Administrative Appeals Tribunal of Australia

Hansen and Civil Aviation Safety Authority [2013] AATA 437 (27 June 2013)

Last Updated: 27 June 2013

[2013] AATA 437

Division	**GENERAL ADMINISTRATIVE DIVISION**
File Number(s)	**2012/1810**
Re	**Victor Hansen**
	APPLICANT
And	**Civil Aviation Safety Authority**
	RESPONDENT

DECISION

Tribunal	**Ms J L Redfern, Senior Member**
Date	**27 June 2013**
Place	**Sydney**

The decision under review is affirmed

.....[sgd].....
Ms J L Redfern, Senior Member

CATCHWORDS

AVIATION - helicopter pilot – fatal accident - duty to safely navigate or operate aircraft –discretion - cancellation of private pilot licence – whether applicant a fit and proper person - decision under review affirmed.

LEGISLATION

Civil Aviation Act 1988

Civil Aviation Order

Civil Aviation Regulations 1988 *reg 269*

Civil Aviation Regulations 1998

CASES

Australian Broadcasting Tribunal v Bond [1990] HCA 33; (1990) 94 ALR 11

Re Taylor and Department of Transport (1978) 1 ALD 312

Re Griffiths and Civil Aviation Authority (1994) 34 ALD 554

Quadrio and ***Civil Aviation Safety*** *Authority [2011] AATA 709*

Shi v Migration Agents Registration Authority [2008] HCA 31; (2008) 235 CLR 286, (2008) 82 ALJR 1147

Civil Aviation Safety *Authority v Central Aviation Pty Ltd [2009] FCA 49*

SECONDARY MATERIALS

Aeronautical Information Publication

Civil Aviation Advisory Publication 92-2(1)

REASONS FOR DECISION

Ms J L Redfern, Senior Member

27 June 2013

1. Mr Victor Hansen was issued with a Private Pilot (Helicopter) Licence on 8 June 2004. He used his helicopter to commute between various properties owned by him on the south coast of New South Wales. He also commuted to Ingleburn in Sydney from time to time to work with his son. Mr Hansen is a retired engineer and cattle farmer.
2. On 24 April 2011, Mr Hansen was the pilot in command of his Robinson R 44 helicopter when it crashed into the ocean off the Lilli Pilli Headland, south of Bateman's Bay. Mr Hansen was attempting to land the helicopter on a helipad on his property at Malua Bay, which was less a kilometre from the crash site. Tragically Mr Hansen's wife was killed as a result of the crash.
3. The **Civil Aviation Safety** Authority (CASA) commenced investigations into the circumstances of the accident and found that Mr Hansen had contravened various provisions of the relevant aviation regulations. As a result of its investigations, CASA was satisfied that Mr Hansen had failed to adequately discharge his duties as a private pilot and was not a fit and proper person to hold a private pilots licence. His licence was cancelled on 19 April 2012.
4. Mr Hansen disputes the finding of contraventions and seeks to set aside the decision cancelling his licence.

LEGISLATIVE FRAMEWORK

5. The *Civil Aviation Act 1988* (the Act) establishes CASA and sets out its functions in respect of civil aviation. The main object of the Act is to "establish a regulatory framework for maintaining, enhancing and promoting the safety of civil aviation, with particular emphasis on preventing aviation accidents and incidents". CASA oversees a licensing regime and is charged with the function of conducting safety regulation in accordance with the Act and the regulations under the Act. It has a range of regulatory tools to promote safety and may prosecute breaches of the Act and the regulations, issue directions and guidelines and take licensing action against participants. Section 9A of the Act provides that CASA must regard the safety of air navigation

as "the most important consideration".

6. Section 98 of the Act provides that regulations may be made, amongst other things, "prescribing matters necessary or convenient to be prescribed for carrying out or giving effect to this Act". The key regulations made under the Act are the *Civil Aviation Regulations 1988* (the 1988 Regulations) and the ***Civil Aviation Safety Regulations 1998*** (the 1998 Regulations). CASA is also empowered to issue directions, instructions or notifications through the making of Civil Aviation Orders (regulation 5 of the 1988 Regulations). Regulation 240 of the 1988 Regulations authorises CASA to issue instructions in relation to flight planning, which includes weather reports and forecasts. Some of these instructions are contained in the *Aeronautical Information Publication* (the AIP) which is published by CASA.
7. It is common ground that the relevant regulations, instructions and guides for consideration in this matter are:

   (a) Regulation 145 of the 1988 Regulations: The pilot in command must "pay due regard to all dangers of navigation and collision and to any special circumstances which may render a departure from those rules necessary in order to avoid immediate danger".
   (b) Regulations 174A(2) and 174C(1)(a) of the 1988 Regulations: A pilot in command must not fly an aircraft under the Visual Flying Rules at night unless the aircraft is equipped with certain equipment, including a landing light, and unless licenced to do so.
   (c) Regulation 224 of the 1988 Regulations: A pilot in command is responsible for the start, continuation, diversion and end of a flight and must discharge his or her responsibilities in accordance with any information, instructions or directions made available or issues under the Act or the Regulations.
   (d) Regulation 233(1)(a) of the 1988 Regulations: A pilot in command must not commence a flight unless he or she has taken such action as is necessary to ensure that the aircraft is adequately equipped.
   (e) Civil Aviation Order 20.11: An aircraft must be equipped with a life jacket for each occupant when the aircraft is over water and, in the case of a single engine aircraft, at a distance greater than that which would allow the aircraft to reach land with the engine inoperative.
   (f) Regulation 239(1)(a) of the 1988 Regulations: Before the beginning of the flight the pilot in command must study all available information, including current weather reports and forecasts for the route to be followed, and plan the flight in relation to the information obtained.
   (g) AIP General (GEN) 2.7 - Sunrise /Sunset Tables, AIP En Route (ENR) 1.2 -Visual Flight Rules (VFR) and AIP ENR 1.10 - Flight Planning.
8. The Visual Flight Rules (VFR) relevantly provide as follows:

   1.1.2 Unless the pilot in command holds a Command Instrument Rating or night VRF (NGT VFR) rating and the aircraft is appropriately equipped for flight at night, a VFR flight must not depart from an aerodrome:
   a. before first light or after last light; and
   b. unless the ETA for the destination (or alternate) is at least 10 minutes before last light after allowing for any required holding.

9. First and last light are calculated in accordance with the Sunrise/Sunset Tables in AIP GEN 2.7.
10. The Flight Planning rules relevantly provide:

FLIGHT PLAN PREPARATION

1.1 Before beginning a flight, a pilot in command must study all available information appropriate to the intended operation and, in the cases of flights away from the vicinity of an aerodrome, flights over water (see ENR 1.1 Section 62.) and all IFR flights, must make a careful study of:

a. current weather reports and forecasts for the route to be flown and the aerodromes

to be used;

b. the airways facilities available on the route to be flown and the condition of those facilities;

c. the condition of aerodromes to be used and their suitability for the aircraft to be used;

d. the Air Traffic Control rules and procedures appertaining to the particular flight; and
e. all Head Office and FIR NOTAM applicable to the en route phase of flight, and location-specific NOTAM for aerodromes.

The pilot must then plan the flight in relation to the information obtained.

Note: Full details on the services provided by the briefing office(s) are available in ERSA GEN.

1.2 Forecasts

1.2.2 For flights for which a forecast is required and cannot be obtained, the flight is permitted to depart provided the pilot is satisfied that the weather at the departure point will permit the safe return of the flight within one hour of departure. The flight is permitted to continue provided a suitable forecast is obtained for the intended destination within 30 minutes after departure.

1.2.5 A pilot in command must ensure that the forecasts cover the period of the flight and that the aerodrome forecasts for the destination and alternate aerodromes, to be nominated in the flight plan, are valid for a period of not less than 30 minutes before and 60 minutes after the planned ETA.

1.2.8 When preflight briefing is obtained more than one hour prior to EOBT, pilots should obtain an update before each departure to ensure that the latest information available can be used for the flight. The updated should be obtained by NAIPS pilot access, telephone, or, when this is impracticable, by radio.

11. Regulation 269 of the 1988 Regulations authorises CASA to cancel, vary or suspend a licence and provides as follows:

Variation, suspension or cancellation of approval, authority, certificate or licence

(1) Subject to this regulation, CASA may, by notice in writing served on the holder of an approval, authority, certificate or licence (an **authorisation**), vary, suspend or cancel the authorisation if CASA is satisfied that one or more of the following grounds exists, namely:

(a) that the holder of the authorisation has contravened, a provision of the Act or these regulations, including these regulations as in force by virtue of a law of a State;

(b) that the holder of the authorisation fails to satisfy, or to continue to satisfy, any requirement prescribed by, or specified under, these regulations in relation to the obtaining or holding of such an authorisation;

(c) that the holder of the authorisation has failed in his or her duty with respect to any matter affecting the safe navigation or operation of an aircraft;

(d) that the holder of the authorisation is not a fit and proper person to have the responsibilities and exercise and perform the functions and duties of a holder of such an authorisation;

(e) that the holder of the authorisation has contravened, a direction or instruction with respect to a matter affecting the safe navigation and operation of an aircraft, being a direction or instruction that is contained in Civil Aviation Orders.

(1A) CASA must not cancel an authorisation under subregulation (1) because of a contravention mentioned in paragraph (1)(a) unless:

(a) the holder of the authorisation has been convicted by a court of an offence against a provision of the Act or these Regulations (including these Regulations as in force by virtue of a law of a State) in respect of the contravention; or

(b) the person was charged before a court with an offence against a provision of the Act or these Regulations (including these Regulations as in force by virtue of a law of a State) in respect of the contravention and was found by the court to have committed the offence, but the court did not proceed to convict the person of the offence.

12. Thus, CASA has discretion to take licensing action against the holder of an authorisation which will be enlivened if CASA is satisfied about the matters listed in regulation 269(1). In exercising this discretion the safety of air navigation is to be given paramount consideration.

ISSUES FOR DETERMINATION

13. CASA exercised its discretion to cancel Mr Hansen's licence on the basis of subregulation 269(1)(c) and/or (d) of the 1988 Regulation. I am not bound by these findings or confined to consideration of these subregulations but it is common ground that the other grounds for suspension, variation or cancellation are not relevant to the facts of this case. While there are allegations that Mr Hansen has breached various provisions of the 1988 Regulations, he has not been convicted of any offence and as such, his licence cannot be cancelled on the basis of subregulation (a). CASA alleges that Mr Hansen breached a Civil Aviation Order relating to life jackets but does not contend that Mr Hansen's licence was, or should be, cancelled under subregulation (e). Similarly, there is no allegation that Mr Hansen fails to satisfy a requirement prescribed by the 1988 Regulations under subregulation (b).
14. The key issue in dispute, and therefore for determination, is whether, in the circumstances of this case, Mr Hansen's licence should be cancelled or whether some other action is appropriate, such as variation, suspension or, as Mr Hansen contends, no further action.
15. As a threshold issue, I must be satisfied that Mr Hansen "failed in his duty with respect to any matter affecting the safe navigation or operation of an aircraft" and/or that he is "not a fit and proper person to have the responsibilities and exercise and perform the functions and duties of a holder of such an authorisation".
16. One of the issues raised by CASA in the notice to show cause issued to Mr Hansen on 5 September 2011 was the fact that he had carried out 50 maintenance inspections on his aircraft when he was not authorised to do so. This was said to be in breach of regulation 42ZC (1) of the 1988 Regulations. Ultimately this was not a breach that formed the basis for CASA's decision to cancel Mr Hansen's licence and the notice from the delegate cancelling Mr Hansen's licence accepted his undertaking not to conduct unauthorised maintenance in the future. While both parties made reference to this breach in their written submissions, the issue was not the subject of dispute. I have therefore made no determination on this matter but for completeness note that I agree with the original decision in this regard.

SUBMISSIONS OF THE PARTIES

17. Mr Hansen contends that he has not breached any of the relevant 1988 Regulations but even if there were breaches, they were technical in nature and did not establish that he failed in his duty or that he is not a fit and proper person. The accident was the result of a series of unfortunate events that could not be avoided or foreseen, such as extreme weather, the lack of safe alternative landing sites on his route and the apparent failure of the altimeter on the helicopter. Mr Hansen has undertaken further training since the accident and is willing to submit to "any reasonable test of competence" to have his licence restored. The weight of evidence is to the effect that Mr Hansen is of "good character" and has taken appropriate action in very difficult circumstances at all times. His actions should not be adjudged with unnecessarily critical

hindsight judgment. It was submitted that the fact Mrs Hansen was disabled was of particular relevance and Mr Hansen was mindful of her disabilities when considering options about where to land. It was also relevant that Mr Hansen had little time to make decisions given the inclement weather and failing light.

18. Mr Hansen submits that his licence should be reinstated on him satisfactorily completing a private helicopter pilot licence flight test.
19. CASA contends that, at the relevant time, Mr Hansen did not hold a rating which would have allowed him to fly at night or under the Visual Flight Rules. This was significant and Mr Hansen knew this. He should have taken the necessary precautions to ensure he was not flying at night in potential breach of the 1998 Regulations. Mr Hansen did not plan his flight adequately on 24 April 2011 and made a number of critical errors of judgment, which led to the accident and loss of life. Based on the available evidence, the Tribunal should be satisfied that Mr Hansen had failed in his duty. Furthermore, Mr Hansen has subsequently demonstrated an inability or unwillingness to acknowledge the various breaches. This suggests that Mr Hansen does not have a proper appreciation of his errors and as such the Tribunal cannot be satisfied this conduct will not recur. Given the seriousness of the errors, the tragic consequences and the failure of Mr Hansen to accept these errors, the Tribunal should be satisfied that Mr Hansen is not a fit and proper person to hold a private pilots licence.
20. CASA submits that the Tribunal should affirm the decision under review. In the alternative, CASA submits that if the Tribunal is minded to make a decision favourable to Mr Hansen, the decision should be set aside and in substitution Mr Hansen's licence should be suspended with the requirement that he pass an examination as determined by CASA.

BACKGROUND FACTS

21. On 24 April 2011 at approximately 5pm Mr Victor Hansen and his wife, Mrs Helen Hansen, set off from a helipad on their property at Eurobodalla to return to their principal place of residence at Berry, which is about 95 nautical miles north of Eurobodalla. The trip was estimated to take about 45 to 50 minutes. The weather at Eurobodalla was overcast at the commencement of the flight but not raining or stormy.
22. As Mr and Mrs Hansen approached Sussex Inlet on the way to Berry, Mr Hansen observed storms crossing his flight path. He decided to turn back. Mr Hansen did not attempt to make a landing at that stage and decided that the best course was to land at the helipad on their property at Malua Bay, which was 1 to 1.5 kilometres south of Batemans Bay. One of the concerns raised by Mr Hansen during the CASA investigation and during the hearing was that Mrs Hansen was disabled at that time as she was recovering from two knee reconstructions.
23. By the time Mr Hansen approached Malua Bay it was after 6 p.m. and visibility was poor. Mr Hansen commenced his descent over the water to what he believed was a cruising altitude of about 150 feet. However, he was mistaken and instead of cruising towards the coastline and the helipad, the aircraft crashed into the ocean about 100 metres off the Lilli Pilli Headland, which was the headland just before Mr and Mrs Hansen's property at Malua Bay. CASA alleges that the aircraft crashed into the water at about 6.15pm. Mr Hansen alleges that the accident was about 5 or 10 minutes earlier.
24. After crashing into the water, the aircraft began to sink. Mr and Mrs Hansen escaped and reportedly attempted to swim towards the rocks at the bottom of the Lilli Pilli Headland. Mr Hansen lost contact with Mrs Hansen and she was later found dead in the water near the crash site.
25. CASA commenced investigations in relation to the crash in May 2011 and interviewed Mr Hansen and other witnesses.
26. There is little dispute about the critical facts, such as the flight path, the time Mr and Mrs Hansen left Eurobodalla, the weather, preparations made by Mr Hansen before the flight and the events just prior to the accident. There is no dispute that Mr Hansen was not authorised to fly at night and did not have the necessary equipment to do so. There is also no dispute that Mr Hansen did not have life jackets on board the aircraft, even though he flew over the water for part of his trip. It is common ground that there was bad weather south of Berry, necessitating a

diversion. Mr Hansen told investigators that just prior to impact he looked at his altimeter and it showed an altitude of 150 feet. According to Mr Hansen, the altimeter must have been faulty, which was why he continued his descent on approaching Malua Bay. CASA did not challenge this evidence. While there was a dispute about when 'last light' should be calculated and the time of the accident, there is no dispute that the aircraft crashed at least 10 minutes after last light.

27. On 5 September 2011, a notice was issued to Mr Hansen requesting him to show cause as to why his licence should not be varied, suspended or cancelled. Mr Hansen provided written responses and attended a recorded interview with CASA officers in December 2011. CASA cancelled Mr Hansen's licence on 19 April 2012. Mr Hansen filed and served his application for review and stay of the CASA decision within five business days, namely by 3 May 2012, and thereby became entitled to an automatic stay of the cancellation order until the Tribunal determined the application for a stay. This application was determined on 12 July 2012 and was refused. Mr Hansen has not flown a helicopter as the pilot in command since this time.
28. Mr Hansen owns four properties on the south coast and, prior to the cancellation of his licence, he reportedly used the helicopter to commute between his principal home at Berry and his properties at Malua Bay, Eurobodalla and Kangaroo Valley. Mr Hansen is a cattle farmer and previously owned a machinery business operated from Ingleburn. According to Mr Hansen he sold the business to one of his sons and while the day-to-day operations of the business are managed by his son, Mr Hansen also used the helicopter to commute to Ingleburn from time to time. It is not in dispute that prior to the accident, Mr Hansen had in excess of 1,500 hours as a pilot in command.
29. Mr and Mrs Hansen were married for many years and Mrs Hansen regularly travelled with Mr Hansen by helicopter between their various properties.

THE EVIDENCE

30. As already noted, there is little dispute about the facts but there is a difference in opinion about whether Mr Hansen breached any regulations and whether the action taken by him in planning and managing the diversion of his flight once there were difficulties adequately discharged of his duties as a pilot.
31. CASA relied on the evidence of Mr John Alexander, a Flying Operations Instructor and CASA officer, as set out in his statement of 28 August 2012 and his oral evidence, together with statements and documents from the investigation comprising eyewitness statements, the transcript of an interview conducted with Mr Hansen on 5 December 2011 and statements from investigators, including a statement of Mr Alexander dated 18 January 2012 and his recommendation dated 16 April 2012.
32. Mr Hansen relied on the statements of Ms Keryl Egan, clinical psychologist, dated 11 February 2013, and Mr William Miller, chief flying instructor from Bankstown Helicopters, dated 13 February 2013, photographs and maps of the South Coast region, the evidence of Mr Hansen, which was set out in his statement of 2 March 2013, and his oral evidence. Both parties relied on documents comprising the relevant operator's manuals and guides.
33. There was no dispute about the operation of the various rules and regulations covering a private helicopter pilot but rather how those rules and regulations apply to the facts of the case.

Mr John Alexander

34. Mr Alexander is a Flying Operations Instructor with CASA and has held this position since 14 March 2011. Prior to this, Mr Alexander worked in various roles as a helicopter pilot, flying instructor and checking captain from about 1991. He has had a commercial pilot helicopter licence and air transport pilot licence for over 30 years and has in excess of 15,000 hours of flying experience in fixed and rotary wing aircraft. Mr Alexander was involved in the investigation of the accident and made recommendations on 16 April 2012 that Mr Hansen's licence be cancelled.
35. In Mr Alexander's opinion, Mr Hansen failed in his duty to properly plan his flight. He did not

obtain an updated weather forecast before leaving Eurobodalla and did not leave sufficient time to reach his destination at least 10 minutes before last light, as prescribed by the VFR (at AIP ENR 1.1.2(b)). Mr Hansen calculated last light at 5:55 pm with his estimated time of arrival at Berry as 5:45 pm. In contrast, Mr Alexander calculated last light at 5.50 pm and therefore concluded that Mr Hansen's estimated time of arrival would not have satisfied the VFR. Regardless of whether the correct time for last light was 5.55 pm or five minutes earlier, Mr Alexander was critical that Mr Hansen had given himself "no margin for error" by deciding to commence a flight so close to last light without current weather forecasts. In Mr Alexander's opinion, this was in breach of regulation 239 of the 1988 Regulations and ENR 1.10 which set out the steps a pilot in command should take before commencing a flight.

36. Mr Alexander produced copies of weather reports from the Bureau of Meteorology for 23 and 24 April 2011 for Area 21, which covers forecasts for the South Coast as far north as Sydney and as far south at Cooma. Relevantly, the report for 24 April 2011 at 1pm noted "ISOLATED SHOWERS SEA/COAST N OF YMRY" (meaning north of Moruya) and "SHRA" which means moderate showers of rain. Mr Alexander gave evidence that Mr Hansen should have formulated a plan that would anticipate the possibility of the weather closing in given the forecast. He did not do so.
37. Mr Hansen diverted from his proposed destination when faced with extreme weather conditions near Sussex Inlet about 35 minutes into the flight. Mr Alexander was of the view that this was appropriate. However, according to Mr Alexander, Mr Hansen's failure to ensure he was able to find a suitable helicopter landing site at least 10 minutes before last light was in breach of his duty in respect of the safe navigation and operation of his aircraft. Subregulation 92(1)(d) of the 1988 Regulations allows a pilot to land on a suitable helicopter landing site if compelled to do so by, for example, deteriorating weather or impending darkness. Mr Alexander identified a number of helicopter landing sites between Sussex Inlet and Batemans Bay which were potentially suitable for landing. In Mr Alexander's opinion, Mr Hansen's failure to appropriately consider and affect a landing before Malua Bay was in breach of his duty under regulation 224 of the 1988 Regulations. According to Mr Alexander the overcast weather, which was likely to bring the time of last light forward, the headwinds on the return flight and Mr Hansen's lack of experience and equipment for night flying, were relevant matters that Mr Hansen should have had considered when making his decision about how to manage his flight after the diversion.
38. Mr Alexander was cross-examined at length. He accepted that Mr Hansen would have had little time to make a decision to land the aircraft after the diversion as once he reached Ulladulla there were no suitable options for landing until Batemans Bay. Notwithstanding this, Mr Alexander gave evidence that the decision of Mr Hansen to attempt a landing at Malua Bay after or at the time of last light in overcast weather conditions where there was no artificial lighting on or near the site and he had no night flying equipment or experience was "foolhardy". In Mr Alexander's opinion, poor flight planning and poor judgment after the decision to divert in attempting to execute a landing on the Malua Bay helipad was in breach of Mr Hansen's duties and contributed to the accident. Mr Alexander also raised concerns that Mr Hansen did not appear to recognise these issues and continued to assert he had made no errors.
39. Mr Hansen disputes Mr Alexander's opinions.

Mr Hansen

40. Mr Hansen gave evidence that he purchased a Robinson R22 model aircraft, which is a two seater single engine aircraft, and began to learn to fly in February 2004 through Mr Miller at Bankstown Helicopters. He obtained his private pilots licence in June 2004 and purchased a second helicopter, the Robinson R44, in 2006. This aircraft has four seats and is more powerful than the Robinson R22. Until the accident, Mr Hansen used this helicopter to commute between his various properties on the South Coast and Ingleburn. He rarely carried passengers other than his wife.
41. Mr Hansen has undertaken Biennial Flight Review, as required by CASA, and has reportedly been certified as competent. There was no evidence of any other regulatory or safety concerns having been raised against Mr Hansen by CASA prior to the notice to show cause issued by

CASA on 5 September 2011.

42. Prior to the accident it was Mr Hansen's normal routine to work at Ingleburn with his son on Mondays. He would fly to Ingleburn on Monday mornings and return on Monday evenings to either Berry or Malua Bay. He would usually fly to his property at Kangaroo Valley on Wednesday and would generally spend Thursdays on his property at Berry or Malua Bay. He and his wife would fly to Eurobodalla on Fridays and spend part of the weekend at this property, returning to Berry on Saturday afternoon.
43. Mr Hansen gave evidence that he obtained a four day weather forecast from the Bureau of Meteorology on Friday, 22 April 2011. He flew to the Eurobodalla property the following day and watched the forecasts on the television on Friday and Saturday nights from the Eurobodalla property. According to Mr Hansen, he and his wife decided to spend the whole weekend at Eurobodalla and return to their home at Berry on Sunday rather than Saturday afternoon.
44. On the day of the departure, the weather at Eurobodalla was "reasonably clear". Mr Hansen did not obtain an updated forecast on 24 April just before the trip as he had been unable to obtain access to the internet on that day. Mr and Mrs Hansen drove to Mogo for lunch (near Batemans Bay) and on his return, Mr Hansen tried to access the internet through the local internet cafe. He was usually able to do this but the internet cafe he frequented was closed because it was a Sunday. Mr Hansen said that he was not concerned about being unable to obtain an up-to-date forecast because the other forecasts had been clear, the weather was overcast but otherwise clear at Eurobodalla and at Batemans Bay on the day of his departure and he was confident the weather was "flyable".
45. When asked about whether he had needed to use the radio to obtain weather forecasts during a flight, Mr Hansen said that this had not been necessary because in the past he had been able to obtain weather forecast for all flights. This was the first flight that he did not have a forecast before departure. Notwithstanding this, Mr Hansen stated he was not concerned because he had formed the view that, based on his observations and the previous forecasts, the weather conditions would allow him to return within an hour if he had chosen to do so.
46. Mr Hansen said that he planned to leave Eurobodalla that afternoon at 4:45 pm but he and Mrs Hansen were delayed and they did not leave until 5 pm. Mr Hansen gave evidence that he "did not really want to get away any later than... 4.45" and "would have preferred to leave earlier".
47. According to Mr Hansen, the trip from Eurobodalla to Berry usually took about 50 minutes but he estimated that the trip would be shorter given there was a tailwind from the south. He estimated that they would arrive at their destination by 5:45 pm, 10 minutes before last light, which he calculated as 5:55 pm.
48. As he and Mrs Hansen approached Ulladulla about 30 minutes into the flight, Mr Hansen said that he noticed dark clouds to the north. He continued to proceed flying north but when the storm worsened, he decided to turn back. This was near Sussex Inlet and it was about 5:35 pm.
49. The issue of what Mr Hansen should have done after making the decision to divert the flight was the subject of examination by the CASA investigation officers. In particular, Mr Hansen was questioned about whether he should have attempted to land earlier than at his helipad at Malua Bay This issue was also dealt with in Mr Hansen's statement and was the subject of questioning in these proceedings. Given the importance of the issue, it is relevant to set out Mr Hansen's evidence in this regard in some detail.
50. In his interview with CASA officers on 5 December 2011, Mr Hansen said that he was familiar with the track from Eurobodalla to Berry as he had been flying this route over the previous 12 months and would have done about 100 flights between these two destinations. After he diverted the flight, Mr Hansen considered the possibility of landing at Ulladulla and identified cattle properties and beaches as possibilities but expressed concern about landing on these sites given the time of day and the inclement weather conditions. Mr Hansen rejected the notion of landing at the helipad at the Ulladulla Hospital because there were "so many wires and trees on the approach". After Ulladulla, Mr Hansen proceeded south with the "general intent of landing at the pad at Malua Bay" but stated that "on the way down, I was certainly considering any alternatives that were obvious there and were possibilities". When asked about whether he considered landing at the Batemans Bay Hospital helipad, Mr Hansen said "I was sufficiently

close to our own pad that I felt this was a satisfactory solution". Mr Hansen also told investigators that he had an emergency to confront, given Mrs Hansen's medical condition and the fact that she would find it difficult to walk on anything other than flat ground.

51. Mr Hansen's statement filed in these proceedings was consistent with his statement to investigators about why he discounted landing at Ulladulla. He further stated that he reset the GPS to Malua Bay when he was flying past Ulladulla and was confident that he would be able to land safely at this site. When Mr Hansen approached Batemans Bay, he commenced his descent towards Malua Bay over the water but at an altitude that would allow him to glide towards the landing. He did not mention any consideration of landing at Batemans Bay in his statement.
52. Mr Hansen gave evidence at the hearing about his consideration of these matters. He said that after he turned around at Sussex Inlet he travelled towards Ulladulla and by the time he was near Ulladulla it was about 5:43 pm. When questioned about his decision-making at this time by his lawyer, Mr Hansen responded as follows:

And you had a decision to make as you reached the Ulladulla region which could have been to go looking here and there for somewhere to look in Ulladulla - - -?---Yeah, yeah, but - - -

What was going on in your mind then please?---Senior Member, what was going on in my mind there is time, and landing possibilities, and I could've spent a lot of time fiddling around trying to ascertain a precise landing area in the bad weather area or I could've flown to the better weather, which was south – it was lighter to the south, and proceed to look at possibilities under those terms. I was also aware of the fact that the end of the day was coming and I had looked at the possibility of going back to Malua Bay from the point of view of how much time would be involved and I figured that the time – if I got on with the job – it would take time to the extent that we'd arrive there about 1755 and as that actually happened, it was probably another five minutes after – after that that we got into the area. But we have time problem in trying to work out whether to go locally in bad weather conditions or to proceed further south and look for possibilities on the way, but with the end possibility that we could land at Malua Bay. But we weren't bent on going to Malua Bay, it was just better weather that way and we were looking for spots on the way down.

53. Notwithstanding this evidence that Mr Hansen believed they would land at Malua Bay by 5:55 pm, he later gave evidence that Malua Bay was 40 nautical miles from Ulladulla and they were travelling at 100 nautical miles per hour. It therefore would have taken Mr and Mrs Hansen 24 minutes to arrive at Malua Bay, which would have made their estimated arrival time at about 6:07 pm rather than 5:55 pm.
54. Mr Hansen was cross-examined as to why he did not attempt an earlier landing. In his statement of 28 August 2012, Mr Alexander identified 17 sites between Sussex Inlet and Malua Bay that would have qualified as suitable helicopter landing sites under CASA guidelines set out in the Civil Aviation Advisory Publication 92-2(1). Several of the sites identified were close to the turnaround point and Mr Hansen said that these sites were not considered by him because he was flying south at the time and had flown past these sites. Mr Hansen said that he had initially considered landing at Milton because he had landed at the Milton hospital helipad before but because he did not know the other areas in Milton and was concerned there were trees and wires near the helipad, he made the decision not to proceed in that direction. He flew towards the coast and did not fly over Milton. Mr Hansen agreed that he flew over the Mollymook region but did not consider landing on any of the sites identified by Mr Alexander in his statement because the weather was poor and because he was unfamiliar with the area. Mr Hansen said that he was more familiar with Ulladulla because he had lived there but he did not consider landing at Ulladulla because it was dark on the ground and there was the threat of wires he could not see.
55. Thereafter there were no suitable landing sites identified by Mr Alexander until Batemans Bay where two sites were identified, one being the Batemans Bay Hospital helipad and the other being a field west of Batemans Bay. Mr Hansen said that the street lights were on as he approached Batemans Bay. He decided against landing on the Batemans Bay helipad site

because he had not been there before and did not know where the wires were. He said that he decided to land at Malua Bay and not Batemans Bay because it was the "most threat-less landing that I could conceive at that point of time". He was more familiar with the Malua Bay helipad and was unfamiliar with the Batemans Bay helipad.

56. As Mr Hansen proceeded to descend towards the Malua Bay site, he was using the altimeter to gauge the height of the aircraft. He noticed that the altimeter was "juddering" but did not think this was cause for concern. He looked at the altimeter which showed that the aircraft was at a height of between 100 and 150 feet as he glided to what he believed was the Malua Bay helipad. Mr Hansen said that he could see the contour of the headland but nothing beneath and he could not see the surface of the water. Mr Hansen described what happened just before the accident in the following passage of the transcript:

Is that you couldn't see at that stage?---I could see over – over sea, but I could not see the face – the surface of the water, that's what I'm saying to you, that's the blackness I'm talking about. There was enough blackness that I could not see the surface of the water, therefore I didn't know I was that close to the water.

But that means you couldn't see?---No, I could see – I could see the broad parameters but I could not see the surface of the water, and when the error in the instrument surfaced I – I didn't know that was there until we hit the water.

But you knew that you couldn't see the surface of the water, so therefore your visibility was impaired, at that point of time?---I knew – I knew we couldn't see the surface of the water.

Why didn't you pull out?---Um, look, I had 150 feet above sea level and I'm on a – a landing run. When you commit for a landing you're trying to commit to land, all right. Now, you can pull out if you've got to pull out but I didn't get the chance.

Ms Keryl Egan

57. Ms Egan, a clinical psychologist, prepared a report dated 5 July 2012. She was asked to assess the likelihood of Mr Hansen "engaging in conduct any way similar to that which occurred at the time of the fatal helicopter crash on 24 April 2011". Ms Egan concluded as follows;

Mr Hansen is a sober, careful, capable pilot and engineer. Circumstances of the crash are almost certain never to be repeated and were they to do so he would not react in the same manner in any event. Hence, removal of his licence will not assist safety, but be no more than punishment issued by an authority whose interest is not to punish, but promote safety. There is no case demonstrated with safety is in issue as Mr Hansen did not take any action outside the law in any event (by reason of the section 30 exoneration).

58. Ms Egan also undertook psychometric testing and concluded as follows:

In interviews and on objective psychometric testing Mr Hansen demonstrates stability, practicality and resilience. He manages stressful situations effectively and clearly has a normal capacity to plan and organise. He has good impulse control as well as having the flexibility to adapt to changing circumstances.

Such stability, calmness under pressure and effective cognitive abilities suggest that he would have considered all the elements in the emergent and complex situations which led to the accident.

In my opinion, given Mr Hansen's slow, deliberate style, his level of effective functioning in the average range and his detailed account of what happened, is most likely that he brought a good or reasonable level of planning, reasoning and judgment to the changing situation in which he found himself.

He impresses as neither impulsive or overconfident and would most likely to have considered his options in the same carefully deliberate manner with which he operates in interview and assessment.

Mr William Miller

59. Mr Miller, chief flying instructor from Bankstown Helicopters, prepared a report dated 13 February 2013. According to Mr Miller, Mr Hansen approached him after the accident and discussed the accident with him. Mr Miller gave evidence that he was able to identify the issues that required retraining, which included a lack of planning of the trip and an appropriate assessment about when he was to arrive at his destination. While these issues were not uncommon, Mr Miller noted that this needed to be reinforced for Mr Hansen. Mr Hansen has undertaken 31.4 hours in dual instruction and 13 days of theory instruction since the accident. Mr Miller reported as follows;

I regard Vic as having demonstrated practical and theoretical skill to the level where he is a fit person to have his PPL(H) reissued to him or for him to be immediately presented to the CASA for a PPL(H) flying test.

DID MR HANSEN FAIL IN HIS DUTIES AS THE HOLDER OF A PRIVATE PILOT LICENCE?

60. CASA contends that Mr Hansen failed in his duties as a holder of a private pilot's licence in respect of matters affecting the safe navigation and operation of his aircraft. According to CASA, the parameters of that duty are informed by the legislative framework. The accident on 24 April 2011 was the result of Mr Hansen's failure to adequately plan and manage his flight and, in particular, to continue with his plan to land at Malua Bay when it was likely he would be landing after last light. CASA contends that Mr Hansen's conduct was in breach of regulations 174A(2), 174C(1)(a), 224(2A), 233(1)(a), 239(1)(a) and the VFR and Flight Planning Rules.
61. Mr Hansen denies that he breached these regulations and contends that he discharged his obligations in a practical and thoughtful manner having regard to the difficult circumstances created by the extreme weather conditions and his wife's disability. Mr Hansen admits that the closing stages of his flight were conducted at night but relies on section 30 of the Act which provides:

In any proceedings for an offence against this Act or the regulations, it is a defence if the act or omission charged is established to have been due to extreme weather conditions or other unavoidable cause.

62. Mr Hansen also relies on section 10.3 (1) of the *Criminal Code 1995* (Cth) which provides:

A person is not criminally responsible for an offence if he or she carries out the conduct constituting the offence in response to circumstances of sudden or extraordinary emergency.

63. The proceedings before the Tribunal are not criminal proceedings or proceedings for an offence under the Act or the regulations, although I accept these provisions are relevant to assess the breaches alleged and whether Mr Hansen's actions were permissible given the circumstances. I also accept the submission of CASA that the question of whether there have been breaches of the Act or the regulations, and in particular the nature and extent of those breaches, will be relevant to the question of whether Mr Hansen has failed in his duty with respect to the safe navigation and operation of an aircraft.
64. Having regard to the evidence of Mr Hansen and Mr Alexander and the undisputed facts set out below, I am satisfied that Mr Hansen breached regulations 174 A(2), 174C(1)(a), 224(2A), 239(1)(a) of the 1988 Regulations and that the nature and extent of these breaches were such that Mr Hansen failed in his duty with respect to the safe navigation and operation of his Robinson R44 aircraft. My reasons follow.
65. Mr Hansen did not obtain a current weather forecast before his departure. His last official

forecast was three days prior to the proposed departure and Mr Hansen's evidence was that this was the first time he had commenced a flight without such a forecast. Under regulation 239(1)(a) a pilot in command must study all available information appropriate to the intended operation including a careful study of current weather reports and forecasts for the route to be followed. Mr Hansen relied on ENR 1 .10 'Flight Planning' paragraph 1.2.2 and his view about the weather at the time of departure thathe would be able to safely return within one hour of departure.

66. Paragraph 1.2.2 of ENR 1.10 provides that the pilot must be satisfied the weather is sufficiently clear at the point of departure, and within the region en route up to 30 minutes of flying time, to permit a safe return within the hour. Once commenced the flight may only continue if a suitable forecast is obtained from the intended destination within 30 minutes after departure. It is clear from regulation 239(1)(a) and the published guidance that the onus is on the pilot in command to make appropriate enquiries about the weather conditions as part of the planning process, not just at the point of departure but on the planned route and destination. If there is bad weather on the planned route the pilot would therefore be able to make a decision not to fly, to take a different route, to delay the flight or to leave earlier.
67. Mr Hansen had travelled to Mogo from Eurobodalla on Sunday which is about 45 minutes north of Eurobodalla by car and a short distance from Batemans Bay. According to Mr Hansen the weather was reasonably clear at both Mogo (albeit earlier in the day) and Eurobodalla, and he therefore formed a view that the weather was "flyable". It is unclear how Mr Hansen could have been "satisfied" about the condition of the weather as far north as Ulladulla, which would have been about 30 minutes into his flight, when he had no information about this yet knew conditions were overcast. If Mr Hansen had been able to access the internet on 24 April 2011, he would have noted the forecast of showers on the coast and may have anticipated the possibility of the weather closing in, as it ultimately did north of Batemans Bay. Arguably, he should have anticipated this from his own observations. While Mr Hansen said there was no rain, he agreed the weather was overcast. The failure to factor in the possibility of bad weather developing, particularly at the end of the day, in circumstances where he had no current weather forecast, evidences a lack of adequate care in his planning.
68. The importance of this failure must be considered in light of Mr Hansen's delayed departure. Mr Hansen gave evidence that he would have "preferred" to leave no later than 4:45 pm. He did not elaborate on the reasons why but the undisputed facts present a concerning scenario.
69. First, the weather was overcast and Mr Hansen did not have an updated forecast to provide him with sufficient detail about what was likely to happen with the weather at the end of the day. Moreover, this was the first time that Mr Hansen had commenced a flight without an updated forecast and it is not unreasonable to expect that this would lead a prudent pilot to take a more conservative approach. Secondly, Mr Hansen had calculated last light at 5:55 pm and estimated his trip, which usually took about 50 minutes, to be 45 minutes because of the tailwind. As Mr Alexander observed, Mr Hansen left no margin for error in his calculations and apparently took no account of the possibility that the overcast weather may affect visibility at the time of the estimated time of landing. Thirdly, it was Mr Hansen's practice at that time of the year and intention to leave no later than 4:45 pm yet he left 15 minutes later. This delay is significant. Fourthly, Mr Hansen knew he was not licensed to fly beyond last light and, importantly, he had no instruments to assist with night flying such as landing lights. Relevantly, his Robinson R44 aircraft was only certified for day visual flight.
70. The fact that Mr Hansen encountered bad weather just over halfway through his journey was unexpected but could have been adequately managed if Mr Hansen had properly planned the flight. Mr Hansen should have left earlier, given his knowledge of the contingencies and uncertainties, or not at all. He left at 5 pm even though he knew this was later than he had planned. Mr Hansen was sufficiently experienced to understand the risks but he had either become complacent or overconfident because of the frequency of flying these short trips. Mr Hansen did not admit to either and maintained that his planning was adequate. Nonetheless, he consulted with Mr Miller after the accident and Mr Miller identified planning as an issue that required further training. Mr Alexander, who is an experienced helicopter pilot, was critical of

Mr Hansen's planning and was of the opinion that Mr Hansen failed to discharge his duty in this regard.

71. This failure had serious repercussions. Mr Hansen was left with few options and this lack of planning placed pressure on him to find an emergency landing site before last light in circumstances where he also needed had to consider Mrs Hansen's condition and mobility. Mr Hansen created this emergency by the delay in his departure and lack of planning. I am therefore satisfied Mr Hansen breached regulation 239(1)(a) and thereby failed in his duty with respect to a matter affecting the safe operation of his aircraft.
72. The second matter relates to Mr Hansen's alleged failure to adequately manage his flight after the diversion by finding a suitable landing site before attempting the landing at Malua Bay. CASA contends this was in breach of regulations 174A(2), 174C(1)(a) and 224(2A) of the 1988 Regulations.
73. Mr Alexander identified 17 possible sides on which Mr Hansen could have landed after the turnaround but before Malua Bay. I accept Mr Hansen's evidence that it would not have been practical for him to use the Cudmirrah, Manyana and Lake Conjola sites as these sites were very close to the point of turnaround, by which time Mr Hansen was travelling south and had flown past these sites. Mr Hansen's explanation as to why he did not consider landing at the Milton Hospital helipad is less clear. According to his statement and his evidence, Mr Hansen made a decision to fly away from Milton towards the coast soon after the turnaround because he knew there were power lines near the site. However, he also said he had landed at Milton Hospital before and this site was familiar to him. Mr Hansen flew over Mollymook and Ulladulla but discounted landing at these locations because of concerns about the weather, the light, power lines and the fact that he was unfamiliar with landing at any of these sites. Mr Hansen said that he did not want to land on cattle properties and beaches but the Mollymook and Ulladulla regions had a number of available sites near the town comprising playing fields and golf courses. At Ulladulla there were two large fields (one 150m x 170m and the other 160m x 170m) on the outskirts of the town near bushland.
74. Mr Hansen said he was concerned about Mrs Hansen's mobility. This is understandable but a number of the sites identified at Mollymook and Ulladulla were relatively flat and close to assistance. While landing at either of these locations was not ideal or convenient, by the time Mr Hansen reached Ulladulla it was 5:43 pm and, on his own calculations, last light was in 12 minutes. The weather was overcast which was likely to exacerbate difficulties in visibility as last light approached. Mr Hansen's helicopter was not equipped with night flying instruments or lights. He knew that there were no suitable landing site after Ulladulla until Batemans Bay but said that he did not want to waste time at Mollymook or Ulladulla looking for a suitable site. Reaching Ulladulla was a critical point of the flight. According to Mr Hansen, Malua Bay was 40 nautical miles from Ulladulla. Mr and Mrs Hansen were flying into a headwind but even assuming they were able to travel at 100 knots, it would have been impossible for Mr Hansen to land at Malua Bay before last light as the return flight would take at least 24 minutes. Mr Hansen must have known this yet he did not admit this at any stage of the investigation or during the proceedings. When giving evidence, Mr Hansen agreed it would take 24 minutes to travel 40 nautical miles but stopped short of admitting he was in error in estimating he would arrive at Malua Bay at 5.55pm.
75. In his evidence before the Tribunal, Mr Hansen said that he knew if he "got on with it" he would land "about 17.55" or 5 minutes later and "this is what happened". This is not what happened. According to eyewitness statement from the investigation, the accident occurred at about 6:15pm. All three witnesses who gave statements to the police noted that it was dark at the time of the crash. They made emergency telephone calls. One witness estimated that he was made a telephone call to emergency about 2 to 3 minutes after the crash. The emergency incident log for 24 April 2011 records a call being received by this witness at 6:18pm. A second witness stated that he heard a helicopter approaching the Lilli Pilli Headland at about 6pm. He later saw the crash and asked his brother Christian to telephone emergency. The incident log shows that this call was made at 6:22pm. I therefore find that the accident was more likely to have occurred at about 6:15 pm rather than 10 minutes earlier as Mr Hansen suggests. This is

not only consistent with the evidence of eyewitnesses but the evidence of Mr Hansen himself who estimated that the 40 nautical mile trip from Ulladulla to Malua Bay would take about 24 minutes. When the headwind is taken into account it is probable that the trip would have taken longer, making the time of arrival at Malua Bay closer to 6.15pm than 6.07pm.

76. Mr Hansen is either mistaken or not being truthful. He may have miscalculated the time it would take to return to Malua Bay under the pressure of the situation and may still be confused about this. Alternatively, he may be mistaken about his estimate of the time when they were at Ulladulla. However, Mr Hansen was very clear about this and this evidence is consistent with his location at the estimated turnaround time of 5:35pm and the distance travelled since this time.
77. Arguably the time difference is not material as either way Mr Hansen was going to land at Malua Bay after last light and well after the 10 minute buffer required under the Visual Flight Rules. Mr Hansen either knew this at the time or should have known this.
78. Mr Alexander is of the opinion that Mr Hansen should have landed at or before Ulladulla as this would have ensured he would land before last light. Failing to land before last light is not merely a technical breach of the rules but is a serious breach given the circumstances of this case. Flying at night when the pilot is not trained or licensed to do so and the aircraft is not equipped for night flying is a serious safety concern, particularly with inclement overcast weather.
79. I accept the evidence of Mr Alexander that Mr Hansen should have taken action to find a suitable helicopter landing site at or before Ulladulla to ensure he was able to land safely before last light. He had 20 minutes to find a suitable site in the region after his turnaround at 5:35 pm.
80. Even if it is accept that Mr Hansen had legitimate concerns about landing in Ulladulla or Mollymook, to continue to fly down the coast with the intention of landing at Malua Bay was, in the words of Mr Alexander, foolhardy. Mr Hansen had the option of landing at Batemans Bay which was 5 minutes closer and well lit with a large open helipad landing site for the Hospital. Mr Hansen's reasons for discounting this site were not convincing. Photographs of the site show it is on flat ground north of Batemans Bay adjacent to a sea break wall in a large open space. It is not near buildings or trees.
81. Once Mr Hansen passed Ulladulla, he made the decision to land on his helipad at Malua Bay. This is clear from the statement he filed in these proceedings and his statement to investigators. Based on his evidence I find that Mr Hansen did not seriously consider landing at Batemans Bay and chose to land on the small helipad on his property which was on a dark headland at least 10 minutes, but in my view more likely 20 minutes, past last light without any visual aids or training in night flying.
82. There is no evidence that the aircraft crashed because of a technical fault. While it is not in dispute that the altimeter was showing the wrong altitude, Mr Hansen flew the aircraft into the sea because he could not see the headland or the surface of the sea and he was relying on the altimeter to guide him to the correct height to glide towards his helipad. All he could see was the contour of the headland and it is relevant to note that all eyewitnesses said the Lilli Pilli Headland was dark both before and at the time of the crash. According to the Visual Flight Rules (ENR 1.2) a VFR flight may only be conducted if the pilot is able to navigate by visual reference to the ground or water. Mr Hansen could not do this, on his own admission, and this is why he did not identify the problem with the altimeter before the crash.
83. The failure of Mr Hansen to manage his flight and to find a suitable landing site before last light resulted in him breaching the Visual Flight Rules. He was thereby not only in breach of regulations 174A(2), 174C(1)(a) and 224(2A) but in breach of his duty to safely navigate and operate his aircraft.
84. Mr Hansen raised two issues in defence of this alleged breach. The first was the submission that Mr Hansen had not breached any regulation because of the extreme weather conditions he faced near Sussex Inlet which provided him with a defence or, as Ms Egan put it, “exoneration”. The second issue was the threat or emergency created by Mrs Hansen's condition affected the obligation and/or opportunity to land on a suitable helicopter landing site. In my view, neither of these matters raises a reasonable excuse or defence.
85. The extreme weather conditions did not cause the breach; it was Mr Hansen's lack of planning.

Furthermore, Mrs Hansen's condition was known to Mr Hansen before departure and was a relevant matter that he should have taken into consideration in his planning. Mrs Hansen's condition did not create an emergency or threat. I accept that her condition may have limited the sites on which Mr Hansen could conveniently land however sites were identified that were flat and, therefore, could have been negotiated by Mrs Hansen, given her condition. There is no doubt that Mr Hansen was considering his wife's condition and did not want Mrs Hansen to have to walk too far. However, this could have been overcome by Mrs Hansen staying with the helicopter after it landed and Mr Hansen arranging assistance. It was clearly more convenient for Mrs Hansen if Mr Hansen were able to land at the Malua Bay helipad because there was only a short walk from the helipad to their home. However, the need to avoid an inconvenience does not amount to a threat or emergency.

86. I therefore conclude that Mr Hansen failed in his duty with respect to the safe navigation and operation of his aircraft on 24 April 2011 in his planning and management of the flight.
87. There was an allegation that Mr Hansen breached regulation 233(1)(a) and Civil Aviation Order 20.11 by flying over water without a life jacket. There was dispute about whether this was in breach because there was evidence from Mr Hansen that he was gliding into the helipad over the water and this was permitted. Mr Hansen had not intended to fly over the water and it was only the unusual circumstances of the flight which resulted in Mr Hansen taking a different route. There was no evidence other than the evidence of Mr Hansen on this issue and I am therefore not satisfied that there was a breach of the regulation.

IS MR HANSEN A FIT AND PROPER PERSON TO BE THE HOLDER OF A PRIVATE PILOT LICENSE?

88. As noted by the parties, the term 'fit and proper' is not defined in the Act or the Regulations. Its meaning is nonetheless informed by the legislative context (*Australian Broadcasting Tribunal v Bond* [1990] HCA 33; (1990) 94 ALR 11) and, in this case, by the responsibilities, functions and duties of a licence holder under the Act and the Regulations (*Re Taylor and Department of Transport* (1978) 1 ALD 312; followed in *Re Griffiths and Civil Aviation Authority* (1994) 34 ALD 554 and more recently in *Quadrio and* ***Civil Aviation Safety*** *Authority* [2011] AATA 709).
89. In considering whether Mr Hansen is a fit and proper person to be the holder of a private pilot's licence it is relevant to examine the nature and extent of his breaches and, in particular, whether those breaches are likely to be repeated. It is also relevant to consider supervening events and the best and most current information available (*Shi v Migration Agents Registration Authority* [2008] HCA 31; (2008) 235 CLR 286, (2008) 82 ALJR 1147).
90. As already noted, Mr Hansen's failure to discharge his duty of safe navigation and operation of his aircraft involved significant breaches of the regulations which resulted in tragic repercussions. The breaches were not deliberate or wilful but at best demonstrated a serious lack of judgment on Mr Hansen's part.
91. Ms Egan opines that Mr Hansen would "not react in the same manner" in the future, which seems to acknowledge there were problems, but she has not provided detailed reasoning for the basis of her opinion. Relevantly, Ms Egan bases her conclusions on what she has been told by Mr Hansen or his lawyers. It is clear from her report that Ms Egan was told Mr Hansen would be entitled to exoneration under section 30 of the Act, that Mr Hansen could still see while flying after dark and that he was "a person caught by circumstances". She was apparently not told that Mr Hansen had left his departure later than planned, he had left no margin for error in his flight plan, he had not obtained an updated weather forecast and he had made a decision to continue flying even though he was likely to land after dark. Ms Egan's report must be considered with this in mind, given the information provided to her was not complete.
92. I therefore give little weight to Mrs Ms Egan's opinion about whether Mr Hansen's breaches will be repeated.
93. Furthermore, I am of the view that Mr Miller's evidence does not materially assist on this matter. Mr Miller provided extra training to Mr Hansen to assist him in calculating last light and flight planning but the key problem is Mr Hansen's lack of insight and judgment in two critical areas of

safety, namely adequate preparation for contingencies and managing the flight under visual flight rule restrictions. Even though Mr Hansen was proactive in approaching Mr Miller after the accident, which demonstrates some insight, Mr Hansen's evidence makes it clear that he did not, and still does not, believe he made errors. The accident was characterised by Mr Hansen as resulting from matters outside his control, such as the extreme weather conditions and the faulty altimeter.

94. When specifically asked about these matters, Mr Hansen said:

There's one question I don't suppose anybody has really asked you, which is probably relevant, and I guess it's implicit in this. Do you believe that what you did on that day – that anything you did was wrong or that you could have done anything differently?---Senior Member, when we always think backwards and consider things that have gone before, we probably have a myriad of alternatives that we would've liked to have done or we could've done alternatives. But I believe that I did the best on that day, under the requirements of that time and under my airmanship as a pilot to do everything within my power to do the right – and make the right decisions. I believe I did that. But so saying, we can all look back and say, "Well, I would rather have done this" or "I would rather have done that", but again, we look back many times with rose-coloured glasses and we don't see the problems that are associated with doing it another way. However I believe I did in the best what I could do then, but had I had my run again, I might do it a bit differently.

95. When pressed about the fact that he had left later than he had planned, Mr Hansen said:

Okay. Let me say this to you. Weather forecasts, we've all observed weather forecasts and we have all seen that sometimes it's not the same as it's been forecast. I guess, if there was any marginality in the - in the future I would be reticent to – to do any marginal flying and I would also try and leave earlier in the day so that there would be less of a threat, or less of a problem with light conditions. So I'd certainly make those changes and I would do everything that I need to do to keep on top of what – what is necessary to satisfactorily and safely fly an aircraft, which I – I believe I've been trying to do but I can see I could do some things a bit better.

96. These extracts from Mr Hansen's evidence demonstrate his inability to accept or understand the significance of his errors. In these circumstances, I cannot be satisfied these errors will not be repeated.
97. Mr Hansen submits he is of good character and is therefore a fit and proper person to hold a private pilot licence. While I do not reject this assertion of good character, as there is no evidence to the contrary, I cannot accept the submission that Mr Hansen is thereby fit and proper. Under subregulation 296 (1) (d) the question is whether "the holder of the authorisation is fit and proper **to have the responsibilities and exercise and perform the functions and duties of a holder of such an authorisation**" [emphasis added]. As observed by Perram J in ***Civil Aviation Safety*** *Authority v Central Aviation Pty Ltd* [2009] FCA 49 at [42] "it is difficult to understand, without more, how honesty might be an answer to a lack of fitness said to be constituted by incompetence". The same can be said for good character. In my view, Mr Hansen's good character is not material to the question of whether he is fit and proper to have the responsibilities of a licence holder under the Act and the regulations. What is relevant is whether Mr Hansen is willing and able to discharge those responsibilities. He must not only be technically competent but he must understand the nature and extent of those responsibilities and be able to discharge them.
98. Having regard to those responsibilities, my findings about the seriousness of the breaches and Mr Hansen's lack of appreciation of these matters, I find that Mr Hansen is not a fit and proper person to hold a private pilot licence.

HOW SHOULD THE TRIBUNAL EXERCISE THE DISCRETION IN REGULATION 269(1)?

99. Given my findings that Mr Hansen failed in his duty with respect to a number of serious matters affecting the safe operation of an aircraft and is not a fit and proper person to hold a private

pilot licence, the question arises as to how I should exercise the discretion under regulation 269(1).

100. Mr Hansen submits I should reinstate his licence subject to the precondition that he should satisfactorily complete a private helicopter pilot licence flight test. I take this to mean that the Tribunal should set aside the decision and in substitution suspend his licence subject to this precondition. I am not satisfied that this would be appropriate in the circumstances of this case. The critical issues relate to Mr Hansen's lack of judgment, preparation and inability to accept or understand his errors. These matters will not be resolved by Mr Hansen undertaking and passing a private helicopter pilot licence flight test. Mr Hansen may technically be a competent pilot but still be unsafe in his operation of an aircraft because of the shortcomings that have been exposed by the accident, the investigation and Mr Hansen's evidence in these proceedings.
101. While I note that Mr Hansen uses his helicopter to commute between his properties and it will be inconvenient and more time-consuming to travel by car, he is still able to commute. His properties are within two and a half hours of each other at the most distant points. In any event, inconvenience or extra cost does not outweigh the consideration of air safety.
102. The Act specifically provides that CASA, and therefore the Tribunal, must regard the safety of air navigation as the most important consideration. I am therefore satisfied that the correct and preferable decision in the circumstances of this case is for Mr Hansen's licence to be cancelled.

CONCLUSION

103. I affirm the decision under review.

I certify that the preceding 103 (one hundred and three) paragraphs are a true copy of the reasons for the decision herein of Ms J L Redfern, Senior Member

.....[sgd].....
Associate

Dated 27 June 2013

Dates of hearing	**6 and 7 March 2013**
Solicitors for the Applicant	**Mr S Perrier, Ferrier & Associates**
Solicitors for the Respondent	**Ms G Bennett, Civil Aviation Safety Authority**