Ministry of Transport
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29 July 2019

Dear Sir/Madam

Submission on the exposure draft of the Civil Aviation Bill

Thank you for the opportunity to comment on the draft Bill. The General Aviation Advocacy Network has examined the submissions of IQ Aviation and Air Law NZ. We are in complete agreement with the views expressed in both those submissions.

In addition, we offer the following observations:

The draft Bill does not adequately address:

Just Culture and Safety Reporting

The policy's intent to encourage aviation participants to provide timely safety reports is admirable.

A successful aviation safety reporting system (ASRS) requires "buy-in" on the part of Regulator and participant. If managers tasked with handling safety reports neglect to engage in a positive way with participants, the result will be emotional withdrawal (rejection) or anger at being ignored.

Strong feedback loops strengthen relationships and a true test of an incident reporting system is the trust of participants in the aviation system. Positive feedback loops are a fundamental concept in psychology, and the science behind this is simple:

- Give people feedback about their actions in a timely manner without fear of reprisal. This creates a healthy opportunity to work toward better flight safety outcomes.

Effective communication is a vital component in making changes.

The CAA's incident reporting system does not work. This serious failure must be addressed in changes to the Civil Aviation Act.

In the meantime, and as a matter of urgency, it should be made a condition of employment that the Regulator's responsible personnel provide feedback to those who file reports and – without exception – acknowledge those reports promptly.

There must also be collective feedback to the wider aviation community. It has been reported to us that reports are triaged and that only 10% of CA005 incident and safety reports are examined. If this is correct, it indicates a poorly functioning internal SMS system, which must attract the interest of the Ministry and the Authority's auditors.

The General Aviation Advocacy Network conducted an online, four-part CAA Client Satisfaction Survey between mid-December 2017 and mid-February 2018. The survey resulted from the frustration caused by the CAA's reluctance to carry out its own client survey in a similar manner to that of the Australian Regulator, CASA.

One question related to the respondents' experiences in filing safety reports. It asked:

On a scale of 0 to 10 where 0 is "very dissatisfied" and 10 is "very satisfied", how satisfied were you with the response to your safety report?

The response from participants returned a score of just 3 out of 10.

Sample feedback from survey participants below:

Have had to insist to CAA that my response was to be received in writing & not just a verbal.

In the past, I have made such reports, and even phoned directly. In one of those we ended up in an "I told you so " situation with a double fatality after CAA ignored our concerns. The other which included video evidence of very questionable practise, was dismissed out of hand. Luckily that operation ceased without any accident, despite their best efforts to have one.

No response to 3 reports. CAA's own SMS material suggests that it's vital fro an effective reporting system to provide feedback to those who input into it, yet they fail to follow what they expect operators to do.

In the survey, there was a demonstrable unwillingness for clients to make voluntary safety reports due to the perception of an overly heavy-handed response from the Regulator. The survey of the CAA produced a score of 8.86 out of 10 in favour of a voluntary confidential incident reporting system, non-punitive and to be administered by an agency such as TAIC.

The case for a confidential aviation reporting system

In May 2006, the Coroner reported on the June 2003 Air Adventures aircraft crash at Christchurch International Airport. At the Minister of Transport's request, the staff of the Auditor General looked at how the Civil Aviation Authority and the Ministry of Transport considered, responded to and reported on each of the Coroner's recommendations.

Coroner's recommendation

That consideration be given to the feasibility and desirability of establishing an independent confidential air safety incident reporting system in New Zealand taking account of previous difficulties with the system known as Icarus, and/or an Office of Aviation Ombudsman.

New Zealand is conspicuously absent from membership of the International Confidential Aviation Safety Systems Group (ICASS).

It would appear that New Zealand does not have a confidential aviation safety reporting system sufficient to invoke an invitation for membership of (ICASS) and if this is the case, New Zealand is falling short in the development of aviation safety systems that have been in place in other developed countries for many years.

If our analysis is correct, we consider that it is of the utmost importance that this subject be re-examined, particularly with regard to the new HSW legislation and the introduction of Safety Management Systems by the CAA.

The ASRS model

The ASRS has been emulated by aviation systems worldwide, and is now being modelled in industries outside aviation. It is simple and straightforward:

- When organisations and industries want to learn more about safety incidents and why people did what they did, the best approach is to ask the participants.
- People are usually willing to share their knowledge if they are assured their identities will remain confidential and, ultimately, they remain anonymous and the information they provide is protected from disciplinary and legal consequences.
- A properly structured confidential, voluntary and non-punitive incident reporting system can be used by any person to share information.
- The system offers a way to ask, and often answer, the question of "why?" There is no substitute for knowing why a system failed or why a human erred.
- A voluntary incident reporting system cannot succeed without the confidence, cooperation, oversight and guidance of the community that will use it. It must be viewed as a safety information resource which is accessible and responsive to all.
- A voluntary reporting system will usually exclude from its protections some types of incidents, such as criminal acts and intentional unsafe acts. In certain systems, such as the ASRS, this exclusion extends to legally defined accidents.
- The safety data gathered from incident reporting can be used to identify system vulnerabilities and gain a better understanding of the root causes of human error. Incident reporting data is complementary to the data generated by mandatory, statistical and monitoring systems.
- The ultimate achievement of an incident reporting system is that it can prevent accidents and fatalities.

It is obvious that in the absence of an independent third party to administer such a programme (the cornerstone of any Ministry and CAA effort to promote a voluntary safety reporting system), everything depends on the operation of a Chinese wall within the CAA and the integrity of the regulator's employees who receive confidential information. This is not acceptable.

Even worse, in examining the Coroner's report on the 2003 Air Adventures aircraft accident, "*The Ministry considered that the changes made by the CAA enabled more effective and transparent relationships between its investigation and safety information functions and that the CAA was in a better position to effectively manage its business in the way the Coroner intended*".

So instead of incorporating an in-house confidential safety reporting system such as a "Chinese wall", the CAA opted for a "transparent relationship" between its investigations and safety information functions, thus allowing the unrestricted flow of confidential information from one department to another. We know that this arrangement is faulty and that it has compromised the personal privacy of reporters, sometimes to the point of endangering their personal safety.

One such organisation in New Zealand that could be tasked with the receipt of safety related concerns is the Transport Accident Investigation Commission. However, to use the TAIC in a similar role to that of NASA in the American FAA system would involve a major policy change with changes to the CA Act and the Transport Accident Investigation Act.

The review of the Civil Aviation Act provides an opportunity to introduce an ASRS system modelled on the well-respected and successful FAA/NASA system <u>which has been operating since 1976</u>.

The draft Bill also does not adequately address:

Accountability of the Regulator to its stakeholders

The New Zealand Civil Aviation Authority and Australia's Civil Aviation Safety Authority (CASA) perform virtually parallel roles. Until recently, their approach to customer relationships was also similar – as was the blind eye they both took to seriously negative consequences of those relationships.

However, in Australia, the 2014 Aviation Safety Regulation Review identified the need to improve service delivery and CASA's relationship with industry stakeholders. The Federal Government accepted most of the review's recommendations, including that CASA

- identify and understand the industry's priorities, concerns and perceptions,
- undertake regular stakeholder surveys to monitor these factors and
- move from an adversarial relationship to a collaborative relationship.

As a starting point, Colmar Brunton carried out survey research between August 2015 and January 2016. It was the first of what are now biennial CASA customer satisfaction surveys.

The results are detailed in *Stakeholder Relationship Health*, published in March 2016. CASA then produced an extensive *Action Plan* to analyse and address the problems that had either been revealed or confirmed.

It pledged: *CASA will continue to work to improve its relationship with industry through the activities outlined in this action plan and its ongoing work as the regulator and service provider. Its progress over time will be measured every two years through the same survey and a comparison of findings with previous surveys. CASA is committed to improving its relationship with industry while maintaining the highest standard of aviation safety.*

A notable difference between the two regulators is CASA's acceptance that it must confront manifest difficulties with its customers and tackle inconvenient truths head-on and transparently, and the NZ CAA's consistent refusal, year after year, to even consider such an open, regular and wide-ranging collaboration with its clients.

This constitutes another concern:

More than 16 years have passed since stakeholders were officially invited to express their level of satisfaction with the performance of the Authority. The new CA Act must mandate clearly defined biennial Client Satisfaction Surveys conducted by a credibly independent third party.

Finally, another issue with the draft Bill is the lack of incorporating into the Purpose of the CAA additional wording, along with Safety, on "reasonable cost" and "economic benefit".

Reasonable cost and economic benefit are directly related to Safety Management Systems, where the concept (at least internationally) is that the operator or licence holder takes responsibility for its operation and manages risks appropriately. This is at the core of SMS and Performance Based Regulation, which the CAA has signed up to, and was started by the UK CAA. Performance Based Regulation assesses not just safety, but costs of regulation and other alternative options that provide a similar outcome, with lower cost, i.e. better economic benefit.

Not including reasonable cost and economic benefit in The Purpose of the CAA actually undermines current and future CAA policy on SMS and Performance Based Regulation.

Yours faithfully

Des Lines and Brian Mackie
Co-principals