Committee Question Number: 386
Departmental Question Number: SQ19-000397

Program: n/a
Division/Agency: Australian Transport Safety Bureau
Topic: pending investigations AO-2016-084 and AO-2017-066
Proof Hansard Page: Written (8 November 2019)

Senator Glenn Sterle asked:

- What is the status of the following investigations?
  - AO-2016-084
  - AO-2017-066
- If these investigations are still classified as “pending”, when do you expect them to be finalised?
- Is there a time period within which ATSB would normally expect investigations to be complete?
- In the case of AO-2017-066 why was the aircraft diverted to Perth rather than landing at its nearest alternative, Learmonth? Is this considered best practice?
- In relation to investigation AO-2016-084:
  - What recommendations were included in this report?
  - Have all recommendations been adopted by the airline?
  - Does ATSB hold any concerns about the safety of this airline to operate in Australia?

Answer:

Investigation AO-2016-084 was discontinued on 7 November 2019, with reasons for the discontinuation published on the ATSB website (see http://www.atsb.gov.au/publications/investigation_reports/2016/aair/ao-2016-084/).

In summarising the discontinuation statement: following the occurrence safety action relating to the provision of air traffic services (ATS) was taken by Airservices Australia. Following a review of that action the ATSB considered ‘…it was unlikely that further investigation would identify any systemic safety issues. Consequently, the ATSB has discontinued this investigation.’

No safety factors or issues relating to the actions of the crews from either operating airline were identified. Consequently no safety recommendations were made. The only improvement arising from the occurrence related to the provision of ATS.

The ATSB has completed and published a number of investigations involving this carrier, and like all operators, continues to monitor the incident reporting data associated with this carrier’s safety record. CASA as the Australian aviation safety regulator, has issued this carrier with a Foreign Aircraft Air Operators certificate.

Investigation AO-2017-066 has completed the evidence gathering and analysis stages, and a draft final report is nearing completion. A significant component of the investigation involved the engine manufacturer’s response to the initiator of the engine failure, the failure of a fan blade. This response has developed over the duration of the investigation as a result of the identification of other international events, both before and after this event, that have the same failure signature. The ATSB has been, and is currently, in discussion with the engine manufacturer concerning the causation of these failures and changes to manufacturing and inspection regimes to prevent further failures. The completion of the draft report is dependent on some final information from the manufacturer.
AO-2017-066 included a diversion to Perth following the engine failure. In regard to the choice of a diversion to Perth rather than Learmonth, the operator’s policies and procedures required specific emergency services to be available at an emergency diversion aerodrome. Learmonth did not have the requisite emergency services available, and was classified as an ‘emergency airport’ for use ‘only in case of dire emergency’. The flight crew response to the engine failure was consistent with their policies and procedures. These policies and procedures are approved by the State of the operator, and are consistent with international standards. CASA accepted these policies and procedures when it issued a Foreign Aircraft Air Operators Certificate to the operator. Australian standards do not require the same level of emergency services to be available at an emergency diversion aerodrome.

Completion of investigation AO-2017-066 is expected in the first quarter of 2020. The delay in publishing of this investigation’s final report is substantially the result of a developing understanding of causation of the fan blade failure, and the requisite corrective manufacturing and inspection action.
Senator Glenn Sterle asked:

Please provide staffing profile (by FTE and classification) for ATSB’s investigation work for each financial year since 2013/14

Answer:

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Notes:

These figures have been obtained from our payroll reports going back to when the system was introduced in 2010. The figures have been rounded to a full value noting some staff were working on part-time arrangements at various times throughout the reporting periods.

The peak for investigation staff was in 2011/12, then gradually reducing to the low in 2015/16. While it has stabilised over the past three years, the aim is to develop and mature the large intake of APS investigators (FY17/18) into senior investigators over the coming reporting periods.

The peak in Team Leaders (FY16/17) reflects a number of senior investigators taking on additional responsibilities to support our agency’s transformation program.
Senator Nick McKim asked:

1. Was flight EK441 grounded at Adelaide Airport on 25 July 2016?
   a. If so:
      b. what was the reason for the grounding?
      c. has an incident report been lodged?
         i. If so, please provide a copy.

Answer:

   a. yes
   b. smoke was detected near the front lavatory
   c. yes
      i. see Attachment A

Attachments
- A: Occurrence Summary Report
201605659 - Occurrence Summary

Overview
Occurrence date  25 Jul 16  
Occurrence time  21:48 CST  
Logged date  25 Jan 17  
Occurrence category  Incident  
ATSB involvement  Data entry  
Status  Reviewed  
Highest injury  Nil

Occurrence Types
Operational - Fumes, Smoke, Fire - Smoke

Aircrafts Summary
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<th>Registration</th>
<th>Model Common Name</th>
<th>Maximum Weight Category</th>
<th>Operation Type</th>
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<tbody>
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<td>A6-ECL</td>
<td>777</td>
<td>Over 272001 Kg (&gt;599650 Lbs)</td>
<td>Air Transport High Capacity</td>
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Safety Factors
Technical failure mechanism - Electrical discontinuity

Summary
ATSB summary  During boarding, smoke was detected near the front lavatory. The engineering inspection revealed a faulty lighting ballast unit.