of low flying, that is he personally had the evidence, then he should report it. **(See : Comments)**

The Investigation by CASA

48. Ms Narelle Tredrea and Mr Owen Richards both produced statements for the investigation and gave evidence for CASA. Mr Richards, at the time of making his statement[26] was the Regional Manager CASA Operations for the Southern Region and Ms Tredrea, at the time of making her statement[27] was the Senior Adviser Enforcement Policy and Practice in the Legal Services Division for CASA. Without descending into the detail of their evidence, in summary their evidence amounted to concessions that CASA was very overstretched during 2006 through to 2008 but that what was done was reasonable within the limitations that were in place at that time.

49. Through these witnesses and their closing written submissions, CASA sought to defend its apparent lack of response to the series of complaints of low flying against Mr How by relying upon the accepted difficulties of proving allegations of low flying and the fact that none of the complainants had given sufficient evidence to proceed with any action against Mr How.

50. There was no evidence available of CASA's ability at that time to give complainant's assistance in how to provide cogent forms of evidence to assist in the investigation of these complaints. The effect of the evidence was that the onus appeared to be placed on the complainant to establish their complaint rather than an investigator having the responsibility to use his or her skills to investigate the complaint.

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23 Transcript p.43
24 Transcript p.43
25 Transcript p.44
26 Exhibit 8
27 Exhibit 9

51. According to the evidence of Mr Richards, at the time of Mr How's death CASA were "waiting" for complainants to provide statutory declarations. He stated that allegations of low flying are hard to prove and their resources were very stretched at the time.

52. Notwithstanding this evidence, the material before the inquest contains an internal CASA email from a Mr John Botham (Regional Manager Southern Region of the General Aviation Operations Group sent on January 6, 2009 to a Mr Greg Hood Group General Manager linking the "very overstretched resources" at the time of the last complaint and noting that action seems to have suffered as a result. The final sentence of his email is *"Looking back, it seems that we may have been able to prevent this. However, there were probably higher priorities at the time."*

53. When Mr Richards was asked about this email, his response was that John Botham was only acting in the position at the time he sent that email. Notwithstanding the relevance of the "acting" nature of his position, Greg Hood agrees with John Botham.

54. The evidence from both Ms Tredrea and Mr Richards was that CASA's resources have increased since that time and that a system of centralized reporting of complaints has now been initiated and consequently CASA now not only keep much better records but are able to give much better guidance and support to staff as to how to follow through with complaints.

Conclusion

55. Mr How, whilst an apparently capable and experienced pilot of light aircraft, had a poor attitude to some aspects of air safety. This poor attitude was well known by the two clubs he had belonged to and resulted in him being banned from one and disciplined by the other. He was also the subject of a series of complaints about his low flying conduct by adjoining neighbours of his rural property. It was his attitude to low flying which caused him to hit power lines at 27 metres or approximately 86 feet above the ground[28] and directly resulted in his death. Given that the height is fixed at 500 feet, Mr How was flying at about 5 times under the regulated limit at the time he struck the powerlines.

56. Despite the issue being raised by one of the complainants, there was no evidence that Mr How had any medical or psychiatric conditions that affected his ability to fly safely and there was no evidence that any medical or psychiatric condition contributed to the fatal collision which took his life.

57. CASA had intermittently received complaints of some of his low flying conduct by neighbours over a three-year period. Its investigation lacked a consistent and clear process for responding to complaints such as these. Whilst it is not possible to conclude that a competent investigation would have resulted in Mr How having his licence revoked and thus this fatality and all of its consequences averted, it is possible to conclude that a competent investigation would have significantly increased the chances of that happening.

[28] Report of the ATSB

58. The threat of his licence being interfered with may have achieved an appropriate change of attitude in Mr How.

59. Such a change of attitude may have saved his life and avoided all of the other consequences of this sad fatality.

COMMENTS:
Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

The difficulty of investigations of this nature

1. In both evidence and closing submissions, CASA submitted that low-flying complaints are difficult to investigate for the following reasons:

(a) it is difficult to estimate the height at which aircraft are flying;
(b) the difficulty is compounded in circumstances where an aircraft is alleged to be low flying near where it is taking off or landing;
(c) it is often difficult to identify both the aircraft and the pilot involved in a particular incident alleged;
(d) perceptions from witnesses may be clouded by lateral issues such as the noise the aircraft is making as it is taking off or landing;
(e) investigations are resource intensive and must be prioritised against other demands.

2. In CASA's closing submissions it was submitted that there was evidence in this investigation that touched upon each of the above recognized difficulties.

3. It is accepted that each of these issues would compound the investigation into allegations of low-flying, but it does not make acceptable an unresponsive investigation. CASA submitted that whilst it accepted that it could have followed up on the process of obtaining statutory declarations in a more timely manner, it also submitted that on the information available at the time, further investigation beyond the complaints was not warranted.[29] This is a circular argument however. An inadequate investigation will lead to the conclusion that an intervention is not warranted because there is not enough evidence to warrant it.

4. One can readily see how CASA may become cynical about neighbour's complaints of low flying, but the picture which emerges here is that there was a considerable amount of material capable of being found during a competent investigation without expending that much effort. For example, an enquiry of the Aeroclubs where he was or had been a member would have readily revealed a similar set of complaints about Mr How including from very experienced people such as the Chief Flight Instructor Mr Robinson.

[29] Final written submissions of CASA, Page 5

Changes since 2008

5. In closing written submissions, CASA stated that "as at December 2008, CASA had not yet implemented a centralised coordinated enforcement policy".[30] Individual regional offices had to prioritise matters referred for formal investigation by CASA investigators, or arrange for them to be investigated by inspectors at the regional office according to safety risk.[31] It was submitted by CASA that in these circumstances, given the need to prioritise resources, these complaints were difficult to investigate and considered at the low level of safety risk.

6. CASA submitted that since this change, it has made significant changes to policy and procedures surrounding investigations of complaints such as this case. It is submitted that its newly developed coordinated enforcement model and policy together with an increase in appropriate operational staff has brought significant improvement and would now result in a very different response. The new model includes a weekly case management meeting resulting in constant auditing and monitoring of complaints together with the provision of advice and guidance unlike what happened with these complaints.

7. CASA also advised in its written submissions that it has restructured its legal branch as at 2010 as a result of difficulties in the requirements in enforcement related matters. CASA submitted that this means that a matter such as this would now be referred to the coordinated enforcement meeting where it will be recorded in the enforcement action register where it could be tracked. It also meant that CASA staff would be given guidance and support from the legal branch and the relevant associated other specialist parts of CASA such as Flight standards or Aviation Medicine.

8. Whilst it is accepted that enforcement will be based on risk assessment in consideration of scarce and competing resources, the difference in the new system is that a coordinated case managed approach with guidance and review of an actual process for assessing the risk and recording of decision and communicating those decisions to the complainants is a very considerable improvement on the system that existed at the time.

9. It is reasonable for the general public to expect of the Civil Aviation Safety Authority (CASA) that a complaint about possible safety hazards will be investigated and a decision made and communicated as to what the authority proposes to do. If it does not propose to investigate the complaint any further or after some investigation proposes no further action, it should communicate that clearly to the complainants. This did not happen in this case.

10. However, I am satisfied that it is at least the aim of the new policy and procedure based on the evidence and the submissions.

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[30] That is, a centralised system of handling its enforcement, which it has now done. The evidence is that the centralised system is aimed at achieving better informed and consistent responses to complaints and investigations generally across the regions.

[31] Final written submissions of CASA; p.4

Mandatory reporting to CASA

11. CASA were invited to make submissions on the issue of an expanded system of mandatory reporting but ultimately, CASA did not appear to take a position on whether or not mandatory reporting of potential regulatory breaches to CASA as the regulator should be considered.

12. As noted above, the issue of whether or not flying clubs should have a mandatory requirement to report dangerous conduct on the part of the licensed pilot surfaced in this investigation. In the course of making submissions on this topic, CASA provided information about the ability to make a voluntary report to the Australian Transport Safety Bureau (ATSB) under the "REPCON" program. The ATSB operates a variety of mandatory and voluntary aviation safety reporting schemes.

14. The Transport Safety Investigation Regulations 2003 prescribe that during air transport operations,[32] an incident involving the operation of an aircraft below the minimum altitude is considered a routine reportable matter, and is required to be notified to the ATSB by a responsible person within seventy-two hours. Examples of a responsible person include the owner or operator of the aircraft, a person performing an air control service, and the operator of an aerodrome. Mandatory reporting requirements for aircraft operations other than air transport operations include injuries, incapacitation, and an occurrence in which a collision with terrain is narrowly avoided.

15. Given the evidence in this case, there is clearly scope to consider the adequacy of reporting of potential regulatory breaches to CASA. Whilst the establishment of a voluntary or mandatory reporting scheme may be complex and involve some duplication with existing ATSB systems, it is critical that the aviation regulator has a clear and unequivocal notification system with which to apply their enforcement model.

16. CASA and the ATSB should engage in a cooperative process to examine the current aviation safety reporting requirements, and to consider how the regulatory arrangements may be better served through a broadening of both mandatory and voluntary notifications using an analysis of the facts in this case.

17. Effective mandatory and voluntary reporting schemes are complex and costly, but so are fatality investigations and the cost to the community of loss of life. For this reason, I consider it appropriate to make the following recommendation for the consideration of the Civil Aviation Safety Authority and the Australian Transport Safety Bureau:

[32] Air transport operation means a regular public transport operation or a charter operation.

RECOMMENDATIONS:

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. That the Director of Aviation Safety of the Civil Aviation Safety Authority and the Chief Commissioner of the Australian Transport Safety Bureau conduct a review of the current safety reporting requirements on Aeroclubs to re-assess whether the current reporting scheme allows for the timely and effective reporting and investigation of complaints of air safety breaches.

I direct that a copy of this finding be distributed to the following parties for their action:

The Chief Commissioner of the Australian Transport Safety Bureau
The Director of Aviation Safety of the Civil Aviation Safety Authority

I also direct that a copy of this finding be distributed to the following parties for their information only:

Mrs Helga How
Leading Senior Constable Baido, investigating member
Ms Gretchen Bennett, Principal Lawyer Legal Branch CASA
Senior Constable Kelly Ramsay, Assisting the Coroner
The Manager, Tyabb Airport
The Manager, Tooradin Airport
Ms Nola Kim
Mr and Mrs Charlton

Signature:

JUDGE JENNIFER COATE
STATE CORONER

Date: February 28, 2012