Transportation Safety Board of Canada | Bureau de la sécurité des transports du Canada

REASSESSMENT OF THE RESPONSES FROM TRANSPORT CANADA TO AVIATION SAFETY RECOMMENDATION A01-01

REGULATORY SAFETY OVERSIGHT

Background

The de Havilland DHC-6-300 Twin Otter, serial number 724, was on a defence visual flight rules flight from Goose Bay to Davis Inlet, Newfoundland, with a crew of two on board. The flight encountered instrument meteorological conditions en route and continued to Davis Inlet in these conditions under the defence visual flight rules flight plan. The crew flew a non-precision instrument approach to the airport and, at minimums, executed a missed approach because the required visual references were not established. A second approach was attempted; on the inbound track, the aircraft struck the frozen surface of the Labrador Sea two nautical miles north-northeast of the airport. The first officer was fatally injured, and the captain sustained serious injuries. The aircraft was destroyed.

The Board concluded its investigation and released report A99A0036 on 13 July 2001.

Board Recommendation A01-01 (13 July 2001)

It is recognized that effective safety oversight of smaller or remote operations is a challenging task. Notwithstanding this challenge, the level of acceptable risk should not be greater for passengers and crews who fly on aircraft operated by smaller operators or who operate in or into remote areas, simply because oversight is difficult. It is also recognized that there have been initiatives undertaken by Transport Canada (TC) to reduce the level of risk in these operations. However, these and other accidents indicate that more needs to be done. It appears that the traditional methods of inspection, audit, general oversight, and regulatory penalties have had limited success in fostering appropriate safety cultures in some companies and individuals; consequently, unsafe conditions continue to exist and unsafe acts are still being committed.

These serious accidents indicate that some operators and crews have disregarded safety regulations and, consequently, put passengers and themselves at an unnecessary and unacceptably high level of risk. In these accidents, findings indicate that, in certain areas of commercial operations, the safety oversight efforts of TC have been somewhat ineffective. Therefore, the Board recommended that:

Canada

> The Department of Transport undertake a review of its safety oversight methodology, resources, and practices, particularly as they relate to smaller operators and those operators who fly in or into remote areas, to ensure that air operators and crews consistently operate within the safety regulations.
>
> A01-01

Response to A01-01 (04 October 2001)

TC's initial response dated 04 October 2001 stated that TC is continually reviewing its safety oversight program methodology, resources and practices to meet the challenge of providing effective safety oversight to all areas of the aviation industry in Canada, including the provision of air service to and within remote regions of the country.

Continuous review and improvement of programs and activities is a long-established operating principle of TC. Recent examples include:

- the promulgation of the *Canadian Aviation Regulations* to replace the Air Navigation Orders in October 1996;
- the Safety of Air Taxi Operations Task Force launched in 1996 producing a final report in May 1998;
- *Flight 2005: A Civil Aviation Safety Framework for Canada* published in December 1999; and
- a comprehensive external review of the Civil Aviation safety oversight program completed in July 2001.

Board Assessment of the Response to A01-01 (29 October 2001)

The response is general in nature and does not provide any specific element of improvement or change. It is, however, positive in tone and seems to accept that there is a deficiency in TC's safety oversight program. Further, there is a stated commitment for ongoing improvement in the effectiveness of the safety oversight efforts. In this context, the response is assessed as **Satisfactory Intent**.

Next TSB Action (29 October 2001)

The TSB Air Branch will continue to monitor TC's future actions related to this recommendation, and will update this assessment if appropriate.

This deficiency file is assigned an **Active** status.

Response to A01-01 (14 December 2005)

TC's update on 14 December 2005 reiterated its initial response in the Minister's response to the recommendation: "Transport Canada is continually reviewing its safety oversight program methodology, resources and practices to meet the challenge of providing effective safety oversight to all areas of the aviation industry in Canada including the provision of air services to and within remote regions of the country." Since this response, TC has moved forward to include:

- Safety Management Systems in the aviation program and regulations instilling a safety culture in the aviation industry;
- instilled a risk management philosophy for decision making;
- produced the *Flight 2010 - A Strategic Plan for Civil Aviation* document;
- adopted the TC Civil Aviation Business Model; and
- reviewing internal organizations optimizing its resources for safety.

It is foreseen that TC will continually and indefinitely review its safety programs to meet future aviation industry needs.

Board Reassessment of the Response to A01-01 (23 June 2006)

TC's letter of 14 December 2005 indicates that, since its initial response to the TSB, TC's safety oversight program has been improved to include a formalized Safety Management Systems program in the regulations, a risk management philosophy for decision making, a strategic plan for civil aviation entitled *Flight 2010 – A Strategic Plan for Civil Aviation*, a Civil Aviation Business Model, and a review of internal TC organizations to optimize its resources for safety. It is foreseen that TC will continually and indefinitely review its safety programs to meet future aviation industry needs. This action taken will substantially reduce the safety deficiency as described in Recommendation A01-01.

Therefore, the assessment is now assigned **Fully Satisfactory**.

Next TSB Action (23 June 2006)

As the safety deficiency associated with Recommendation A01-01 is considered rectified, no further action is necessary.

This deficiency file is assigned an **Inactive** status.