SUBMISSION TO	**:**	**MINISTRY OF TRANSPORT**
CONCERNING	**:**	**EXPOSURE DRAFT CIVIL AVIATION BILL**
ON BEHALF OF	**:**	The families of four persons killed in the Carterton Balloon Tragedy on 7 January 2012
NAMELY	**:**	(a) **Allan & Vivienne Still**, who lost their daughter, Alexis
	:	(b) **Jan & Annie Jordaan**, who lost their son, Chrisjan
	:	(c) **Sarah Scarlett**, who lost her father Howard Cox and his wife Diana.
		[collectively *"the families"*]
Contact Details	:	[redacted]
Dated	:	24 June 2019

Introduction

1. On the 7th January 2012, 10 paying passengers died as a result of a hot air balloon becoming caught under power lines in flight. Two passengers jumped out of the balloon basket but died as a result of their injuries suffered in the fall. The remaining 8 died due to the effects of a fire and the impact of the basket with the ground. The balloon was piloted by Lance Hopping. At the time this was NZ's third worst air accident – after a 1963 Kaimai ranges crash, and the Mt Erebus crash in 1979. The pilot did not hold a current medical certificate. He should not have been flying or piloting an aircraft that day. He flew below the 500ft flight level. He flew below the level of high voltage power lines. He tried to then fly over the power lines in a wind gust rather than descending. Once the basket was snagged, instead of pulling the rip cord, the pilot tried to push the basket away, with the burners on full, which eventually caused a power line to break. These actions were not reasonable, and, as the Coroner concluded, may have been attributable to the carry over effect of the pilot smoking cannabis. The Coroner described the pilot's actions as *"a gross error"*.[1] Prior to 7 January 2012, aviation related concerns (ARCs) concerning this pilot, Lance Hopping, had been raised with the CAA. The CAA acknowledged deficiencies in their processes for investigating those ARCs.

2. As the CAA evidence to the Coroner, and the Coroner's Report itself, made clear, the legislative provisions relating to pilot medical certification, Drug and Alcohol testing, and incident and accident investigations, and the fit and proper testing requirements were inadequate to prevent the tragedy. Indeed the Coroner found that this pilot had been non-compliant, and should not have been piloting balloons, since November 2010.[2]

3. The Carterton Balloon tragedy is a classic orthodox example of the Swiss cheese model of accident causation in action. The balloon itself (the aircraft) was safe. The pilot was not. The legislation/regulations were inadequate. The regulatory oversight was deficient.

4. As the Commentary Document records (at least twice, paragraphs 41 and 67) many legislative changes in this Exposure Bill are a direct result of the Coroner's recommendations and the TAIC Report following the Carterton Balloon tragedy.

5. **This background; and the TAIC Reports[3]; and the Coroner's Findings Report[4] - are all fundamental factual background to the families' support for the Bill in its current iteration.**

Summary of Families' position

6. The families support the protection of safety information – the just culture approach – except where there is a public safety interest which requires enforcement action.

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[1] The contents of this entire paragraph are based on the Report dated 16 April 2015 of Coroner Ryan following his Inquiry into the 11 deaths which was held during May and July 2014.
[2] Findings paragraph [141].
[3] There are two TAIC Reports : (i) An interim report 12-001, released April 2012; and (ii) a Final Report released 31 October 2013.
[4] The Reserved Findings Report of Coroner Ryan is dated 16 April 2015 and totals 57 pages.

7. The families support the inclusion in the legislation of the detailed prescriptions and requirements on commercial aviation operators to have an effective Drug and Alcohol Management Plan – a DAMP. This will become more important, in the future, if cannabis is ever legalised as alcohol presently is. The families support the random testing requirements. They support the audit requirements.

8. The families support the independent[5] Director drug and alcohol testing regime included in the Bill which also enables and supports random testing by the Director. In this respect, for Commercial Balloon operations in the adventure aviation sector in NZ as at June 2019, it appears from information on the CAA website there are only 11 pilots holding Class 1 CPLs, for balloons, and only 4 commercial licensed Balloon Operators, 3 in the South Island and 1 in Hamilton.

9. The families support the inclusion and strengthening of the *"fit and proper"* threshold for commercial pilots. The exemption from Privacy Act constraints is a clear and obvious concomitant of this important health and safety strengthened regime.

10. The families support the new medical certification regime in Part 4 Subpart 5 and Schedule 2. They are particularly pleased to see a requirement on the CAA to maintain a register of current medical certificates.[6]

11. The families support the inclusion of detailed duties to notify accidents and incidents in Part 5 of the Exposure Draft.

12. The families support the detailed powers of investigation in Part 10.

13. The families are concerned about the length of the transitional period in respect of the coming into effect of the DAMP provisions – 2 years. Given the current obligations in existence under CAR Part 115, this seems excessive. The families would prefer a much shorter period – a maximum of 12 months.

14. The families have not seen any proposal in the Exposure Bill to amend the Transport Accident Investigation Commission Act 1990. Following the Carterton Balloon tragedy TAIC noted that it did not have any power to conduct drug or alcohol testing on surviving pilots or crew after an aviation accident or incident. The families advocate for this power to be given to TAIC. It may be thought that with the introduction of Director testing it is not necessary for TAIC to also have a post incident/accident testing power. The families do not agree for the following reasons:

    14.1 TAIC sought the power in its *"watchlist"* published after the Carterton Balloon tragedy.

    14.2 The recent PWC audit of the CAA, and the TAIC Final Report into a helicopter crash on Fox Glacier on 21 November 2015, both disclose ongoing and recurrent deficiencies within the CAA in carrying out its existing regulatory oversight responsibilities in the adventure aviation sector.

[5] That is, independent of the operators.
[6] Clause 23, Schedule 2.

14.3 As recently as this month, there was a balloon incident in Moutere involving powerlines where the pilot and passengers survived – who tested the pilot after that?

14.4 Where there is an aviation incident or accident, where the pilot survives, the TAIC team are likely to be the first or very nearly the first in control of the scene with access to the pilot, so it makes sense they have the (independent) power to carry out drug/alcohol testing as soon after the event as possible.

15. Accordingly, the families urge officials responsible for taking the Exposure Bill to the next level – a Bill introduced into Parliament – to add this power to TAIC's legislation as part of this Bill – it would logically appear after clause 380 of the Bill in subpart 7 of Part II.

Conclusion

16. Overall, in summary, the families are relieved to see the final recommendations of Coroner Ryan appearing in the Exposure Bill as part of proposed legislative reform. The families participated in the coronial process, and in subsequent processes involving the Coroners Amendment Bill, and the *Clear Heads* consultation because they want to see legislative and regulatory and cultural changes in the commercial ballooning aviation sector in NZ, to ensure, as much as is humanly possible by such means, that there is never again a repetition of the events of 7 January 2012, where such a Swiss chess confluence of non-compliance could re-cur.