

DRAFT

**Inquiry into Regulatory Institutions and Practices
New Zealand Productivity Commission
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Submission by Aviation New Zealand

1 Introduction

1.1 Who are we – Aviation New Zealand is the trading name of the Aviation Industry Association Incorporated. We represent the interests of the commercial aviation community. In all we have around 400 company members and 200 individual members representing close to 90% plus of all aviation activity by hours flown in New Zealand.

1.2 Why are we interested – aviation is a heavily regulated sector with its own safety legislation pertinent to the sector and many additional pieces of regulation which it shares on common with all other businesses and the general public. However our aviation specific regulation is there normally not to prevent or preclude an activity, but to enable or facilitate an activity to occur. Much of our legislation has its origin in international treaties or agreements however these treaties or agreements are rarely if ever so prescriptive that they do not permit differences or for the regulations to be customised for the New Zealand environment.

1.3 Our biggest challenges are -

- A regulatory framework which unleashes the productive potential of the sector while concurrently providing societal assurance in respect of safety
- A transparent regulatory tool kit which provides for the appropriate exercise of discretion
- Equitable division of funding between public, private and club goods in an environment where government is reluctant to contribute its fair share
- Having rules and regulations developed in a timely and appropriate manner to meet the pace of change whether change is driven by technology; competition, obsolescence or no longer workable and or relevant.

- The disjointed nature of the regulatory framework in some instances; for example the serious overlap of regulatory philosophies when it comes to health and safety of employees and the safety of all who participate in aviation. There is one standard for employees and another for everyone else. This doesn't make sense when there is only "one death"

1.3.1 Tertiary legislation such as the Civil Aviation Act can have an equally debilitating impact on the sector's productivity as the Rules and Regulations. The Civil Aviation Act was world class and leading edge when written in 1990. The Act has not been modernized since although it should be noted there is a project underway to do this but we feel it unlikely to result in any change until at least 2016.

1.4 **Aviation contributes** around 3% of New Zealand's GDP. The sector has the potential to grow at around 9% compounding per annum. This potential is being constrained by an absence of cohesive focus and application of the government's growth agenda to the sector. Aviation is a high productivity sector contributing \$138,534 per FTE to the New Zealand economy ¹ yet concurrently is facing critical skills shortages in a number of areas due to the application of tertiary education policies and practices.

2.1 What sort of institutional arrangements and regulatory practices should the Commission review?

2.1.1 Our priority would be

- Institutional arrangements and regulatory practices which detract from or impede our international competitiveness
- Institutional arrangements and regulatory practices which unnecessarily constrain business growth
- Institutional arrangements and regulatory practices which impose additional compliance costs in the domestic operating environment
- Institutional arrangements and regulatory practices which need to be modernized for other reasons

2.2 The Commission has been asked to produce guidelines to assist in the design of regulatory regimes. What type of guidelines would be helpful?

¹ BERL Facts and Figures Overview prepared for Service IQ 2013

2.2.1 Yes that would be helpful, for example :

- Best practice in licensing procedures
- Regulatory tools kits and their deployment
- Consultation best practice
- Policy development – there is considerable variation across agencies in how policies are developed however there does seem to be some excellent best practice models
- Best practice in exercising discretion
- Development of regulatory intelligence tool kits

2.3 Does New Zealand have (or need) a unique “regulatory style” as a result of our specific characteristics?

2.3.1 Yes we do. Our style is very reflective, in the aviation environment of the following:

- Regulatory philosophy – presently we operate under a philosophy dominated by “less regulation better regulation”. Such a philosophy is generic but fails to recognise that for aviation many of our rules are enabling so not only can we not progress rules which enable us to be more productive we can’t get rid of those that hamper productivity.
- Reactive – if there is a major event, money is applied to fixing perceived problems however very little funding is there to proactively address issues before they occur
- One size fits all – our regulatory philosophies are adopted from large economies that have seemingly limitless resources. We accept that the International Civil Aviation Organisation’s recommended standards must be accepted and applied even to the domestic operating environment whereas ICAO does provide some relief through the “differences” filing process

2.3.2 However for New Zealand we need to recognise that our regulatory environment must be international competitive, even in respect of regulating aviation safety. It needs to be proactive using superior risk management practice and that in many respects international frameworks enable practices to be exceeded and or a “difference” filled. In considering whether to exceed a requirement it is essential to assess and appreciate the underlying risk that is being addressed.

2.3.4 Not all rules/regulations should be looked at as restraining or constraining – in our environment many of our rules enable us to do

things and do things better. We must be careful not to be caught up in the same mantra of "less is better".

2.4 What influence has New Zealand's specific characteristics had on the way regulation is designed and operated in New Zealand?

2.4.1 A small open internationally competitive economy which must be safe but also prosper and grow.

Size does matter because it means that we can be both more responsive – i.e. led change and concurrently develop innovative solutions.

We were global leaders in the development of risk management practice. New Zealand and Australia essentially developed the global standard however we don't appear to optimize or encourage use of the practice.

As a culture we have developed good communication structures that means those that are most impacted by regulatory change can participate in the decision making process.

We have amended regulations to reflect New Zealand conditions but these have inhibited our ability to develop international business (e.g. pilot training).

2.5 What other ways of categorising New Zealand's regulatory regimes and regulators would be helpful in analysing their similarities and differences? How would these categorisations be helpful?

The risks being treated e.g. all safety regulatory risks could be grouped as their objective is treatment of harm and hazards to individuals.

2.6 Can you provide examples of regulatory regimes with particularly clear or (conversely) unclear objectives? What have been the consequences of unclear regulatory objectives?

2.6.1 In aviation we had a very clear objective of safety at reasonable cost. All participants in the aviation community could apply a cost benefit test to regulatory changes. We had a common mantra and a common way of addressing issues.

2.6.2 On November 30 2004 the Act was amended by amending the objective of the Minister to now be "to undertake the Minister's functions in such a way that contributes to the aim of achieving an integrated, safe, responsive and sustainable transport system"

2.6.3 Nobody understood what the change meant or how it impacted on the functions of the Authority. However one thing did become clear: that the quite precise tests which we previously applied to decisions became diluted at least at the regulatory level.

2.6.4 Of more recent times the Ministry of Transport has developed a new process for rule making which takes account of the statutory imperative but also makes much greater use of cost benefit analysis and PIRA. This introduces the risk assessment process in the context of rule making. A document entitled "Transport Regulatory Policy Statement" has been released to industry and we consider this a step in the right direction, although the industry would submit that such a process was introduced in the Scholton's report on industry engagement in rule making in 2002, however, because of a limited understanding of how the risk management process was intended to work was never properly introduced.

2.7 Where regulators are allocated multiple objectives, are there clear and transparent frameworks for managing trade-offs? What evidence is there that these frameworks are working well/poorly?

2.7.1 There were no frameworks to make the statutory objectives work, instead, we have had to muddle through as best we can. This has seen some fairly significant swings from very prescriptive rules, heavy handed interventions, an inability for the industry to understand the key safety imperatives driving regulatory interventions through to "value for money exercises" which have closely examined the regulatory tool kits to be applied.

2.7.2 In our view, in the aviation environment, there has been very little thinking about regulators being given multiple objectives from

competing and overlapping sets of legislation. However, where the agency has taken on a growth objective along with aviation safety the risk management process applied correctly addresses these objectives in a systematic and analytical way. For example the CAA's strategic objective is "Safe flight for social connectedness and economic benefit"

2.7.3 The best evidence we have of this process working well was the different treatments between the Australian and New Zealand regulators in respect of volcanic ash discharge and its impact on air services. In June 2012 the Civil Aviation Safety Authority of Australia made the following release

Australia's aviation operations are under greater than normal safety oversight during the passage of the latest volcanic ash clouds. The Civil Aviation Safety Authority is working to ensure airlines are following the correct procedures when making decisions on flights while the volcanic ash clouds pass. CASA is also working closely with other government agencies such as Airservices Australia and the Bureau of Meteorology to provide airlines with the information and support.

2.7.4 The Civil Aviation Authority of New Zealand ("the CAA") issued similar warnings but the outcomes, on each side of the Tasman, were very different. The New Zealand industry continued operating whereas Australia's commercial aviation industry grounded operations. In part the reason why New Zealand's aviation industry was able to continue operating was because of the greater confidence had in the risk management and assessment process conducted. As we have said this is very contingent upon the data, intelligence and information all coming together and the parties' collaborating to make a high quality decision.

2.7.5 The importance for the New Zealand economy of ensuring air transport services continued was critical. For the Australian economy the disruption was significant but not critical.

2.8 Can you provide examples of where assigning a regulator multiple functions has improved or undermined the ability of the regulator to achieve the objectives of regulation?

2.8.1 In the early 2000's "the CAA" became the Health and Safety regulator for aviation personnel in the air. Prior to this date aircrews had not been covered by this legislation. There was no detailed briefing as to what this change meant, how the overlapping legislation

would be administered, or any particular or specific work programmes established to embed the change.

2.8.2 Duplicate categorization of accidents occurred. For example, accidents in many industry participant's minds were categorised as a CAA accident or an HSE accident. Separate reporting systems for accidents were required because the definitions differed and different investigatory processes and treatment of information process applied. It could be argued that rather than improving safety outcomes the focus shifted to understanding how to comply with overlapping jurisdictions whose safety philosophies and practices did not sit well together.

2.8.3 Instead of there being a substantial change in the work place environment as some anticipated, the matter of health and safety on those board aircraft has largely been deferred to "the CAA". Of more recent times prosecutions of aviation personnel have taken place pursuant to both pieces of legislation and while it could be argued that that is what government intended, there are consequences.

2.8.4 Aviation's safety system is predicated around information disclosure which facilitates and enables continuous learning. However in the HSE environment there is a belief that it's best not to self incriminate. "The CAA" has an understanding and appreciation of the importance of learning from accidents – the same cannot be said for agencies involved in HSE matters where investigations are conducted to determine whether to prosecute or not. If this prosecution culture crosses over into aviation then there will be a rapid deterioration in reporting. Even a loss of confidence in the robustness with which safety information is treated can lead to a loss of confidence in regulatory systems and processes and a reduction in reporting.

"The goals of a criminal investigation and a safety investigation are not the same, and the investigations are not conducted in the same way," explains Gary Doernhoefer, IATA General Counsel. "Safety investigators try not to reach any conclusion or form any hypothesis during the investigation itself. Their goal is to defer reaching a conclusion until they have exhausted the collection of facts. They are trained to undertake the investigation in this way, which can actually be quite difficult.

"But the criminalization of accidents creates a problem," says Doernhoefer. "Having gathered all this data for the purposes of improving safety, the industry is becoming increasingly concerned that

the data can then be used to prosecute in a court. This is not just the data related to a specific incident, but any report that might be construed as part of the evidence."

The upshot of all this is that, if the confidentiality of the information is broken and it ends up being used in criminal court cases, frontline personnel are going to be increasingly unwilling to self-report, and a rich seam of safety data will be lost.

Source IATA 2102 Safety the Blame Game

2.9 Can you provide examples of where a single agency is responsible for both industry promotion and the administration of regulations? What processes are in place to align the incentives of the regulator with the desired regulatory outcomes? What evidence is there of success or failure of these processes?

2.9.1 "The CAA" when operating overseas has a role in promoting the regulatory environment in New Zealand. This is about providing confidence and assurance that New Zealand's regime is compatible with the likes of Australia, the US, UK and Canada. These assurances in turn create opportunities for New Zealand's aviation businesses to prosper and growth. Concurrently of course "the CAA" is clearly responsible for administration and oversight of the operation of those regulations.

2.9.2 "The CAA" is audited by ICAO the International Civil Aviation Organisation. This audit examines a number of aspects of "the CAA's" operation. They are for example interested in the application of the international recommended practices and standards within the New Zealand environment.

2.9.3 Foreign regulators can also exercise oversight if they have specific concerns – for example the EU operates a black list of carriers which are prevented from entering the EU's airspace. The Federal Aviation Authority ("the FAA") operates a similar system.

2.10 Are there examples of where regulators have clearly defined policy functions? Conversely, are there examples of where the policy functions of a regulator are not well defined? What have been the consequences?

2.10.1 In this area we think the respective roles and responsibilities become very muddy.

2.10.2 "The CAA" very clearly has a policy development function however we were told recently that the line between policy development and assessment has been redrawn for the purposes of who funds what. Policy assessment is now the Industry's responsibility to fund whereas policy development remains a core government funded activity. We think that this was a division of "convenience" and have never had the issue explained to us. However, we have had to fund the full amount of the changed activities in this area.

2.10.3 It would be of assistance if there was a common understanding as to what the term "policy" meant particularly when it comes to who funds which activities.

2.10.4 The line between the Tertiary Education Commission ("the TEC") and the Ministry of Education ("the MOE") is frequently blurred although to be fair of recent times we have come to understand what is high level education policy and what is policy delivery. In the past, a consequence has been being past from one agency to another and neither being prepared to answer the specifics of our question. This led to frustration for all parties.

2.11 Can you provide examples where two or more regulators have been assigned conflicting or overlapping functions? How, and how well, is this managed?

2.11.1 Health and Safety in Employment and Civil Aviation Safety – there is only one state of safe and that is people are not hurt or injured, but we have different definitions of "safe". We have different definitions of serious harm. We have different threshold tests. We have very different ways of investigating incidents and accidents – we have different definitions of accident.

2.11.2 To place some semblance of accountability into this complex confusing and conflicting regulatory regime, an artificial line was drawn between which regulatory agency is accountable for investigation. Not only was the line drawn at a point that makes little or no sense to some operations in industry, but also the conflicting regulatory philosophies have taken years to rationalize their way through the operational environment.

2.11.3 There are very clear cases where the operational health and safety philosophy makes a lot of sense and that is where the more prescriptive philosophy of "the CAA" has been unable to develop significant change or improvements in safety. An example is striking wires in the low level operating environment. The Industry and Regulators ("the CAA" and Department of Labour) have guidelines and have run numerous educational campaigns over a long period of time (in excess of 15 years) however farmers continue to string wires in highly hazardous environments. The point has been reached now where a failure to heed warnings has resulted in the Industry requesting a more punitive approach to dealing with the problem.

2.12 Are there examples of where regulators are explicitly empowered or required to cooperate with other agencies where this will assist in meeting their common objective?

2.12.1 Section 97(e) of the Hazardous Substances and New Organisms Act 1996 creates a statutory duty on the Director of Civil Aviation to ensure that the provisions of that Act are enforced in or on any aircraft.

2.12.2 With respect to pesticide spray drift arising from aerial application activities, the HSNO Enforcement Agencies Technical Guide produced by the Environment Protection Agency (EPA) identifies the CAA as the lead enforcement agency. This approach is intended to recognise that in enforcing the HSNO Act the enforcement agency needs to start its investigation at the place where the potential non-compliance occurred. It also needs to be familiar with such places, how work can be safely carried out in them, identify what any problem may be and understand how any such problem can be fixed.

2.12.3 In the case of spray drift arising from aerial application activities the place in question is an aircraft. Given that the CAA has specialist knowledge regarding aircraft, aircraft operations, and operating procedures it was considered logical and appropriate that it has the lead role in such cases, as the Technical Guide identifies. Such an approach, in the case of pesticide spray drift events, is consistent with the provisions of the HSNO Act which, as noted above, create a specific statutory duty on the Director of Civil Aviation to ensure its provisions are enforced in or on any aircraft.

2.14.4 In looking at this area it has been identified that in the past the CAA has also investigated events involving aerial 1080 poison drops

and alleged mis-applications. It was identified in liaison with EPA, that there are specific controls relating to 1080 and an established process for dealing with 1080 incidents. These involve the relevant local public health unit as the primary point of contact.

2.13 Can you provide examples of where two seemingly similar regulatory areas are regulated under different regulatory structures? What factors have contributed to differences in the regulatory structures?

2.13.1 here are two presently two statutory systems which govern "safety" in the aviation environment

- The HSE Act which is a catch all and incorporates workplaces and people who visit places, contractors etc; and
- The Civil Aviation Act which deals with aviation safety on the ground and in the air.

2.13.2 Compliance with one i.e. the Civil Aviation Act does not guarantee compliance with the other. Aviation companies are required to comply with both including their significant differences.

2.13.3 Competent authority

The Civil Aviation Authority administers both the HSE Act and Civil Aviation Act refer S3A of HSE Act –

3A Application of Act to aircraft

- (1) This Act applies to—
 - (a) a person employed or engaged to work on board an aircraft; and
 - (b) the person who employs or engages the person specified in paragraph (a); and
 - (c) the aircraft as a place of work.
- (2) However, this Act applies only while an aircraft is—
 - (a) operating on a flight beginning at a place in New Zealand and ending at that same place; or
 - (b) operating between 2 places in New Zealand (not as part of a flight beginning or ending outside New Zealand); or
 - (c) operating outside New Zealand, and the person is employed or engaged under an employment agreement or contract for services governed by New Zealand law.

(3) For the purposes of subsection 2(c), an aircraft operating in New Zealand as part of a flight beginning or ending outside New Zealand must be treated as operating outside New Zealand.

(4) Section 16 does not apply to an aircraft while it is taking off, flying, or landing.

(5) To avoid doubt, where this Act applies outside New Zealand, the provisions relating to offences apply even though an act or omission that constitutes an offence occurred in respect of an aircraft outside New Zealand

2.13.4 For matters on the ground the CAA is the competent regulator if the matter is "on the aircraft as a place of work" but the previous Department of Labour or MBEI deals with all other matters when the aircraft is not a place of work.

2.13.5 Jurisdictions. The jurisdictions are substantially overlapping and investigations can and are conducted under both Acts.

2.13.6 Differences. There are a series of significant differences between the two for example under the HSE Act "safe" equals "all practicable steps" whereas under the CAA Act safe equals "contributes to the aim of achieving an integrated, safe, responsive and sustainable transport system".

2.13.7 this further manifests itself into two quite separate definitions of accident; two very different reporting methodologies for accidents and incidents; two differing investigation methodologies; two differing sets of penalties.

2.13.8 The HSE Act requires S5 Objects

- "(a) promoting excellence in health and safety management, in particular through promoting the systematic management of health and safety; and
- (b) defining hazards and harm in a comprehensive way so that all hazards and harm are covered, including harm caused by work-related stress and hazardous behaviour caused by certain temporary conditions; and
- (c) imposing various duties on persons who are responsible for work and those who do the work; and"

2.13.9 The Civil Aviation Act presently has no comparable provisions. There is no reference to "the systematic management of health or safety" and no reference to hazard or hazard management.

2.13.10 The Civil Aviation Act is presently limited to the requirement for a quality management system (QMS) and this system is in turn a restricted requirement to the larger operators and engineering workshops. There is no requirement for a QMS system for smaller (i.e. less than 3 aircraft CAR 135 operators or smaller). Even with a QMS system there is no requirement for hazard identification and mitigation.

2.13.11 A framework and structure akin to HSE is about to be introduced by CAA but contextualized for the aviation environment based on global ICAO recommended practices.

2.13.12 For operators who carry passengers and transport others in their workplace the requirement for a comprehensive system of managing safety has been a requirement since the HSE Act was first introduced in 1992.

2.13.13 Coverage of pilots and flight attendants were excluded from the HSE Act until 2001 but since that date all activities whether in the air or on the ground have been required to comply with the HSE Act.
Annex A

2.14 Are the dimensions of regulator independence discussed in Figure 4.2 helpful in thinking about New Zealand regulators?

Yes

2.15 Which of these dimensions of independence is most important to ensure a regulator is seen to be independent?

2.15.1 For aviation it is operational independence. Without operational independence then the credibility of regulating aviation is challenged by foreign jurisdictions and ICAO

2.16 Can you provide examples of where a lack of independence or too much independence according to one of these dimensions undermines the effectiveness of a regulatory regime?

2.16.1 "The CAA" has the ability to suspend and revoke a number of certificates and licenses. The Director has absolute power in this area which we think it important to maintain. However, this places incredible responsibility on the persons appointing the Director to have

an absolute understanding of the behavioural characteristics of the individual. A "rogue" director has the potential to significantly harm the credibility of the institution of regulating civil aviation and to the industry being regulated.

2.16.2 An additional issue is that there is no way of quickly redressing or seeking third party independent assessment of the Director's decision. At best there is a high court judicial review process and our experience is that a judge is very loath to intervene when the matter of aviation safety is raised.

2.17 What should be the limits of regulator independence? What sorts of regulatory decisions should be the preserve of Ministers rather than officials?

2.17.1 Limits of regulatory Independence – where matters are akin to tertiary legislation these matters should be approved by a Minister; decisions which will cost other parties a substantial amount of money e.g. the Industry has ended up paying for a decision to shift into expensive accommodation. The decision was made on advice from Officials however there was no consultation with the funders.

2.17.2 Decisions the preserve of the Minister - Rule making; Policy decision which may not end up in a Rule; Delegation of powers to external groups or individuals; International Treaties; extensions of emergency rules; fees and charges

2.18 Do you agree with the list of features in Figure 4.3 which indicate a need for more or less regulatory independence? What other criteria are missing?

Yes

2.19 Is regulatory capture more or less likely in a small country? Can you provide examples of capture in New Zealand?

2.19.1 We think the whole concept of regulatory capture is quite an antiquated term. However we understand that the populous at large think regulatory capture occurs. In our view more focus should be given to thinking about how to prevent perceived capture. We have found the consistent application of the risk management standard to

particular issues is the best way to deal with the problem. We have had as much challenge with regulators being captured by their own ideas and beliefs as we have had of purported industry capture of the regulator.

2.19.2 When an Industry speaks out in support of our regulatory system this is perceived as capture however in aviation it is equally critical that the public retain a high degree of confidence in the performance of the regulator. It is easy for lack of support to be translated into loss of confidence. The analysis and data driven nature of the risk assessment process eliminates most of the concerns and gives a platform to move issues forward.

2.20 Are there other institutional forms for government-established regulators?

We have industry delegates who may be individuals or companies discharging regulatory functions. In this capacity they act as delegates of the CAA.

2.21 Do particular types of institutional form lend themselves to more enduring regulatory regimes?

No comment

2.22 What are the key differences of institutional forms in terms of their regulation, operational, institutional or budgetary independence?

No Comment

2.23 Are there aspects of regulatory independence that are more or less important in regulating state power or government-provided/funded services?

No comment

2.24 Are there other types of governance structure than the three listed above? How well do they work?

No comment

2.25 What type of governance and decision-making structures are appropriate for different types of regulatory regime?

2.25.1 We favour for civil aviation the present structure – it is already challenging funding an entity where the government will not contribute its “fair share” and the travelling public and industry are levied or required to pay inflated hourly rate charges to pay for government services. If this funding model was then re-absorbed back into the Ministry of Transport or then as some suggest merged with Maritime New Zealand, it is considered we would lose transparency around funding and accountability for decisions.

2.25.2 Having a Board dedicated to aviation matters means that we do not have to contest for focus or governance of an operation

2.26 How effective and consistent are the review and appeals processes provided for in New Zealand regulatory regimes?

2.26.1 We think there are a number of different appeal mechanisms short of the District Court which is the primary appeal mechanism we have available to us.

2.26.2 For example, we know that some agencies operate with an Appeals Board as opposed to decisions resting on the shoulders of one person. We think this has some merit as Boards can comprise persons who have a number of different perspectives on issues.

2.27 Can you provide examples where the review and appeals processes provided for are well-matched or poorly suited to the nature of the regulatory regimes?

2.27.1 Detailed below is a specific issue we have with the open ended nature of our present regulatory regime in respect of investigations. As we have said the Civil Aviation Act is being overhauled but we would like to contrast our process with that prevailing in Australia where there are more options to enforce time frames for response.

2.27.1 2 The first example is particularly sensitive. It relates to a decision to suspend an air operator’s certificate. The decision was made during a period of an emergency audit pursuant to Section 15 A of the Civil Aviation Act.

2.27.1.3 The emergency audit was initiated at the end of January. The decision to suspend was made three days later and the operation was effectively grounded. It is not until mid April that the report pursuant to Section 15 was released to the company but by then the company had completely shut down. Although an avenue of appeal to the District Court was possible at that point, there was nothing left.

2.27.1.4 We don't want to comment on the merits or otherwise of the particular case but merely make the point that the same issue would be treated very differently in Australia.

2.27.1.5 In Australia CASA must apply after five days to the equivalent of our High Court for an extension of suspension. After that the parties are again back before the Court at 40 days. During the period between the initial hearing and a further hearing the emphasis is on resumption of operations i.e. what undertakings are necessary prior to removal of the suspension whereas in New Zealand's environment there is no pressure on the parties to resume flying.

2.27.2.1 A second example we have is where an airworthiness certificate has been suspended for a number of aircraft. This period of suspension went on for a period of over two years. The aircraft by that point were unsalvageable due to deterioration. There is no requirement for CAA to be accountable to a third party for the decision in the first instance, and no pressure on CAA to remove the revocation. Again we are not commenting on the merits or otherwise of CAA's action but merely contrast the differing legislative frameworks.

2.27.2.2 If the differing frameworks produced safer outcomes then the difference between the two jurisdictions could be understood, however, the safety performance of both countries' aviation sectors is broadly comparable.

2.27.2.3 New Zealand's framework is very punitive from an economic perspective. Neither of the aircraft operator examples quoted above have flown again. In Australia, the emphasis was on attempting to achieve compliance and as a last resort the operation is closed. This is an example of how different legislative frameworks can operate to the competitive advantage of businesses based in one country and to the disadvantage of businesses in another.

2.27.2.4 We see the administrative appeals tribunal in Australia as delivering further competitive advantages to Australian aviation

businesses as it places constraints on the power of CASA and CASA officers to behave reasonably. In New Zealand we are much more reliant on the competency of the Civil Aviation Board and the Director to exercise the appropriate checks and balances. When the Board becomes distant or remote from the Industry or the Director is similarly remote, conflicts can escalate to the political level as frustration boils over.

2.28 What are the advantages and disadvantages of a general merits review body like the Australian Administrative Appeals Tribunal?

2.28.1 We favour a process akin to the Australian Administrative Appeals Tribunal because:

- It provides a more immediate avenue for matters to be resolved where no agreement can be reached between the regulator and those contesting the regulators decisions;
- It improves the quality of decision making. It certainly makes decisions more transparent and is much more inquiring of the evidence
- A decision may be considered incorrect by the Regulator but it provides some "regulatory relief" if the system fails as the Regulator is not held personally accountable. Rather it is a panel or tribunal decision
- Evidence is produced which is objective and before an expert panel. Where change is being resisted by the Regulator the Tribunal is a good way of effecting change provided of course the evidence justifies such change.
- It de-personalises decisions
- Its about providing fairness whereas District Courts are loathed to rule against the Regulator because the Regulator is considered to be quasi judicial
- It provides a safety valve – presently the time taken to get matters before the District Court places enormous cost on the Industry

28.2.1 There are disadvantages:

- The Regulator may not be persuaded to change its views on a matter merely because a Tribunal has ruled differently
- The Regulator may take an unnecessarily harsh view of an issue knowing full well the Tribunal will probably rule down the middle. There is little incentive for the Regulator to reach a

just conclusion of its own volition when they know any decision can be appealed

- The Tribunal must be equipped with appropriate skill and expertise
- There are transaction costs for government

We question if it is not possible to establish such a mechanism using the Board of CAA as a quasi judicial forum to review decisions of its employees

2.29 Can you provide examples of regimes where risks are borne by a regulator, regulated party, or the public/consumers, but they are not best-placed to manage those risks?

2.29.1 In our view this is one of the most challenging issues faced by regulators. For example our regulator has recently had to engage in the regulation of commercial adventure aviation. New Zealand is the only country in the world that has adopted this course of action even though the accidents we have in this sector are not unique to this country, nor is the reputational damage to our tourism industry significantly different to a similar accident happening in Australia.

2.29.2 The sport recreational sector, we think, is very difficult to regulate using traditional aviation tools. The objective is not to engineer the risk out of the activity but rather to manage it in such a way that the thrill is there but not unconstrained.

2.29.3 There is a perception now that because the regulator has deployed the tools to adventure aviation that they would normally apply to regular scheduled transport, that the risk is somehow managed or controlled. As this is a recent change the evidence is not yet available. The adventure sector would say that the costs of regulation have increased substantially and are now significantly more than the rest of the world, where the sector essentially regulates itself.

2.30 Can you provide examples of where the mix of funding sources? contributes to the effectiveness or ineffectiveness of a regulatory regime?

2.30.1 The CAA is funded via a mix of hourly rate charges, levies and government contribution to rule making.

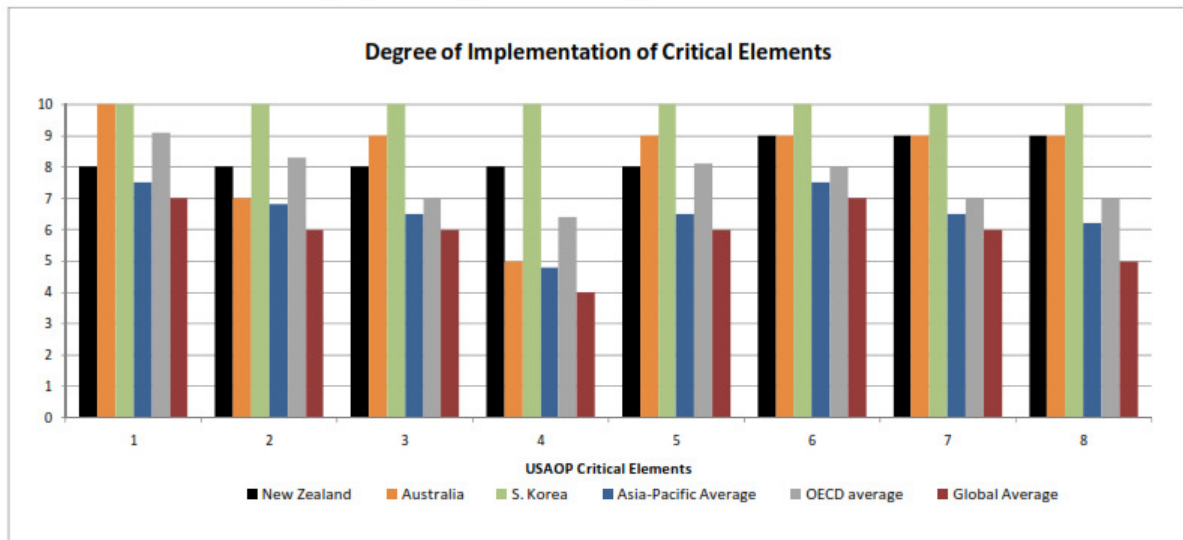
2.30.2 The CAA would say the fact that hourly rate charges were not adjusted for 19 years, has compromised their effectiveness. The Industry on the other hand would make the point that the CAA's funding has benefited from a growing tourism sector, increased use of domestic air travel and a vibrant and growing aviation industry. The 9% annual compounding growth rate over the period from 2000- 2009 more than provides CAA with the financial "headroom" to provide for improving effectiveness.

2.30.3 Being reliant on growth in the sector to fund improved effectiveness is a challenging concept for a monopoly agency to embody because quite clearly pricing signals are generally meaningless. The critical issue is the performance of the Board driving and demanding change.

2.30.3 If funding or the inadequacy thereof was a major issue you would expect to see New Zealand's performance relative to foreign jurisdictions rate quite poorly under ICAO's universal audit programme.

2.30.4 This information is derived from a CAA document entitled "General Information –Civil Aviation Authority (CAA) Supporting Document B Funding Review Consultation 12 October 2010"

Chart 1: ICAO Universal Safety Oversight Audit Programme



Key:

Level of implementation: 1= Not implemented, 10 =fully implemented

Critical element:

1. Primary aviation legislation (in New Zealand, it is the responsibility of the Ministry of Transport)
2. Specific operating regulations
3. State civil aviation system and safety oversight function
4. Technical personnel qualification and training
5. Technical guidance, tools and the provision of safety-critical information
6. Licensing, certification, authorisation and approval obligations
7. Surveillance obligations
8. Resolution of safety concerns

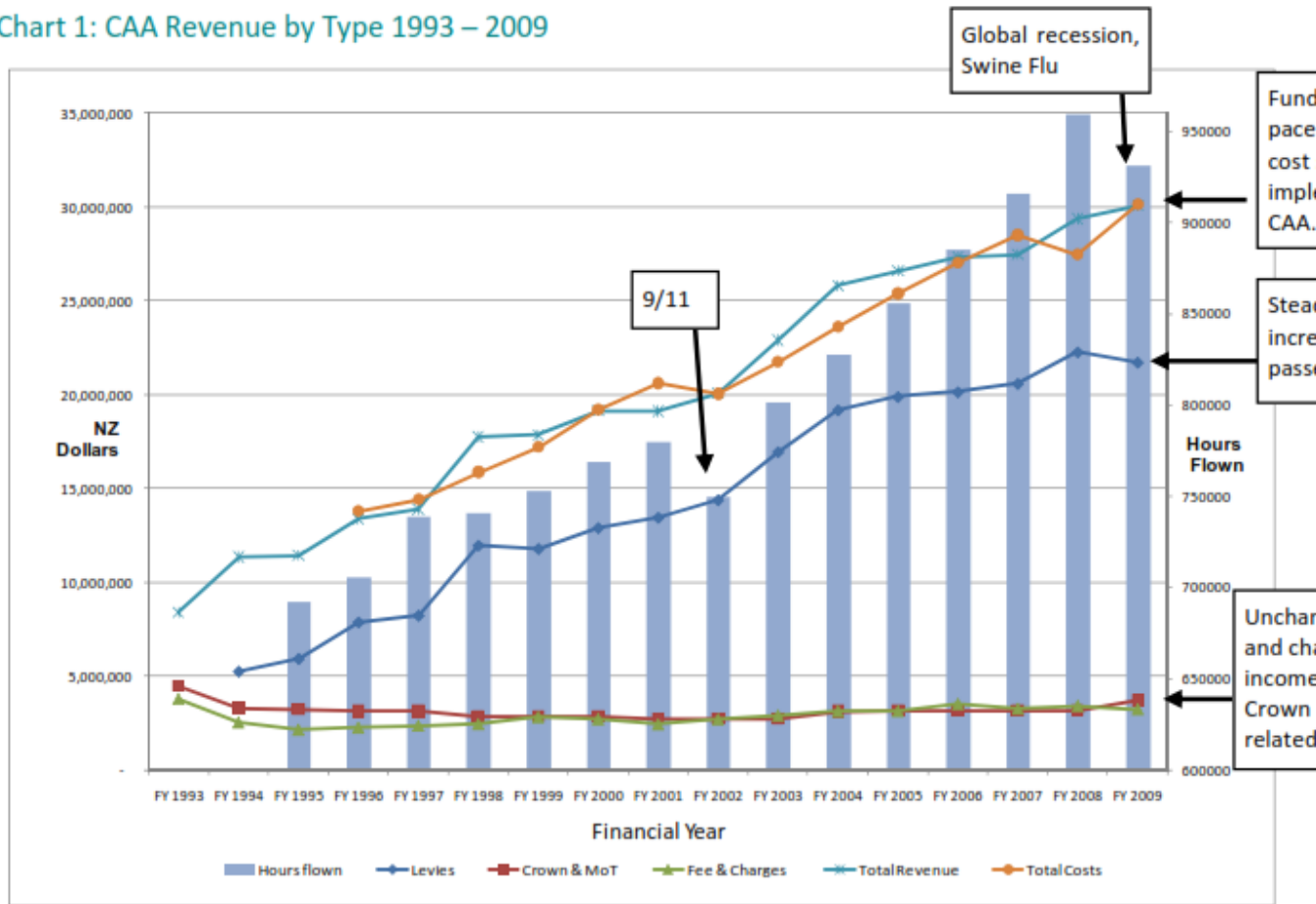
OECD average comprises 25 of the total 30 countries.

Data source (8 July 2010): www.icao.int/fsix/auditRep1_csa.cfm

2.30.5 New Zealand in black significantly outperforms the global average and is closely comparable to Australia in most indicators even through Australia’s regulatory spend is five times greater than New Zealand on a market that is three times larger.

2.30.6 Data in the funding review document dated 12 October 2010 examined the review by type from 1993-2009 demonstrates very clearly that a regulatory agency contingent on funding largely from levy payments must be very careful as costs are driven by growth in hours flown and not necessarily passengers carried or increased numbers in the fleet of aircraft registered here in New Zealand or the number of pilots holding licenses. Reference charts One and Two below.

Chart 1: CAA Revenue by Type 1993 – 2009

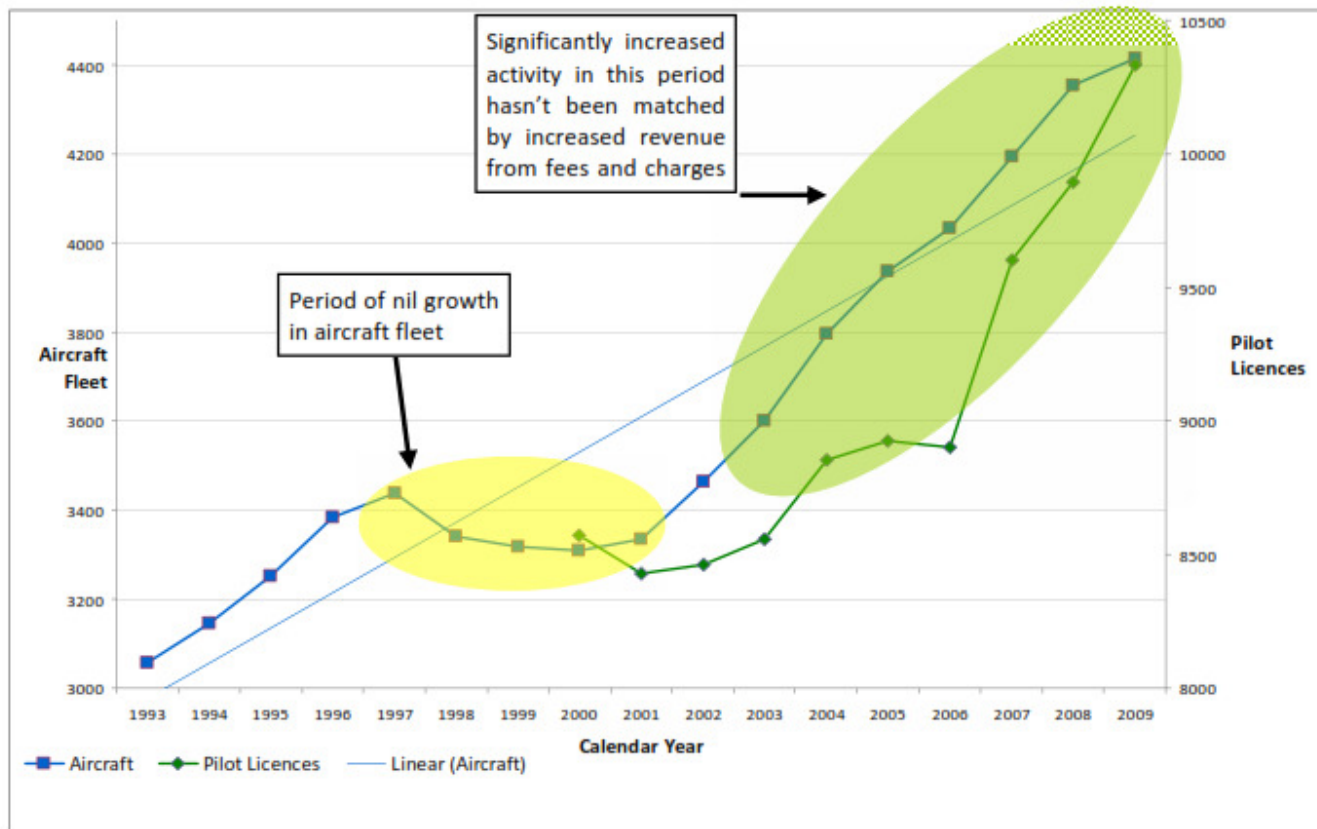


Source: CAA

Note 1: 2009 Hours Flown data extrapolated on the basis of known values for first six months.

Note 2: Cost saving activities included a freeze on staff levels, salaries, recruitment, reduced training and travel, cessation of sponsorship activities, and deferred introduction of new services.

Chart 2: Aircraft Fleet and Pilot Licences 1993 – 2009



Source: CAA

Note: The pre-2000 annual total of current pilot licences is not available.

2.30.7 Both these charts come from "General Information –Civil Aviation Authority (CAA) Supporting Document A Funding Review Consultation 12 October 2010". Because licenses issued are generally for a life time the growth in numbers for pilot licenses does not provide any indication of pilots actively engaged in the New Zealand industry. However with the growth in number of aircraft registered you would anticipate to see CAA's revenue increasing but can only conclude there was substantial rationalization of business occurring at the same time i.e. fewer number of business but with larger fleets.

2.31 Is the mix of funding sources for individual regulators consistent with their stated funding principles?

2.31.1 For CAA it is not.

2.31.2 We have recently made the attached submission to the Regulations Review Committee – the document is privileged however it covers the problems of not adopting a first principles approach; secondly the consequences of poor decision making in respect of moving into a top of the market premise and then expecting the productive sector to pay the full costs of the decision; the issues associated with cross subsidization; the lack of transparency around the financial analysis; the difficulties of improving efficiency i.e. the degree of inefficiency is only understood once a price is put on a product.

2.31.3 It also highlights the difficulties of dealing with public sector pricing methodologies when the government is owner and price setter.

2.31.4 It is difficult to mount a successful independent challenge via the courts because in general they will examine only process and not the underlying merits of the case. Prices are set by state owned and operated monopolies but there is no redress to the Commerce Commission and the complaint to the Regulations Review Committee must be framed in the context of a breach of standing orders. Without full financial disclosure it is difficult to sustain a challenge and many of the agencies do not have systems which record hours spent on particular activities with any precision – to develop these financial management systems imposes a cost on the users so it's a vicious cycle.

2.31.5 We are not aware that Regulators have consistent funding principles. We are aware that they are reliant upon the application of Treasury and Auditor General Guidelines for pricing however equally there is extensive commentary that it is up to the Executive i.e. government to set an appropriate price. When government is cash strapped our experience is that these guidelines are not applied. Customers have very limited leverage other than to complain. We cannot suddenly obtain services from other suppliers.

2.31.6 In the instance of Aviation Security this service is largely funded via passenger levies. Any review of funding is far less complex even though the business itself is subject to the same vagaries of passenger flows as CAA.

2.32 Which New Zealand regulators (or regulatory regimes) provide good examples of open and transparent funding arrangements? Can you provide examples where the transparency of funding needs to be improved?

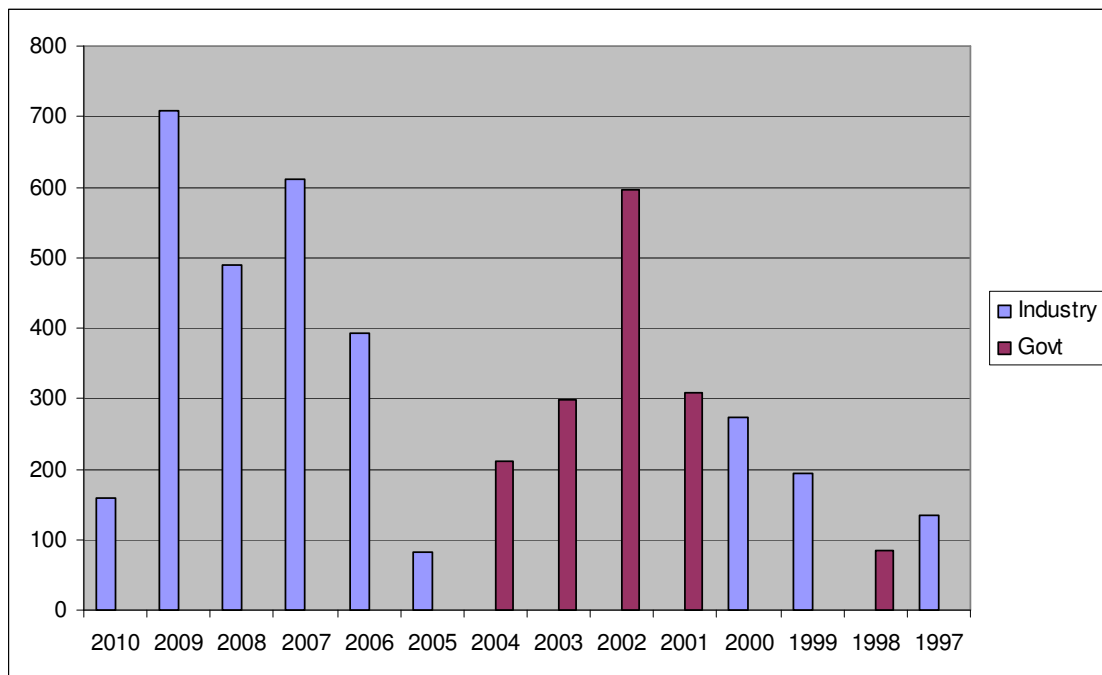
2.32.1 We believe the Aviation Security service funding model is now a good example of open and transparent funding arrangements. This has evolved over at least 10 years and is only now starting to reflect a high level of transparency. Maritime New Zealand also has much greater transparency of funding than “the CAA”

2.32.2 Both Maritime and CAA have undergone or are undergoing funding reviews. The Maritime new charging regime has been released very recently. This document discusses in much greater granularity how various activities will be funded and what triggers the type of activities. “The CAA” funding model on the other hand is subject to a series of complaints to the Regulations Review Committee. Industry’s complaints range from inappropriate application of public, private and common good costs to insufficient information and data relating to activities for which industry is being charged. It is not simply the charges but the lack of control over activities i.e. the CAA is the final arbiter of when a “job” is finished. The Industry is unable to get to any other provider to seek the service. There are no appeal rights and there are no controls on price, quality or service.

2.33 Can you provide examples where a regulator’s funding arrangements support or undermine its independence?

2.33.1 Because of the mixed funding model for CAA we are firmly of the view that it is nearly impossible for CAA to ensure Government contributes its fair share.

2.33.2 As demonstrated in the table below which has been derived from data in successive reports of “the CAA” the industry since 2005, has consistently cross subsidized provision of services to government. The blue bars indicate that government services have cost more to provide than the income derived from government. The purple bars indicates the years when government services cost less than the income from government



In 2010 the definition of "government services" was arbitrarily changed. Industry accordingly doesn't know what constitutes "government services".

Under the mixed funding model it is easy for agencies to not adopt a principled approach to funding and capitulate to the demands and requirements of central agencies such as Treasury.

2.33.3 When the CAA was established in 1991 we had precisely the same problem. Government did not wish to contribute its fair share. It was only after intervention from the Regulations Review Committee was there any redress.

2.34 What approaches are there to identifying, building, and maintaining workforce capability? How effective have they been?

2.34.1 A key issue we have is that very limited work was undertaken to build capability and capacity in the workforce. The Value for Money reviews conducted in respect of CAA started the process of modernization of regulatory processes. Our question would be why does it take an agency running out of money to prompt a "value for money review" and then it would appear that the primary purpose of the review was to extract money from the productive sector.

2.34.2 In saying this we are very supportive of the direction CAA are now travelling as we can very clearly see aviation is the beneficiary of enhanced policy analysis, intelligence gathering and analysis of safety incidents and accidents.

2.35 What restrains or enables a regulator to develop the capability they need in the New Zealand context?

2.35.1 The salaries paid by the regulator to some of personnel are simply too low and thus uncompetitive with the aviation industry. There is also a preference for the regulator being staffed by personnel who are from the New Zealand environment or at least very familiar with the way the New Zealand aviation environment operates.

2.35.2 Strong governance and good leadership by the regulator will act as an attractant.

2.35.3 If the regulator can not attract the necessary capability then potentially other ways of doing business should be examined. We think there is tremendous scope for delegation of roles, assurance models which make much greater use of third parties such as a co-assurance model and for the regulator to take a much more professional role than having to have all knowledge

2.36 Where are there gaps in regulator workforce capability? Can you provide examples?

2.36.1 Our observation is that few Regulators have consistent practice when it comes to undertaking good high quality risk analysis and utilization of the risk management standard.

2.36.2 This is critical in building consensus. Most regulators appear to hold preconceived notions of the "way" issues should be treated. They also tend to be quite risk averse and this acts as a hand break on industry.

2.36.3 In part the problem is driven by an absence of high quality analysts who understand the information and in part driven by the fact that we are a small country and thus our data sets are not rich.

2.36.4 An example being some very good quality analysis undertaken on identifying the risks in agricultural aviation but an absence of a

transparent programme to take the project forward and agree treatment strategies.

2.37 What is the potential to improve capability through combining regulators with similar functions, compared with other alternative approaches?

2.37.1 We do not support regulators combining regulatory functions when there are mixed and very different funding mechanisms at play. We see there is serious room for scope creep and one industry group cross subsidizing the performance of another sector.

2.37.2 For example some \$7.5m of levy money from aviation security was channeled into providing working capital for CAA. Essentially the money was over recovered from one sector of the aviation travelling public. There is an argument that is group under contributed to CAA funding however we can see such practices would be difficult to accept for example if the levy on Maritime was suddenly diverted to pay for aviation activities

2.38 When do changes to institutional arrangements work best to improve capability, and when are other solutions preferable?

2.38.1 Devolution of activities and scrutiny by an independent governance Board unleashed major productivity shifts within the sector. Over time we have seen a recentralization of some activities as concerns grew from the regulator that industry did not have the necessary skills or systems to deliver.

2.38.2 We think the whole process of regulators considering different ways to regulate the industry have stopped. There is very little innovation despite the fact that there is a general acknowledgement that it is difficult to attract persons with the right capabilities into a central agency.

2.39 Can you provide examples of strengths and challenges in the way regulators monitor and enforce regulations? What are the consequences?

2.39.1 Aviation has a long history in this area with multiple reports by the Office of the Auditor General:

- 1997 Report on 3 Transport Safety Agencies
- 2000 Report on CAA's surveillance functions

- 2005 Follow up Report on CAA's surveillance functions

2.39.2 It is difficult for us to comment on the present performance of the CAA as it has recently undergone further structural change and the General aviation group which had been merged into the airlines group is once again separate. However our perception is that there is much great consistency across CAA than in previous years and more resources are applied to ensure good risk management practices are being adopted.

2.40 Do New Zealand regulators have access to a sufficient range of enforcement tools? If not, what evidence is there to suggest that a broader range of tools would promote better regulatory outcomes?

2.40.1 We think they have a wide range of enforcement tools – it's the consistency of application between regulatory agencies that is the issues particularly where statutory frameworks overlap.

2.41 What sort of regulatory regimes are suited to more (or less) discretionary enforcement?

2.41.1 Those regulatory regimes where there is voluntary reporting of accidents and incidents are reliant upon discretion being exercised. If it is not exercised then the quantity and quality of reporting diminishes.

2.42 Can you provide examples of where a regulator has too much or too little discretion in enforcing regulations? What are the consequences?

2.42.1 The Civil Aviation system vests considerable discretion in the Director. In general we think this is appropriate however equally we believe the regulator must back decisions made with a high level of transparency and analytical capability.

2.42.2 This is particularly true where long standing practices are changed without consultation. First the industry knows little about the change and thus is unable to comply bringing about allegations of regulatory inconsistency or perceptions of personal prejudice. Secondly the industry is very aware of the safety case process and where this is not used by the regulator there are questions of double standards around decisions pertaining to safety. Thirdly if we are to operate in an

environment where there are no time requirements to make decisions it is unreasonable to leave decisions in limbo. There must be some process whether it is via Board accountability mechanisms to ensure decisions are made in a timely manner.

2.43.2 Australia has a combination of both discretion, time requirements to make decisions and third party independent appeal rights – we think this is a better model. Australia also has a governance Board, one of the members being the Director.

2.43 Can you provide examples of where risk-based approaches have been used well? What are the critical pre-conditions for effective implementation of risk-based approaches to compliance monitoring and enforcement in New Zealand?

2.43.1 A risk based approach was adopted by the Regulator, the Airways Commission the MetService and Air New Zealand in respect of the decision to continue operations when Volcanic ash from the CordónCaulle volcano in southern Chile entered New Zealand airspace in June 2011.

2.43.2 A further example is work this Association undertook in the Queenstown Basin assessing the risks associated with mixed use operation in a congested and confined space.

2.43.3 We have found critical pre conditions are:

- A willingness for all parties to debate issues with an open mind
- A willingness for all key parties to participate
- High quality data in the instance of volcanic ash real time data assisted greatly
- An understanding that operations would either be curtailed or reduced if certain conditions prevailed
- A very clear understanding of scope
- Operational experience
- High quality application of sound and robust risk management practices
- A collegial atmosphere where people worked together and co-operated without fear of possible punitive action
- A wish to find a solution

2.44 What are the challenges to adopting risk-based approaches in New Zealand?

2.44.1 A risk based approach is, in our environment, very reliant on data and data analysis. In general New Zealand doesn't have enough instances or examples of the particular issue and so we are reliant on information from foreign jurisdictions which may not be relevant to our environment.

2.44.2 On the other hand there are very few circumstances where New Zealand is so unique that someone would not have encountered this particular issue or concern in the past.

2.45 Can you provide examples of where regulatory regimes require too much or too little consultation or engagement? What are the consequences?

2.45.1 An example of too little - CAA is required to consult on rule changes but not price changes. They do consult but there is no requirement to and no requirement to be transparent in the analysis of information presented. Once prices are set there is a very limited ability to have the charges reviewed. Judicial review of the charges is extremely expensive and generally only looks at process and not the merits of the case. The Regulations Review Committee is limited in its ability to look at issues to fairly narrow breeches of the Standing Orders and there is no appeal rights to the Commerce Commission even though these charges are set on a monopoly basis.

2.45.2 An example of possibly too much for some and not enough for others. Airports are required to consult users on price where the user constitutes over 5% of the income for the airport. The disclosure regimes and requirements are enormous yet the fundamental issue remains which no one agrees on and that is what is the underlying value of the asset. This has been the problem since Airports were corporatised and some privatized over 25 years ago. None of the parties appear incentivised to develop a more efficient regulatory regime.

2.45.3 The point we would make is there is no common framework. For example many charges imposed by government and government agencies are outside the scrutiny of the Commerce Commission and for others the primary statute excludes them from consultation at all.

2.46 What are the characteristics that make some regulations more suited to prescriptive consultation requirements than others?

2.46.1 In highly technical and safety sensitive environments or ones involving substantial capital expenditure it is our experience that the consultations have to be quite intensive. For example a redefinition in one area can have significant consequences in another area which is totally unrelated.

2.47 What forms of engagement are appropriate for different types of regulatory regime? When do formal advisory boards work or not work well?

2.47.1 We have no experience of formal advisory Boards but we do have quite a range of advisory groups dealing with specific issues. We value these groups as they enable ideas to be exchanged and better understanding developed.

2.47.2 However there is a limit to which a small Industry can engage with multiple advisory boards as we still have businesses to run. We think good high quality dialogue in terms of communication and consultation with the industry as opposed to an advisory Board probably works best in this industry

2.48 What elements of a regulatory regime's design have the biggest influence on culture? Why?

2.48.1 Regulatory design

The appointment of the Chairman of the Board – this role essentially set the tone and clear expectations in respect of performance

Clear accountability for timely decisions

Leadership practices of the Chairman and CEO

Leadership through communications i.e. clear expectations and consistent communications as to performance

An understanding of the critical issues confronting the sector and some alignment of goals and objectives

No surprises

Confidence of the Minister and other key stakeholders

2.48.2 When any of these elements are missing there is an absence of alignment of vision between the Regulator and the sector. In our environment this lack of alignment can lead to a deterioration in safety performance. We also observe that it can also lead to improved performance as the industry becomes more reliant on its own safety initiatives to compensate for poor regulatory performance

2.49 How best can the challenges of working in partnership with Māori be met by regulatory agencies? What models, methods, and approaches are most successful?

No comment

2.50 How well do regulatory agencies ensure consistency of approach between or amongst regulatory staff, so that individual variations are minimised?

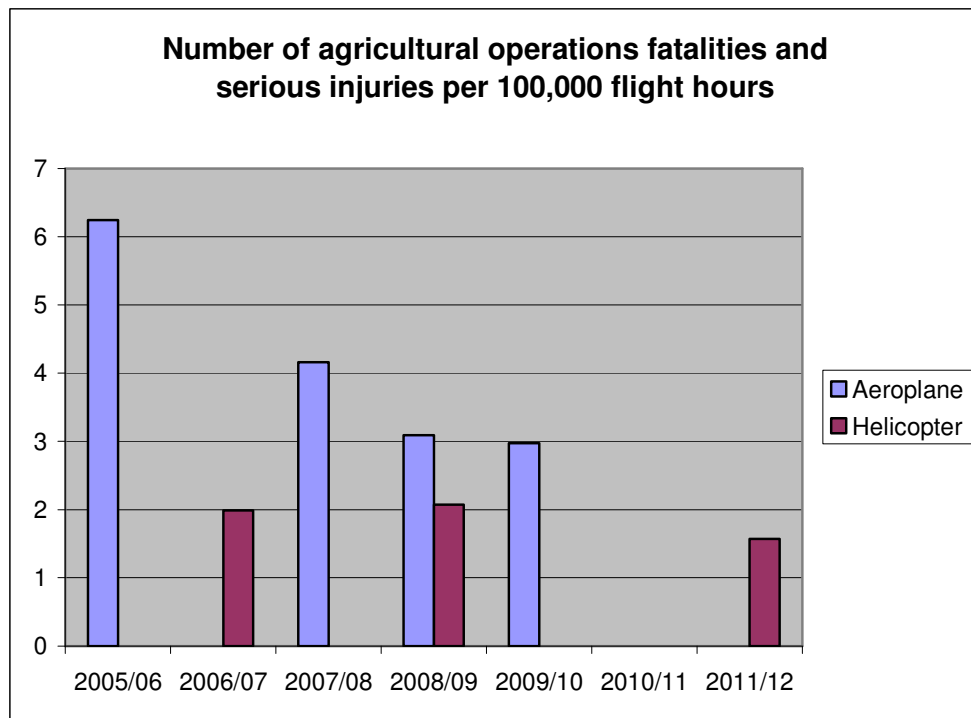
2.50.1 Our experience is most try very hard. Some regulators are not aware of the inconsistencies until sector groups such as us take the matter to them. CAA have made considerable investment in training and along with the other factors listed above at 2.48.1 this is critical to regulatory success

2.51 Can you provide examples where the culture or attitude of the regulator has contributed to good or poor regulatory outcomes? How?

2.50.2 Over the past 18 months we have seen a noticeable shift in the way in which civil aviation policy is developed. One of the projects that we are approximately half way through is an exercising examining the risk profile of the agricultural aviation sector.

2.50.3 In numerous CAA annual reports this sector drew particular attention because of its unsatisfactory safety performance. Over the last three years there has not been a fatality or accident resulting in serious injury within agricultural fixed wing operations – we think this is largely to do with a significant cultural shift within the sector. The

introduction of sector risk profiling is intended to take this sector to the next level of performance and attempt to lock in on a sustainable basis some of those gains.



2.51.3 A copy of the sector risk profile document entitled Sector Risk Profile Agricultural Aviation June 2013 and companion document can be found on the CAA's web page.

2.52 Can you provide examples where the culture within a regulator supports or inhibits staff in making difficult decisions, particularly where those decisions may be unwelcome to government, regulated parties or the general public? How?

2.52.1 Yes however the particular matter is still before a Coronial inquest and we would prefer not to comment. We would make the point that issue arose prior to the present CAA Board being appointed and prior to the present Director being appointed

2.53 Can you provide examples where a regulator places too much value on managing risks to itself, relative to other priorities (such as the regulatory objective, or customer service)? What are the consequences?

2.53.1 Yes we had one example where the regulator placed the perceived risk to itself greater than the perceived or real risk attributed by other regulators around the globe. This issue was raised as quite a technically complex issue however the regulatory response from other agencies to the perceived problem was very consistent with the views of the New Zealand industry. In the interim some within the New Zealand industry suffered considerable economic damage. This issue has been subsequently resolved with sensible dialogue and the disinterest of foreign regulators in the issue.

2.54 Can you provide examples of regulators whose approach to their business is largely shaped by their reliance on a particular profession? How might that approach be different if it drew on a wider range of professions?

No comment

2.55 Can you provide examples of how accountability or transparency arrangements improve or undermine the effectiveness of a regulatory regime?

2.55.1 The Civil Aviation Act is very clear in terms of accountabilities. The Director has extensive powers and when these powers are exercised neither the Minister nor the Board can intervene. The Board has the authority to appoint the Director and holds the ultimate sanction if the Directors performance is not acceptable.

2.55.2 However without a high level of transparency the decisions of the Director can be subject to quite intense scrutiny. We think an example of poor transparency and very limited accountability was the decision made by the then Board and Director to shift premises to Wellington. One of the reasons given was Industry's concerns about the cost of travel to Petone. However the Industry was never made aware of nor consulted in respect of the shift.

2.55.3 In its own right movement from one premise to another would not have been an issue however the premises selected by the CAA were right at the top of the rental price range at \$500 per square

whereas the average rental in Wellington was around \$350. With user pays and the governments unwillingness to contribute any more money the cost of this decision is borne by the Industry with excessively high hourly rate charges.

2.55.4 Maritime New Zealand's hourly rate charges set in 2013 vary from \$144 per hour increasing to \$235 per hour in July 2018. By comparisons CAA's hourly rate charges for the same type of work – audit and surveillance are \$243 (1 July 2013) increasing to \$284 (1 July 2014) with potentially further increases to \$355 if full cost recovery is applied. Wage rates and personnel costs between the two agencies are broadly the same – we ascribe the substantial variance in hourly rate charge largely to the cost of top of the range premises in Wellington.

2.55.5 Decisions of this nature are impacting on our domestic competitiveness and obviously our ability to compete internationally.

2.56 What types of accountability or transparency arrangements are appropriate for different types of regulatory regimes?

2.56 We think the above example is a failure in transparency regime although it could equally be argued that accountability is also an issue.

2.56.1 Appointed on the CAA's board are two representatives from Industry. However of recent times there has been no consultation with industry in terms of nominating potential candidates. One of the important factors is to have an appropriate skill mix of industry representation. At the present time we do not think it appropriate to have two representatives of the "airline" industry but rather there must be representation as there has been in the past from general as well as the airline industry. In our view more weight has to be given to the connectedness of industry representatives although we agree that under the present leadership of the Chairman of the Civil Aviation Authority there is much better quality of dialogue at all levels with the aviation community and a real effort has been and is being made to encourage stakeholder participation.

2.56.2 In terms of transparency we would wish to see much greater enshrinement of the risk management process in everything that regulators do. This process by its very nature encourages greater transparency.

2.57 Are the problems that the Commission identified in the assessment of local government regulatory performance also evident in the assessment of central government regulatory performance? If not, how do the problems differ for central government?

No comment

2.58 Can you provide examples of where performance assessment of regulatory regimes is working well, or needs improvement?

2.58.1 Our experience is that the Office of the Auditor General provides a reasonably holistic over view of performance assessment provided there is a very clear theme in terms of objectives. For example the Civil Aviation Authority was encouraged to introduce the concept of risk based auditing. This was a new and leading edge concept when proposed around 14-15 years ago however there was no agreement on what the term "risk based" auditing meant. Over time we have become more and more confident with the concept however this process is a journey as it is constantly evolving.

2.58.2 A major accident disrupted the process and we reverted to tick the box auditing which of course had no impact on improved safety outcomes and sent the industry and regulator into a period of intense frustration with each other.

2.58.3 We are back on the evolutionary track now but there was three or four years of disruption and some new an emergent ideas are coming to the for – all however are based on the intensity of data collection and intelligent analysis

2.59 When are feedback loops being used well to improve the performance of New Zealand regulatory regimes? When aren't they?

2.59.1 An accident is the ultimate feed back loop in respect of a failure however our experience is that no matter how well meaning people may be in examining ways to rectify issues there tends to be overcompensation.

2.59.2 Some times this is generated by persons who have limited knowledge but hold positions of responsibility. An example is the

coroner in a coronial inquiry. Quite often they sit without any expert independent assessor or are assisted by an assessor with limited or no qualifications. These assessors generally are not acknowledged as persons having any specific expertise in the issue and as a consequence we end up with a whole series of recommendations which don't do a lot to get to the root cause of the accident. Of course in our environment by the time it arrives with the coroner we have already participated in two or three investigations inquiries.

2.59.3 Of recent times we have observed much improved analysis of issues and we think this can be put down to better interagency co-ordination between various investigatory bodies in aviation.

2.60 Can you give examples of indicators or proxies that are effective as early warning signs of regulatory noncompliance or failure?

2.60.1 Yes not paying critical creditors in a timely manner. This is normally a sign of quite severe stress in our environment.

2.60.2 Abnormally high turnover of senior managers or the senior management team

2.60.3. Shifting problems onto everyone else as opposed to taking accountability for the issues

2.60.4 The culture of the organisation i.e. is it proactive in addressing issues or always reactive.

2.61 Can you provide examples of regulatory regimes with effective processes for formally or informally raising concerns about potential regulatory failures? What examples are there of regimes that handle this poorly? What are the consequences?

2.61.1 Aviation has a formal reporting requirement detailed in Rule Part 12 of the Civil Aviation Rules. This Rule part is derived from international (ICAO) requirements for reporting.

2.61.2 Where a matter is outside that prescribed in the Rule Part 12 we have a process where by we can raise an Aviation Concerns. Aviation Concerns can be filed in respect of any matter which is of concern to an individual which may possibly impact on aviation safety.

2.6.1 3 The issues associated with reporting are as follows:

- De-identification of the information. In some instances the information must be reported very specifically however in others to foster a culture of being open and reporting incidences and accidents the specific name of the individual or company concerned needs to be de-identified. In a small country this can be quite challenging and difficult
- The information is reported into the Civil Aviation Authority who has an enforcement role as well as a safety investigatory role. The Industry is not totally satisfied with the separation between the two
- There is no always sufficient analytical capability available to get to the root cause of the problem – however it is understanding the root cause which gives us the greatest capacity to ensure the problem doesn't reoccur.
- Use of the data/information remains a significant issue and comes down to the degree to which the Regulatory is trusted. At times of low trust reporting will reduce
- The Regulatory philosophies of agencies differ – the perception is that an infringement under the HSE Act is more likely to result in a heavy handed investigation than an investigation conducted by those who are knowledgeable of the industry and operating environment. As we say this is a perception and whereas the data does not always support this view.
- Serious accidents or "systemic failures" are investigated by the Transport Accident Investigation Commission. Protection of data and information in this environment is very strict and controlled under a legislative framework.

Concluding remarks

Thank you for the opportunity to respond to your questions. We would be pleased to comment further on any specific points made. We will send you a copy of our submission to the Regulations Review Select Committee as soon as the submission is made public by the committee.

Yours sincerely

Irene King

Chief Executive