Administrative Appeals Tribunal of Australia

McSherry and Civil Aviation Safety Authority [2014] AATA 119 (6 March 2014)

Last Updated: 7 March 2014

[2014] AATA 119

Division	**GENERAL ADMINISTRATIVE DIVISION**
File Number	**2013/4183**
Re	**Peter Damien McSherry**
	APPLICANT
And	**Civil Aviation Safety Authority**
	RESPONDENT

DECISION

Tribunal	**Deputy President K Bean** **Professor P Reilly AO, Member**
Date	**6 March 2014**
Place	**Adelaide**

The respondent's decision of 6 August 2013 is set aside and in substitution for that decision it is decided that Mr McSherry is entitled to the issue of class 1 and class 2 medical certificates, without conditions.

..... [Sgd] .....

Deputy President K Bean

CATCHWORDS

CIVIL AVIATION - Conditions imposed on class 1 medical certificate issued to applicant - Whether applicant meets medical standard 1 - Whether deep vein thrombosis and risk of bleeding as a side effect of Warfarin are safety-relevant conditions - Negligible risk of an adverse event having safety consequences occurring - Conditions not likely to reduce applicant's ability to perform as a commercial helicopter pilot - Decision under review set aside.

LEGISLATION

Civil Aviation Act 1988, ss 9A and 20AB

Civil Aviation Safety Regulations 1998, regs 11.056, 67.015, 65.150, 67.155 and 67.180

Civil Aviation Regulations 1988, reg 5.04

CASES

Re Window and Civil Aviation Safety Authority [1999] AATA 525; (1999) 56 ALD 316

Re Hall and Civil Aviation Safety Authority [2004] AATA 21

REASONS FOR DECISION

Deputy President K Bean
Professor P Reilly AO, Member

6 March 2014

INTRODUCTION

1. The applicant, Mr McSherry, is a qualified helicopter pilot. Until early 2013, he operated a business, currently known as South Coast Helicopters Pty Ltd, offering charter flights to paying customers. However, on 20 December 2012, the respondent, the Civil Aviation Safety Authority (**CASA**), made a decision to impose certain conditions on Mr McSherry's class 1 medical certificate which is a necessary accompaniment to the use of a commercial helicopter pilot licence. The conditions imposed on Mr McSherry's class 1 medical certificate had the consequence that Mr McSherry could no longer operate his charter flight business.
2. Mr McSherry made a subsequent application for renewal of his medical certificates in 2013, and on 6 August 2013 **CASA** made a further

decision in identical terms to the decision of 20 December 2012, imposing the same conditions on his class 1 medical certificate.

3. There is no dispute that it is the later decision, that of 6 August 2013, which is the operative decision for our purposes and it is that decision which is the subject of the current proceedings and our decision.[1] For completeness, we note that Mr McSherry's earlier application (2013/2154) for review of **CASA**'s decision of 20 December 2012, was dismissed with the consent of both parties on 8 November 2013.
4. In broad terms therefore, the main issues before us are whether Mr McSherry should be granted a medical certificate allowing him to fly helicopters commercially, and whether it is necessary to impose any conditions on that certificate.

FACTUAL BACKGROUND

5. The factual background to the matter is not in issue and is summarised below.
6. Mr McSherry was first granted a private helicopter pilot licence on 16 August 2004 and was granted a commercial helicopter pilot licence on 2 November 2005. He subsequently held both private and commercial helicopter pilot licences, together with unrestricted medical certificates allowing him to use those licences, until 20 December 2012, when the decision referred to above was made. Although Mr McSherry continues to hold both private and commercial helicopter pilot licences, since December 2012 he has been unable to fly commercially as a result of the conditions imposed on his class 1 medical certificate.
7. On the material before us, it appears that Mr McSherry and his wife established their helicopter charter business during 2006, and purchased helicopters at significant expense in April 2004 and October 2006.
8. In September 2006, Mr McSherry and his wife travelled overseas to study a number of helicopter charter businesses and investigate several aircraft for sale *"with a view to expanding the business"*.[2] For at least three hours during their flight from Ireland to Singapore, Mr McSherry says that his wife slept with her legs lying *"over the top and inner part* (sic) *my upper right thigh"*. On disembarking in Singapore, Mr McSherry *"felt one very sharp and excruciating stab of pain in my right calf muscle which lasted less than a second"*,[3] but had no further symptoms at that time. However, on 5 November 2006, Mr McSherry flew one of his helicopters from Strathalbyn in South Australia to Moorabbin Airport in Victoria for scheduled maintenance. He says that toward the end of the return flight, on 7 November, he *"noticed a heavy feeling in my right calf muscle"*.[4] After he had landed and left the helicopter, he noticed that his *"right leg was painful to stand on and my right calf muscle was swollen and hot to touch"*.[5] A short time later, he was diagnosed as suffering from a right leg deep vein thrombosis (DVT) and also pulmonary emboli. On 8 November 2006, he was admitted to Flinders Medical Centre for anti-coagulant treatment.[6] Mr McSherry says that as a result of the DVT, he immediately ceased all flying and promptly advised **CASA** of what had occurred. He was discharged from hospital after five days.
9. **CASA** subsequently sought further information from Mr McSherry about his condition and its management, which Mr McSherry supplied, and between 21 March 2007 and 20 December 2012, Mr McSherry continued to hold unrestricted class 1 and class 2 medical certificates issued by **CASA** on an annual basis, which, in conjunction with his licences, allowed him to continue to fly as a commercial helicopter pilot, as well as privately. It appears that these certificates were issued following review by **CASA** of medical examination reports relating to Mr McSherry, reports from his treating specialist, Dr McRae, and reports on his blood clotting susceptibility, as measured by what are known as "INR" or International Normalised Ratio levels.
10. However, in the latter part of 2012, Mr McSherry's case was apparently referred to **CASA**'s complex case management review panel.[7] As alluded to above, on 20 December 2012, **CASA** issued Mr McSherry with class 1 and class 2 medical certificates valid for 12 months. However, the class 1 medical certificate was subject to the following conditions:

(If passengers are not carried)
You will be required to measure your INR on a 'near patient' testing system (such as CoaguChek S) no more than 90 minutes prior to the flight and only fly if the INR is within the target range (2-3). The INR should be recorded in the Log Book. The Log Book should be reviewed at each medical examination. An electronic download of the recorder is to be provided at each medical examination.
If the INR is within 2-3, the flight may be undertaken.
(If passengers are carried)
You will be required to measure your INR on a 'near patient' testing system (such as CoaguChek S) no more than 90 minutes prior to the flight. The INR should be recorded in the Log Book. The Log Book should be reviewed at each medical examination. An electronic download of the recorder is to be provided at each medical examination.
The flight is to be conducted with another pilot on board. The other pilot must be fully qualified to carry out the sortie in question.[8]

11. As we have indicated above, the same conditions were imposed on Mr McSherry's class 1 medical certificate issued on 6 August 2013.[9]
12. For completeness, there is no dispute between the parties that Mr McSherry has suffered no recurrence of DVT and that his INR levels have remained stable since he commenced anti-coagulant therapy. There is also no dispute that, apart from the DVT episode referred to above, he is otherwise in good health.
13. Having explained the factual background to the matter, we will now outline the applicable legal framework before identifying the issues and addressing those issues by reference to the evidence before us.

THE LEGAL FRAMEWORK

14. The starting point in setting out the applicable legal framework is s 9A of the *Civil Aviation Act 1988* (the Act), which requires **CASA**, in exercising its powers and performing its functions, to regard the safety of air navigation as the most important consideration. Where, as here, the Tribunal is reviewing a decision made by **CASA** under the Act, that obligation also applies to this Tribunal.
15. It is also relevant to note that, as a result of the applicable statutory regime, it is not sufficient for a pilot to simply have a pilot licence. Both s 20AB(1) of the Act and the *Civil Aviation Regulations 1988* (CAR), by reg 5.04, require the holder of a pilot licence to also hold a current medical certificate appropriate to that licence. In the case of a commercial pilot licence (helicopter), a class 1 certificate is appropriate and, in the case of a private pilot licence (helicopter), either a class 1 or a class 2 certificate is appropriate.[10]
16. The effect of reg 67.180 of the *Civil Aviation Safety Regulations* (CASR) is that **CASA** must issue a medical certificate to an applicant if the applicant meets the requirements of CASR reg 67.180(2). Only para (e) of the sub-regulation is relevant to this matter and it provides as follows:

...

(2) For subregulation (1), the requirements are:

...

(e) either:

(i) the applicant meets the relevant medical standard; or
(ii) if the applicant does not meet that medical standard—the extent to which he or she does not meet the standard is not likely to endanger the safety of air navigation;

17. In order to meet medical standard 1, and thus qualify for the issue of a class 1 medical certificate, an applicant must satisfy the criteria in Table 67.150 of the CASR. Three items from that table are relevant to this matter, including the following:

Abnormalities, disabilities and functional capacity

1.1 Has no safety-relevant condition of any of the following kinds that produces any degree of functional incapacity or a risk of incapacitation:

(a) an abnormality;
(b) a disability or disease (active or latent);
(c) an injury;
(d) a sequela of an accident or a surgical operation

1.2 Has no physical conditions or limitations that are safety-relevant
1.3 Is not using any over-the-counter or prescribed medication or drug (including medication or a drug used to treat a disease or medical disorder) that causes the person to experience any side effects likely to affect the person to an extent that is safety-relevant.

Items 2.1 to 2.3 of Table 67.155 pertaining to medical standard 2, which applies to the issue of class 2 medical certificates to holders of private pilot licences, are relevantly identical in their terms.

18. In accordance with CASR reg 67.015, a condition is *"safety-relevant"* if it reduces, or is likely to reduce, the ability of a person to exercise the privileges conferred by a relevant licence. It is also relevant to note that CASR reg 11.056 allows **CASA** to grant an authorisation, including a medical certificate, subject to any condition that **CASA** is satisfied is necessary *"in the interest of the safety of air navigation"*.
19. As to the meaning of the term *"likely"* in this context, both parties accepted that this should be construed consistently with earlier Tribunal decisions which have held that an event is *"likely"* if there is a real or substantial and not remote risk that it will occur.[11]

THE ISSUES

20. The parties also agreed it was appropriate for the Tribunal to approach its task by addressing each of the following questions in turn:
(a) Whether Mr McSherry meets the medical standard set by Table 67.150 (medical standard 1) and Table 67.155 (medical standard 2); and if not,

(b) Whether the extent to which Mr McSherry fails to meet the medical standard is likely to pose a risk to the safety of air navigation; and if so,

(c) Whether the relevant certificates can be issued with conditions which will ameliorate any risk posed?

21. Accordingly, to the extent they arise, we propose to address each of those issues in turn by reference to the evidence before us.

DOES MR MCSHERRY MEET THE MEDICAL STANDARD SET OUT IN TABLES 67.150 AND 67.155?

22. There is no dispute between the parties and we accept that Mr McSherry has two *"medically significant conditions"* within the meaning of the CASR.[12] As conceded by Mr McSherry, those medically significant conditions are *"a risk of recurrent DVT"* and *"a risk of bleeding as a side-effect of Warfarin."*[13] However, the issue for our determination is whether either of these conditions is *"safety-relevant"*.
23. On the evidence before us, the relevant events which could conceivably occur as a result of Mr McSherry's relevant medical conditions are:
    (a) A distracting or incapacitating recurrent episode of DVT; or
    (b) A distracting or incapacitating bleed as a result of taking anti-coagulation medication, namely Warfarin.
24. We have had the benefit of written and oral evidence as to the likelihood of events of this kind in Mr McSherry's case from a number of medical specialists, whose evidence can be summarised as follows.

Associate Professor Christopher Ward

25. Associate Professor Christopher Ward, a clinical haematologist, has provided written reports dated 28 March 2013[14] and 1 August 2013[15].
26. In his first report of 28 March 2013, Associate Professor Ward indicated that he agreed with an assessment made by Mr McSherry's treating specialist, Dr McRae, that Mr McSherry would be at significant risk of recurrent thrombosis without medication. However, he also stated that Warfarin therapy should *"result in a risk of recurrent VTE*[16] *on therapy of less than 1% per annum"*.[17]
27. In his subsequent report of 1 August 2013, Associate Professor Ward sought to make a distinction between *"thrombotic recurrence"* and *"incapacitation"*.[18] He went on to state that:

> *... I am assuming that incapacitation in this case would be an acute, severe clinical event that would impact on the patient without warning and lead to him losing control of his aircraft.*[19]

He went on to state that:

> *The only possible scenarios that are likely to cause this are a massive pulmonary embolus (PE) or severe intracranial haemorrhage. Both of these events are extremely rare events in stable and otherwise fit patients of this man's age on longterm warfarin, and there is very little information from clinical trials specifically on these very severe complications."*[20]

28. Associate Professor Ward went on to indicate that the risk of a massive/fatal PE in Mr McSherry's case would be much less than 1%, *"possibly below 0.1% per annum"*.[21] He also went on to state that the risk of a severe, incapacitating intracranial haemorrhage would be significantly lower than 1% and in the order of 0.1% or less.[22]

29. Associate Professor Ward essentially confirmed the opinions expressed in his report of 1 August 2013 in the course of his oral evidence. When asked whether, aside from a massive pulmonary embolus or a cerebral bleed, there were other possible events someone with Mr McSherry's history could be subject to and which would be distracting to them, Associate Professor Ward replied as follows:

> *Not to the extent that it would stop them, you know, I believe, controlling an aircraft. If someone had some discomfort in the leg, or shortness of breath, again, unless it was a massive event, you know, they would still continue to do their job, I think, for some hours and to me that would get them out of trouble.*[23]

30. As to the cumulative risk of either a massive venous thromboembolism (VTE) or an incapacitating intracranial haemorrhage, Associate Professor Ward stated:

> *Well all I can speculate is less than 0.2 per cent. These are very rare events so you know, it is not something that the trial data will necessarily give us any information on because, I would argue, the populations which have been looked at, where we are recorded for cerebral haemorrhage are quite different from Mr McSherry. They typically involve people of a much greater age range with other medical illnesses and I think he's at the lower risk end, so you know, less than 0.2 per cent, but it could be substantially less, there could be another zero in there.*[24]

He also clarified that this 0.2% risk included the risk of a massive pulmonary embolism.[25]

31. Associate Professor Ward also clarified in the course of his evidence that it was appropriate to add together rather than multiply the risks of a DVT incapacitation and a bleeding incapacitation because, one being caused by excessive anti-coagulation and the other by inadequate anti-coagulation, the two events could not happen simultaneously. Indeed, given that the conditions for one of these events would preclude the conditions for the other, Associate Professor Ward also indicated that a case could be made for an overall risk of either event of 0.1% rather than 0.2%.[26]
32. Associate Professor Ward also indicated later in his evidence that the risk of one of these events occurring without any warning would be below 0.2%, because most people developed symptoms in advance of an intracranial haemorrhage or pulmonary emboli.[27]
33. Assuming that Mr McSherry was flying between 200 and 300 hours per year, Associate Professor Ward further indicated that the risk of one of these incapacitating events occurring whilst Mr McSherry was flying was *"tiny"*.[28]

Dr Simon McRae

34. We also have before us a number of reports from Mr McSherry's treating haematologist, Dr Simon McRae, the most relevant of which is his report of 26 March 2013.[29] In that report, he estimated Mr McSherry's annual risk of recurrent thrombosis as being *"certainly no greater than 1% per annum"*[30], and his risk of *"significant incapacitation"* due to recurrent thrombosis as *"likely to be under 1 in 1000 per year."*[31] As to the risk of incapacitation due to acute haemorrhage, he estimated the overall risk of annual bleeding as no greater than 1% with the risk of an incapacitating bleed being 0.2 to 0.3% per annum.[32] He also estimated the *"overall risk of incapacitation from both recurrent thrombosis and bleeding"* as *"no greater than 0.5%."*[33]

35. Dr McRae essentially confirmed these opinions in the course of his oral evidence, although he also indicated that he would accept a 0.2% cumulative risk as being reasonable.[34] He also agreed with Associate Professor Ward that the risk of an incapacitating event occurring suddenly, without any warning symptoms, was less than 0.2% per annum.[35]
36. As to the risk of Mr McSherry suffering from a clotting or bleeding event that could be distracting to him while he was flying, Dr McRae said:

> *... there's a low risk of that and I suppose that goes along with the overall risk of occurrence being low, I think, as well, so in any event use* (sic) *I think the risk is – well, we've certainly discussed what we think the estimates are. I doubt that the symptoms would be enough to distract him to the extent where he's unable to make* (sic) *control, I think that would be unlikely.*[36]

Associate Professor Pooshan Navathe

37. In addition to the evidence of Dr McRae and Associate Professor Ward, we have also had the benefit of the evidence of Associate Professor Navathe, who is currently the Principal Medical Officer with **CASA** and is a specialist in aviation medicine. It is also relevant to note that Associate Professor Navathe made the decision under review in this matter, imposing conditions on Mr McSherry's class 1 medical certificate.
38. Associate Professor Navathe has provided a detailed statement, dated 8 October 2013, and also gave oral evidence at the hearing.
39. In his statement of 8 October 2013, Associate Professor Navathe explained his conclusions and reasoning as follows:

> *... I consider that, given Mr McSherry's history of thrombosis, which he currently controls with the medication Warfarin, there are two risks which apply to him. There is the risk of thrombosis which is limited by the Warfarin medication, and there is the risk of bleeding (as a result of Warfarin) which is limited by tight control of the medications, and by monitoring the bleeding factors (INRs).*
> *There is a substantial or real and not remote possibility that Mr McSherry will suffer a recurrence of thrombosis or bleeding whilst in flight. Were Mr McSherry to suffer either of these events whilst at the controls of an aircraft in flight, then this would pose a clear threat to the safety of air navigation, and thus I have reached the conclusion that the extent to which Mr McSherry fails to meet the class 1 and class 2 medical standard is such that I cannot issue him with a medical certificate under r.67.180 of the CASR.*[37]

40. Whilst he maintained his view that Mr McSherry's medical conditions meant he did not meet the medical standard, in the course of his oral evidence Associate Professor Navathe elaborated upon and refined his opinion to some extent, having regard to the oral evidence of Dr McRae and Associate Professor Ward. Ultimately, under questioning from the Tribunal, Associate Professor Navathe conceded that the risk of bleeding concerned him more than the risk of a clotting event. He further conceded that the risk of a catastrophic clotting event was *"negligible"*.[38] He differed from the other two doctors, however, in his assessment of the bleeding risk. He explained his opinion during his oral evidence as follows:

> *The clotting risk – if you have any other clot it's not likely to be distracting or incapacitating, but if you have another bleed it is likely to be distracting or incapacitating, that's the differential in the two, because if you get a clot, like has happened in the past with him, he had a little – you know, sore leg, and then after a while it got – and so on and so forth, but if you get a major*

> *bleed – is defined as a bleed in – you know, there are – they're called 'minor bleeds' and 'major bleeds' you have* (sic) *little skin bruising – minor stuff, so the major bleed percentages we are looking at – if you take the specialist's advice – a little less than 1 per cent. If you look at the studies around 1.3 per cent.*[39]

41. He went on to explain that he did not agree with the other doctors that the only bleed of real concern was a catastrophic bleed, such as an intracerebral bleed. He explained his opinion as follows:

> *I'm talking about conditions, as I said before that, which have got major bleeds, you've got a gastrointestinal bleed, you've got some other bleed which is causing symptoms adequate to severely degrade the safety of the flight – but not incapacitating. It's diverting, and the examples I gave earlier as minor headaches and that sort of stuff. It is going to – it is going to distract you from the flight. And if you look at the – that's when you look at it – if you look at the papers which have been referred to, they talk about major bleeds of 1.3 which include all of those – or (indistinct) about .2 would be incapacitating – instantly incapacitating bleeds. I think the difference in our interpretation of the word 'incapacitating' is where that comes. Where the two specialists that we spoke to today, talk about incapacitation meaning 'that's it' there's nothing more than can be done. But if we consider a condition which causes colicky pain or something which causes sufficient symptoms that you are not able to concentrate on your flight as being a level of incapacitation. It's not total incapacitation but there's a level of incapacitation.*[40]

42. Associate Professor Navathe went on to indicate that, based on the opinions of Dr McRae and Associate Professor Ward, together with other information, he understood the risk of a major bleed to be less than 1% over the course of a year. He went on to confirm that what he perceived to be a 1% risk of an incompletely incapacitating bleed was in effect his main concern with or objection to granting Mr McSherry an unconditional class 1 medical certificate.[41]
43. Under questioning from the Tribunal, Associate Professor Navathe also conceded, consistently with the evidence of the other doctors, that a proportion of the bleeds he was concerned about would have warning symptoms which may allow Mr McSherry to take some evasive action before he became incapacitated. He conceded that reduced the risk to some extent. He also confirmed that his concern was not necessarily with Mr McSherry flying per se whilst partially incapacitated, but rather with this period of partial incapacitation coinciding with a high cognitive load.[42] He also added that the type of helicopter flying Mr McSherry was engaged in meant that his cognitive load would be relatively high during most of the flight. However, he conceded that there was a possibility of him being able to land his helicopter relatively quickly in response to any symptoms, which further reduced the risk of harm being caused.
44. Associate Professor Navathe further conceded under questioning from the Tribunal that it was a *"fairly remote likelihood"* that all of the things he was concerned about would *"line up"* at the same time such as to result in an adverse event.[43] In other words, it was a relatively remote likelihood that Mr McSherry would suffer an incompletely incapacitating bleeding event whilst he was flying a helicopter, whilst his cognitive load was relatively high and in circumstances where he did not have sufficient warning of the incapacitation such as to allow him to avoid flying, or land the helicopter before he was further incapacitated, and before any adverse event occurred.
45. Associate Professor Navathe also conceded that in Mr McSherry's case he had shown good compliance with his medication and had been stable for many years with no bleeding events, which further reduced the risk in his case.[44]

Consideration

46. In the event therefore, all of the doctors who have given evidence in this matter agree that the risk of Mr McSherry suffering a catastrophic clotting or bleeding event is negligible and, in effect, not such as to pose a real risk in the context of him flying a helicopter privately or commercially. All three doctors further agree that the risk of an incompletely incapacitating clot is not such as to pose a real risk associated with Mr McSherry flying commercially. However, whilst the other two doctors also regard the risk of an incapacitating but not catastrophic bleed in Mr McSherry's case as being negligible and unlikely to pose a safety risk, Associate Professor Navathe maintained that the risk of an incompletely incapacitating bleed in Mr McSherry's case was such that he did not meet the medical standard.
47. Whilst he maintained that view however, Associate Professor Navathe also conceded that the statistical bleeding risk was reduced in Mr McSherry's case for a number of reasons. Those included the following:
    - Mr McSherry had been taking Warfarin for approximately seven years and had never experienced a bleed associated with Warfarin;
    - He was otherwise in good health;
    - There was a possibility that Mr McSherry would suffer symptoms in advance of any such event which would allow him to either not fly or take some other evasive action;
    - There was a possibility that any incompletely incapacitating event would not coincide with a high cognitive workload, which reduced the risk of an adverse event;
    - There was a real possibility that Mr McSherry would be able to land his helicopter in the event of an incompletely incapacitating event, which further reduced the risk;
    - When he has flown commercially, Mr McSherry has flown for between 200 and 300 hours per year, with 300 hours being in the order of 3% of a year; and
    - Thus in statistical terms, the likelihood of an incompletely incapacitating bleed coinciding with a time during the year when Mr McSherry was flying was in the order of 0.03%.
48. Accordingly, we understood the effect of Associate Professor Navathe's evidence to be that the only risk which he considered to be real related to an incompletely incapacitating bleed related to Mr McSherry's use of Warfarin. However, he also conceded that the risk of an incompletely incapacitating bleed occurring and having adverse consequences in terms of safety was significantly below 1%, noting that the statistical likelihood of an incompletely incapacitating bleed occurring whilst Mr McSherry was flying was in the order of 0.03%. Whilst Associate Professor Navathe resiled during his oral evidence from a number of the opinions and conclusions expressed in his written statement, he maintained his view that Mr McSherry suffered from a safety-relevant condition, because of the risk of him suffering from an incompletely incapacitating bleed.
49. Having carefully considered all of the medical evidence however, together with Mr McSherry's evidence as to the history of his condition and the nature of the flying he does, we have concluded that whilst we accept many aspects of Associate Professor Navathe's evidence, we do not accept what we took to be his ultimate conclusion, that the risk of an incompletely incapacitating bleed occurring whilst Mr McSherry was flying had the result that his need to take Warfarin was a *"safety-relevant"* condition.
50. We note that in expressing that opinion, Associate Professor Navathe differed from both Associate Professor Ward and Dr McRae, each of whom regarded the risk of an incompletely incapacitating bleed causing problems for Mr McSherry whilst he was flying to be extremely small. Further, we do not consider this aspect of Associate Professor Navathe's evidence to have been well-supported or well-reasoned and we formed the impression that this aspect of his evidence may well have been influenced by his desire to justify the decision he had made, to impose conditions on Mr McSherry's class 1 medical certificate. We were also troubled by the significant differences between the opinions expressed in Associate Professor

Navathe's statement of 8 October 2013 on the one hand, and his oral evidence on the other.

51. We have concluded on the basis of all of the evidence before us that the risk of an incompletely incapacitating bleed occurring whilst Mr McSherry is flying, and posing a safety risk, is extremely small. We note that in raw statistical terms, the likelihood of an incompletely incapacitating bleed coinciding with Mr McSherry flying is in the order of 0.03%. Even if Mr McSherry was to fly for 600 hours per year, the risk would be in the order of 0.07%. However, as Associate Professor Navathe conceded, that risk is further reduced by the matters we have referred to above.
52. We have concluded that a medical condition which carries a risk of an adverse event having safety consequences which (in the case of an incompletely incapacitating bleed) is under 0.07%, and in the case of an incapacitating bleed is even less, cannot properly be described as a condition which is *"likely"* to reduce Mr McSherry's ability to perform as a commercial helicopter pilot. For that reason, we have concluded that Mr McSherry's risk of bleeding as a result of taking Warfarin is not a *"safety-relevant"* condition.
53. As all three doctors ultimately agreed that the risk of a clotting event having adverse safety consequences was negligible, we have also concluded that Mr McSherry's risk of recurrent thrombosis is not a *"safety-relevant"* condition. We have therefore concluded that neither of Mr McSherry's medically significant conditions is *"safety-relevant"* and for that reason he is entitled to the issue of class 1 and class 2 medical certificates pursuant to CASR reg 67.180.
54. We have accordingly decided to set aside **CASA**'s decision of 6 August 2013 and substitute a decision that Mr McSherry meets the relevant medical standards and is therefore entitled to the issue of class 1 and class 2 medical certificates, without conditions. In light of this conclusion, it is unnecessary for us to proceed to address the other issues identified above.
55. For completeness, we should also add that we sought further submissions from the parties after the hearing as to the significance for our decision of the endorsements on the relevant medical certificate issued to Mr McSherry,[45] the *"special requirements"* referred to in **CASA**'s letter of 6 August 2013, and the *"condition"* that Mr McSherry's certificates remain valid only for 12 months. In the event, essentially for the reasons set out in the submissions filed by Mr Abbott SC on behalf of Mr McSherry, dated 18 February 2014, we are satisfied that none of these matters constituted *"conditions"* within the meaning of CASR reg 11.056. We are further satisfied that, in light of our conclusion that Mr McSherry meets medical standards 1 and 2, he is entitled to the issue of class 1 and class 2 medical certificates, pursuant to CASR reg 67.180. In these circumstances, there is no power to impose conditions on his certificates pursuant to CASR reg 11.056, and we do not propose to do so.

DECISION

56. The respondent's decision of 6 August 2013 is set aside and in substitution for that decision it is decided that Mr McSherry is entitled to the issue of class 1 and class 2 medical certificates, without conditions.

I certify that the preceding 56 (fifty –six) paragraphs are a true copy of the reasons for the decision herein of Deputy President K Bean, Professor P Reilly AO, Member

..... [Sgd] .....
Associate

Dated 6 March 2014

Dates of hearing **31 October 2013 and 8 November 2013**

Counsel for the Applicant **Mr H Abbott SC**

Solicitor for the Applicant **Mr J Glynn**
McMahon Broadhurst Glynn

Solicitor for the Respondent **Ms C Swain**
CASA Legal Services Group

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[1] Mr McSherry lodged an application seeking review of that decision on 22 August 2013, giving rise to application number 2013/4183.

[2] Exhibit 3, [9].

[3] Exhibit 3, [9].

[4] Exhibit 3, [13].

[5] Exhibit 3, [13].

[6] Exhibit 3, [14].

[7] Transcript, 31 October 2013, page 35, lines 4-5 and page 5, line 26.

[8] Exhibit 1, T86/267-268.

[9] Exhibit 2, T3/15.

[10] See CAR reg 5.04 and CASR regs 67.150(7) and 67.155(7).

[11] See *Re Window and Civil Aviation Safety Authority* [1999] AATA 525; (1999) 56 ALD 316 at [60] and *Re Hall and Civil Aviation Safety Authority* [2004] AATA 21 at [35]- [36].

[12] See CASR reg 67.010.

[13] Applicant's Outline of Submissions, [12].

[14] Exhibit 1, T100/296.

[15] Exhibit 2, T8/37.

[16] We understand this to be an abbreviation of *"venous thromboembolism"*.

[17] Exhibit 1, T100/296.

[18] Exhibit 2, T8/37.

[19] Exhibit 2, T8/37.

[20] Exhibit 2, T8/37.

[21] Exhibit 2, T8/37.

[22] Exhibit 2, T8/38.

[23] Transcript, 31 October 2013, page 17, lines 8-12.

[24] Transcript, 31 October 2013, page 19, lines 14-21.

[25] Transcript, 31 October 2013, page 19, line 25.

[26] Transcript, 31 October 2013, page 20, lines 22-23.

[27] Transcript, 31 October 2013, page 24, lines 20-22.

[28] Transcript, 31 October 2013, page 24, line 46.

[29] Exhibit 1, T99/293.

[30] Exhibit 1, T99/293.

[31] Exhibit 1, T99/293.

[32] Exhibit 1, T99/293.

[33] Exhibit 1, T99/293-294.

[34] Transcript, 31 October 2013, page 31, line 2.

[35] Transcript, 31 October 2013, page 31, line 7.

[36] Transcript, 31 October 2013, page 31, lines 36-41.

[37] Exhibit 4, [81] – [82].

[38] Transcript, 31 October 2013, page 86, line 10.

[39] Transcript, 31 October 2013, page 86, lines 15-24.

[40] Transcript, 31 October 2013, page 87, lines 1–17.

[41] Transcript, 31 October 2013, page 87, lines 39-42.

[42] Transcript, 31 October 2013, page 88, line 19.

[43] Transcript, 31 October 2013, page 89, lines 16-17.

[44] Transcript, 31 October 2013, page 90, lines 12-14.

[45] Exhibit 2, T11/50.
