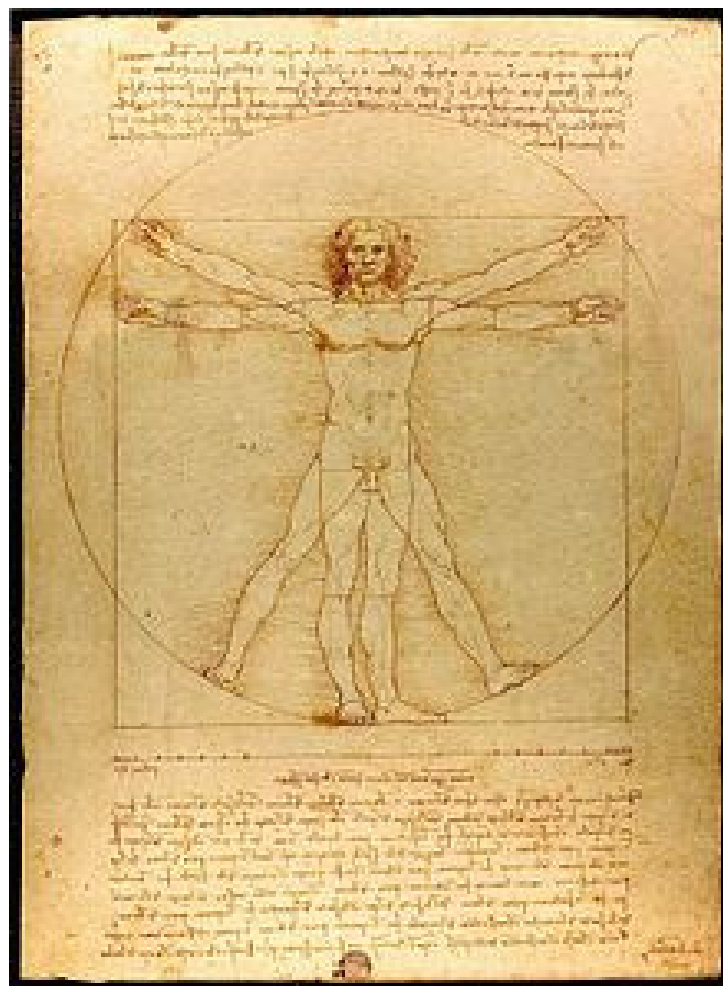


# Professional Aviators Investigative Network.

## Supplementary submission-2.

Prepared for CVDPA.

[ASRR@infrastructure.gov.au](mailto:ASRR@infrastructure.gov.au)



Covering letter.

28 January 2014.

Mr David Forsyth AM (Australia)—Review Panel Chair.  
Aviation Safety Regulation Review.

Dear Chairman.

1) This supplementary submission is provided on behalf of a number of PAIN associates who wish to express their concern with the inconsistent, subjective, arbitrary, contentious and highly litigious regulatory oversight of Australian pilot medical standards.

2) The narrative is provided to define widely held industry perceptions that the regulations, whilst cumbersome and overly complex are not a radical cause of anxiety. The disparate way in which an individual can choose to interpret rules, even parts of rules to obtain a desired outcome is seen as a major obstacle to providing legally safe, consistent ICAO compliant, procedural certainty.

3) The list of medical hearings conducted by the Australian Administrative Appeals Tribunal (AAT) is extensive and has progressively increased within the past five years to a point where the huge costs of resolution for both the industry and public purse is becoming insupportable.

4) In this supplement although we have selected only one case for analysis, we submit that it identifies not only weakness and inconsistency within the rule set; but the contrary, subjective manner in which the rules are translated. The selected case study defines how an opinion of Avmed is being prosecuted, at great public expense. CASA Avmed is calling no less than 12 expert witnesses, several from overseas. This, in an attempt to overturn two previous, legally determined decisions, dismiss a strong safety case and regress to medical 'standard' abandoned more than 25 years ago. The ICAO does not now, nor ever has supported the CASA-Avmed argument.

5) This contentious, litigious stance typifies many cases. There exists a significant body of transcript evidence where Avmed has presented an argument diametrically opposed to their own previous submissions as presented in disputes related to very similar matters.

6) We submit this case effectively documents and demonstrates one, of the many reasons why there must be consistency in the actions of the regulator, enforced through the Civil Aviation Act, before serious consideration is given to reforming the existing regulations or adopting those of any other National Aviation Authority.

7) Fully documented research supporting the summary notes may only be made available under terms of strict confidentiality and with parliamentary privilege. There are patient-doctor confidentiality and impending litigation considerations which we must honour. We believe the Terms of Reference (ToR) for the current review are fatally flawed; and, as such believe confidentiality or privilege cannot be realistically guaranteed. We reserve the right to abstain from presenting any confidential documentation obtained from and not released for publication by the originating source.

Yours sincerely.

The editors – Professional Aviators Investigative Network. (PAIN).

## Table of Content.

Covering letter.	1
Table of Contents.	2
Appendices.	3
Glossary:-	3
1.0. Executive summary.	4
2.0. Extracts - ICAO Manual of Civil Aviation Medicine.	5
3.0. Aviation Colour Perception Standard:	8
4.0. Medical CVD Testing v Real World Performance.	9
5.0. The safety case	10
6.0. Inconsistent decision making.	11
7.0. CVD pilots AAT Appeal.	12
8.0. CASA Tactics.	14
9.0. In conclusion	15

## Appendices.

## 1. Correspondence from former CASA Medical Officers.

- (a) A. Heggan (former Group Manager – Safety Regulation) to Dr A. Pape.
- (b) Dr J. Brock (former acting Principal Medical Officer) to Dr A. Pape.
- (c) Dr J. Brock to ATPL Applicant (de-identified).
- (d) Dr J. Brock to ATPL Applicant (de-identified).
- (e) J. Pike (former acting CASA Director) & J. Brock to Pape.
- (f) Dr P. Wilkins (former acting Principal Medical Officer) to Dr A. Pape.
- (g) De-identified Medical renewed in 2013 with restriction.

## 2. ICAO Manual of Civil Aviation Medicine – Part 1 - Licensing Practices.

Refer to Chapter 2 (Medical Requirements) from Page 20 onwards (relevant sections highlighted).

## 3. Correspondence from CASA requesting withdrawal of Dr Pape AAT witness statement.

## 4. Correspondence from CASA indicating that a medical Certificate may not be renewed.

## Glossary:-

AAT.	Australian Administrative Appeals Tribunal.
ANA.	Australian Air Navigation Act.
ACPS.	Aviation Colour Perception Standard.
ATPL.	Airline Transport Pilot Licence.
CAAA.	Civil Aviation Act.
CASR.	Civil Aviation Safety Regulation.
CAR.	Civil Aviation Regulations.
CASA.	Civil Aviation Safety Authority.
DAME.	Designated Aviation Medical Examiner.
CVD.	Colour Vision Deficiency.
ICAO.	International Civil Aviation Organisation.
IFR.	Instrument Flight Rules.
ASAM.	Journal of Australasian Society of Aerospace Medicine.
NAA.	National Aviation Authority.
NTSB.	National Transport Safety Board.
PMO.	Principal Medical Officer.
SARP.	Standards and Recommended Practices.
VFR.	Visual Flight Rules.

### 1.0. Executive summary.

- 1) A largely unchallenged, esoteric rule set affects the life of each and every flight crew member operating under the Australian Air Navigation Act (ANA) the Civil Aviation Act (CAAA) and the Civil Aviation Regulations (CAR). These are the regulations which empower and guide the setting of Australian medical rules and protocols.
- 2) The Australian Civil Aviation Safety Authority (CASA) hosts a burgeoning, increasingly inefficient aviation medical service, 'Avmed'. Of particular concern is the openly expressed reasoning for not accepting the opinion of 'specialist' medical advice and the increasing use of insular 'in-house' rulings. This adds an additional dimension to another contentious issue; that of the Avmed stated lack of trust in the approved Designated Aviation Medical Examiners (DAME). There are many cases where a DAME has approved a medical certificate, only to be overruled by Avmed, this leading to additional cost in seeking 'specialist' advice; only to have the specialist opinion overturned.
- 3) In the interests of brevity, our overall concerns may be adequately expressed by an analysis of one subject, Colour Vision Deficiency (CVD). The subject encapsulates issues which other International Civil Aviation Organisation (ICAO) compliant National Aviation Authorities (NAA) do not have. The rulings provided by Avmed on CVD are demonstrably inconsistent; this in concert with the highly litigious Avmed culture provides a degree of uncertainty, at every individual medical examination. There are recorded cases where:-
  - a) A CVD pilots holding ATPL have been refused previously held unrestricted Class 1 medical certification.
  - b) CVD pilots being routinely granted 'waivers' to exercise command rights on the basis of demonstrated competence during practical flight testing.
  - c) CVD pilots holding an ATPL being refused a Class 1 medical certificate allowing them to exercise their licence authority due to their condition.
- 4) Australia has, for many years been a leading light in it's approach to CVD and despite the 'confused' ad-hoc approach to individual medical certificates, has a well documented history of there being no increased risk to safety related to the enlightened, tolerant, flexible attitude toward Australian CVD pilots. Avmed are seeking to revert to a less enlightened rule set, despite the safety case been proven, twice, in tribunal many years ago.
- 5) The tactics being used against individuals are reprehensible. Should the ruling in an anticipated hearing in the Australian Administrative Appeals Tribunal (AAT) on an individual matter be against the individual, Australia will have taken a huge retrogressive step, damaged a precedent which was set many years ago and will not have improved the safety case one iota.
- 6) Attached for reference is the ICAO manual, for convenience; the extracts on the following pages are provided to clarify the ICAO any many other NAA stance on CVD and on 'flexibility'.
- 7) The appendices to this submission are provided in support of the construct.

## 2.0. Extracts - ICAO Manual of Civil Aviation Medicine.

- 1) The Convention on International Civil Aviation, which was signed in Chicago on 7 December 1944, includes several articles which call for adoption of international regulations in all fields where uniformity facilitates and improves air navigation.
- 2) These regulations, known as Standards and Recommended Practices (SARP) have been promulgated in Annexes to the [Convention] which are amended from time to time when necessary. Each Annex deals with a specific aspect of international civil aviation. Aspects relating to medical regulations for licence applicants are included mainly in Annex 1 — *Personnel Licensing*.
- 3) Although the purpose of SARP is to provide provisions only for *international* air navigation, they have greatly influenced national regulations governing domestic aviation in most Contracting States.
- 4) ICAO also originates guidance material which is intended to assist States in the implementation of SARP, but places no regulatory responsibility upon States for compliance. The *ICAO Manual of Civil Aviation Medicine* (Doc 8984) falls within this category and offers guidance on the implementation of the SARP as contained in Annex 1.

## 2.1. ICAO Introduction.

- 1) Two basic principles are considered essential when assessing an applicant's medical fitness for aviation duties, as specified in Annex 1, Chapter 6, Medical Provisions for Licensing, namely:
  - a) The applicant shall be physically and mentally capable of performing the duties of the licence or rating applied for or held.
  - b) There shall be no medical reasons which make the applicant liable to incapacitation while performing those duties.
- 2) The main objective of the *Manual of Civil Aviation Medicine* is to provide guidance material and present concepts on how to achieve these principles by assessing symptoms and signs that occur commonly in medical examinations for the aviation licences but which have not been or cannot be included in detail in Annex 1.
- 3) It is also envisaged that the guidance material will help ensure international uniformity in the implementation of the SARP.

## 2.2. ICAO Flexibility.

- 1) The range of variation between individuals is such that if medical Standards are laid down in rigid terms, they will inevitably exclude a number of applicants who, though not meeting the Standards in all respects, may nevertheless be considered capable of performing duties safely in the aviation environment.
- 2) Since the Chicago Convention lays on Contracting States the duty to promote efficient and safe aviation as well as to regulate it, provision has been made in Annex 1 for the exercise of a degree of flexibility in the application of medical Standards, thus avoiding the hardship and injustice which might otherwise occur.
- 3) It is essential for the maintenance of flight safety that the manner in which flexibility is exercised should be reasonably uniform throughout the Contracting States if international acceptance of licences is to be maintained. In the past, flexibility has been used in widely differing ways by States. The application of the principles set out in this chapter will assist in achieving uniformity.

### ICAO 1.2.4.9.

If the medical Standards prescribed in Chapter 6 for a particular licence are not met, the appropriate Medical Assessment shall not be issued or renewed unless the following conditions are fulfilled:

- a) accredited medical conclusion indicates that in special circumstances the applicant's failure to meet any requirement, whether numerical or otherwise, is such that exercise of the privileges of the licence applied for is not likely to jeopardize flight safety;
- b) relevant ability, skill and experience of the applicant and operational conditions have been given due consideration; and
- c) the licence is endorsed with any special limitation or limitations when the safe performance of the licence holder's duties is dependent on compliance with such limitation or limitations.

The provision of a degree of flexibility must not lead to a situation where its use becomes the rule rather than the exception. Annex 1, 1.2.4.9 has been worded to make it clear that flexibility may be exercised only in the exceptional case.

Failure to observe this requirement could result in routine approval of individuals not meeting specific medical requirements, such as visual standards, thus creating an abuse of the primary object of flexibility.

When evidence accumulates that flexibility is being utilized repeatedly in a particular respect, then the appropriateness of regulations defining the medical requirements comes into question and the suspicion is raised that the regulations define a requirement which is not in keeping with the demands of flight safety.

However, when decisions to exercise flexibility are backed by an accredited medical conclusion, it indicates that these decisions have not been regarded as a routine measure but that they have been taken following close examination and assessment of all the medical facts and their relationship to occupational demands and personal performance. The degree and intensity of investigation lying behind each decision accurately measures compliance with the principles behind the flexibility Standard. I

The decision of a Licensing Authority to exercise the —flexibility Standard of Annex 1 should be documented in each individual case and it should show how a particular decision was arrived at by means of the accredited medical conclusion.

Continued.../..

../....An applicant may be found fit to operate an aircraft as a pilot under supervision or as a co-pilot but not as a pilot-in-command.

In cases where prognosis cannot be given with the necessary degree of certainty, any potential risk to flight safety may, in general aviation where two pilots are not normally required, be mitigated by a restriction to fly without passengers, outside controlled airspace or with the carriage of a —safety pilot.

Such a pilot should receive adequate information about the medical condition which has led to the restriction —valid with safety pilot only.

In addition, he must be capable of acting as pilot-in-command in case of an emergency. In commercial aviation, a restriction to multi-crew operations may serve a similar purpose.

In such a manner it is often possible to fit individuals into aviation by restricting their licence or limiting their duties and thus mitigating the risk to flight safety while retaining the experience of individuals who would otherwise be denied a licence.

#### Visual deficiencies.

The following circumstances represent some of the typical conditions defining the visual abilities required of a general aviation pilot. Possession of these abilities by an applicant or the applicant's inability to meet the required level of proficiency may be established by simulation or, more realistically, in actual flight conditions. In either case, the ability of an applicant to perform specified tasks is a practical requirement which is not easily established by a conventional test. Suggested testing procedures may determine the following:

- a) Ability to select emergency landing fields from a distance, preferably over unfamiliar terrain and from high altitude.
- b) Ability to undertake simulated forced landings in difficult fields. Note the manner of approach, rate of descent, and comparative distance at which obstructions (stumps, boulders, ditches) are recognized.
- c) Ability to recognize other aircraft approaching on a collision course (possibly by pre-arrangement), especially aircraft approaching from the far right or far left.
- d) Ability to judge distances (compared with the examiner's judgement), such as distance from other aircraft and from the ground, and to recognize landmarks at the limit of the examiner's vision.
- e) Manner in which landings are made, including crosswind landings.
- f) Ability to read aeronautical maps in flight and to tune the radio on a predetermined station accurately and quickly.
- g) Ability to read instrument panels quickly and correctly (including overhead panel, if any).

#### Additional colour perception tests.

An applicant failing to obtain a satisfactory score when tested with pseudo-isochromatic plates may nevertheless be assessed as fit, as specified in Annex 1, 6.2.4.4, provided the applicant is able to readily distinguish the colours used in air navigation and correctly identify aviation coloured lights. This can be tested, usually for aviation red, green and white light, by means of a colour perception lantern recognized by the Licensing Authority. Failure of the applicant to name each colour correctly *within the time during which the light is being shown* (usually about four seconds) shall indicate failure of the test. Several such lanterns are in use in States.



### 3.0. Aviation Colour Perception Standard.

1) The regulations related to Aviation Colour Perception Standard (ACPS) were developed to suit needs of industry, as it was, almost one hundred years ago. At that time, there existed two established, undeniable facts:

a) Coloured light signalling was used to convey instructions to airborne and taxiing aircraft.

b) There existed a group of people whose colour discrimination and recognition abilities were demonstrably degraded.

*"The applicant shall be required to demonstrate the ability to perceive readily those colours the perception of which is **necessary** for the safe performance of duties."*(ICAO Convention Annex 1 – Chapter 6.2.4.2).

2) The wording has changed little during the preceding decades; however, the catalogue of colour usage in the aviation environment has expanded exponentially. The original justification based on colour signals has disappeared as electronic communication became universal, reliable and diverse.

3) Almost 10% of human males have an inherited deficiency in one or other of the three colour receptor pigments rendering them Colour Vision Deficient (CVD). The type of colour vision deficiency depends directly on which of the three pigments is deficient; the degree of colour vision deficiency may vary from mild to severe, depending on how much the function of the pigment is missing or degraded.

4) There are extensive variations in the way the aviation colour perception standard is administered. Some jurisdictions prohibit any participation by CVD pilots, others tolerate even extremely CVD pilots who are fully engaged at all levels of the aviation industry, even as captains of large modern jet aircraft.

5) Australia presently has the most modern, scientifically proven, liberal applications. This has been the result of two successful legal challenges to the implementation of the ACPS. [Refers - *Pape v CAA (1987)*. *Denison v CAA (1989)*]. A summary of the AAT findings and comparison to ICAO CV standard was published in ([article](#)) the Journal of Australasian Society of Aerospace Medicine, 2011.

6) The authority decided that the Pape ruling could only apply to the appellant alone. This arbitrary ruling denied other CVD pilots the right to fly at night; and, by extension, the ability to pursue careers in aviation was denied.

7) By mutual agreement between the concerned parties, the Commonwealth funded, second test case, 'Denison' was to be wide ranging. The scope of evidence widened to include all forms of CVD through all levels of professional pilot medical certification. The case ran for 35 days and examined every conceivable use of colour in aviation. To this date, it remains the largest, **independent**, in depth analysis and examination of aviation colour vision standards in the world.

8) Since the Denison decision, Australian CVD pilots have been free to progress to all levels of professional flying including international airline operations. Before Pape and Denison, many pilots would have even been restricted in their approval to fly even a light aircraft at night.

9) Since the Denison ruling, CVD pilots have consistently demonstrated the ability **necessary for the safe performance of duties** through regular, rigorous flight and simulator assessments.

#### 4.0. Medical CVD Testing v Real World Performance.

1) CVD pilots expect varying degrees of difficulty passing any medical Colour Vision Test (CVT). 'Laboratory' based tests are specifically designed to identify the CVD pilot. There is however a demonstrated, significant disparity between CVDP performance during 'laboratory' CVT and the performance noted when physically flying aircraft. This is acknowledged by the ICAO in the statement below:

*"The problem with colour vision standards for pilots and air traffic controllers is that **there is very little information which shows the real, practical implications of colour vision defects on aviation safety.**" (ICAO Manual of Civil Aviation Medicine 2012, Section 11.8.29)*

2) This fact was recognised during the Denison appeal and defines why the tribunal recommended (paragraph 78) that suitable "practical" tests be devised. This ultimately led to the inclusion of Civil Aviation Safety Regulation (CASR) 67.150 (6)(c) which approved the option of a test which "simulates an operational situation".

3) It should be noted that at the conclusion of the Denison appeal, the Authority undertook to promote the outcome of the appeal to the wider aviation world. This undertaking was implemented in particular by former CASA Aviation Medical Directors, Dr Rob Liddell, Dr Jeff Brock and Dr Peter Wilkins. The ruling provided a brief period of pragmatic, sensible reform within the Avmed. The Avmed department during this enlightened era was much in favour of promoting the Australian experience at the international level, with a view to promote more research and define universal colour vision standards in other countries; and, to examine the case for the removal of standard entirely.

4) During this era, each Doctor associated expressed concerns that the CVD testing methods were flawed and that they needed to be redesigned to reflect operational relevance; as the tribunal had recommended. Waivers were routinely provided allowing pilots to exercise ATPL privileges. This, despite individual inability to meet 'laboratory' CVT standards, allowed CVD pilots to demonstrate ability **necessary for the safe performance of duties**, thus allowing CVD pilots to exercise, to the full, the authority of an Airline Transport Pilot Licence (ATPL).

5) CVD assessments were made by way of practical flight tests, written references and check reports from accredited testing officers (ATO/TRE). There were, of necessity in some cases, additional restrictions imposed, such as weight limitations; or, the requirement to fly as or with a pilot who had normal colour vision. (Refer Appendix 1).

6) However, since 2002, this activity appears to have devolved to a halt; and, has been replaced by active denigration of AAT rulings, a marked reluctance to promote the established protocols, supported by an active campaign to regress to rules which were conceived several decades ago.

7) Australia has and must retain the most liberal implementation of aviation colour vision standards. This achievement is directly attributable to industry, departmental and individual efforts, at great expense.

8) The resultant two landmark rulings, by the AAT in the late 1980's are more than adequately justified by the absence of any incident or accident during the period since 1989; the performance and safety record may speak for itself.

#### 5.0. The safety case.

1) There is only one recorded accident in history which supporters of the CVD standard rely on to justify their assertions. This accident is often quoted as a reason for the justification of more stringent colour vision standards.

The USA National Transport Safety Bureau (NTSB) advises of the crash of a B727 in Tallahassee, Florida in 2002 (FedEx Flight 1478)

2) The accident investigation relates to where the CVD co-pilot was implicated following a 'black hole' approach at night, relying on a Precision Approach Path Indicator (PAPI).

3) We submit, the medical evidence provided to the NTSB related to colour vision was from a single source, whose enthusiasm for promoting colour vision standards is legendary. Notably, the evidence was not subjected to 'cross examination' and was refuted during the Denison appeal.

4) We have researched this accident extensively including reviewing almost 200 submissions (dockets) provided to the NTSB from various parties which were relied upon in producing the final accident report.

5) Within the 'dockets', there are numerous contradictions which infer that the root cause was the failure of the PAPI device itself to provide correct glide-slope information, under the prevailing meteorological conditions, to any of three pilots on the flight deck. Of three pilots, only one had defective colour vision.

6) In the case of FedEx Flight 1478 all three crew were actively involved in the approach, none saw four red lights (too low) that the PAPI should have been displaying. They flew the aircraft as if the PAPI was showing four white lights, indicating to them that the approach was too high.

7) This alternative explanation for the crash is supported by three separate scientific studies which were conducted years earlier, by Australia, the USA and Canada. The studies clearly demonstrated that under certain meteorological conditions, the visual guidance from the PAPI could be degraded to such an extent that the observer would perceive a "fly down" display when in fact the approach angle was already dangerously low.

**This "fail unsafe" condition was demonstrated to be independent of the colour vision status of the observer.**

8) The findings are summarised in ([article](#)) published in the Journal of Australasian Society of Aerospace Medicine (ASAM), 2013; further supporting documentation is available on request.

#### 6.0. Inconsistent decision making.

1) A number of experienced airline pilots in Australia have not been able to meet the CASA defined, 'laboratory' colour vision testing; yet continue to safely and competently meet the operational standards "**necessary for the safe performance of duties**" and continue to exercise their full licence authority.

2) Individual CVD pilots, many with in excess 6000 command hours, function within a wide operational range; including:- many thousands of night hours, single pilot and multi-crew operations, under the Instrument Flight Rules (IFR), in turbo-prop and turbo-jet operations, encompassing modern 'glass' and EFIS equipped aircraft. The numerous references and check reports clearly indicate their ability to perceive those colours which are "**necessary for the safe performance of duties**"; is not, in any way adversely affected by their CVD diagnosis.

3) Well documented assessments have been carried out by a number of both independent and company based Approved Testing Officers. There can be no doubt that the abilities of highly experienced ATO to assess CVD pilots within in an operational environment is more germane and relevant to safety, than that of a remote, arbitrary 'standard' defined by 'laboratory' testing parameters.

4) Complying with the precedents set by previous directors of Avmed, CVD pilots have each applied to Avmed providing the requisite aforementioned documentation to support their previously granted 'waiver'. In recent years, in each instance, CASA have responded by refusing to even contemplate the legally established protocol of safe, tested, proven, sensible waivers on this one item within their medical certification.

5) CVD pilots are, once again, being restricted from exercising ATPL rights and are unable to progress their careers beyond the rank of First Officer. The reasons cited by CASA essentially ignore the tribunal decision on Denison, ignore precedents set by past Medical Directors, ignore empirical evidence that the CVD pilot is tested as "**necessary for the safe performance of duties**".

6) We submit that the current Avmed regime is at odds with ICAO recommendations in their decision making process. The ICAO Manual of Civil Aviation (Part 1 Licensing Practices) highlights many areas which appear to have been subjectively disregarded; for example.

#### ***Flexibility in the Application of Medical Requirements:***

Relevant ability, skills and experience and operational considerations should be given due consideration in making medical decisions

There should also be consultation with aviation experts in making a decision – including flight managers and employers (not just medicine experts. i.e. doctors).

#### ***Practical Flight Tests:***

A practical flight test may include items such as map reading, navigation, operation of aircraft equipment, communications, simulated malfunctions etc.

## 7.0. CVD pilots AAT Appeal.

- 1) As a result of the CASA refusal to sensibly negotiate a fair and reasonable outcome with the CVD pilots, the only viable option remaining is to lodge an appeal with the AAT. Refer to Appendix 2 for details.
- 2) The original intention of the appeal was for the tribunal to answer the question of whether a particular CVD pilot could safely exercise the rights conferred by an ATPL, notwithstanding an inability to meet the arbitrary, laboratory CVT parameters defined by Avmed.
- 3) The appeal will be obliged to re examine the previous Denison decision, based on 35 hearing days of evidence. Reappraising, for the third time, the CVD question. A large body of evidence and operational data now supports the notion that practical, in flight or simulator testing is far more appropriate than a 'laboratory' attempt to artificially create an operational environment.
- 4) However, it is clear from AAT lodged Avmed witness statements, that any form of reasonable approach is not contemplated. Avmed are proposing regression by introducing draconian restrictions, even more severe than those which existed prior to the Denison appeal. The proposed recommendations include medicals valid for Visual Flight Rules (VFR), daytime operations only, preventing the carriage of passengers.
- 5) Should Avmed be successful, this will discriminate against and restrict CVD pilots from career progression. Avmed propose, for no measurable safety gain to effectively end the careers of CVD pilots by making them 'unemployable'.
- 6) We submit that there are potential abuses, if not breaches of both human and constitutional rights contained within the Avmed construct. Furthermore; the tenets set in Air Navigation Act 1920 are disturbed, particularly in relation to the states obligations to ICAO.
- 7) Avmed are calling numerous international 'experts' (all of whom have normal colour vision, most of whom have limited if any actual professional flying experience). By doing so, they are financially disadvantaging the applicant from being able to present an equal case. Present legal fee estimates for the applicant are at AUD \$385,000.
- 8) The chief instigator and proponent of the Avmed course of action is the Principal Medical Officer (PMO), Dr Pooshan Navāthé, who for a number of years has publicly expressed a personal desire to reverse the Denison decision.
- 9) Dr Navathe's decision making abilities have been called into question on numerous occasions, notably during previous coronial and AAT hearings; including the now infamous 'Hempel' case; 2013, in which Dr. Navāthé presented a diametrically opposed argument to that which he espoused during an almost identical medical scenario, ([Hazleton v CASA](#)); 2010, in which different rulings were made; but, the comments relating to Dr. Navathe performance and knowledge were similar. The Hazelton AAT findings are germane and support the CVD pilot construct.

## 7.1. Hazelton findings.

*496. Having considered the conflicting evidence, we find that the risk of post-traumatic epilepsy for Mr Hazleton is well within the acceptable medical criteria for the aviation industry. We have taken account of all of the evidence and appropriately given weight to the factors affecting the disputed facts. In determining what are acceptable limits or tolerances in this case, **we reject the oral evidence of Dr Wallis and Dr Drane and the written evidence of Dr Navāthé.***

*Continued../...*

./...500. We find from the clinical and epidemiological evidence, Mr Hazelton's virtually uneventful history since the accident (particularly in relation to the absence of post-traumatic epilepsy in that period), there appears to be a preponderance of weight pointing to an "inherent unlikelihood" of post-traumatic epilepsy for the applicant[638]. In so concluding we note in a complementary way, that the respondent's case was not uniformly robust. **In particular, we placed weight adversely for the respondent on the fact that three of the doctors, the Principal Medical Officer, Dr Navāthé and the medical officer Dr Drane, and Dr Wallis from his New Zealand consultancy, who had worked together previously had inconsistent opinions with other doctors from within CASA and with external expert opinion, and we were not satisfied that all of the views of those doctors were objective assessments.** We considered Dr Drane's evidence, who had the benefit of the opinion of Dr Hastings, the United States specialist, but **we found Dr Drane seemed unduly influenced by Dr Navāthé's opinion.**

501. We noted in particular, in July 2009 (8 months after Mr Hazleton's assault incident), email evidence of the strong views taken by Dr Sham Tak Sum and the more moderate views of Dr Fitzgerald, both of whom are employed by CASA. Clearly, Dr Sham Tak Sum and Dr Fitzgerald would have been sympathetic to re-licensing Mr Hazelton, but **those views seemed to have been minimised by the other medical officers at CASA and that evidence is at odds with Dr Navāthé's written statement.**



## 8.0. CASA Tactics.

1) As a consequence of the Avmed expressed desire to overturn the Denison findings, Dr Arthur Pape, a lifelong campaigner for the rights of CVD pilots posted an opinion on a public web site ([thread on PPRuNe](#)) with the intention of alerting the general pilot community to the potential ramifications of the CVD pilots at AAT appeal.

2) As a direct result of posting an opinion, CASA wrote to the applicant's legal counsel suggesting the Pape statement be withdrawn from proceedings, proposing that he was not to be called as an expert witness, as he is no longer considered suitable, by Avmed (Refer Appendix 3).

3) The views of Dr Pape on CVD pilot issues have been on the public record for almost a quarter of a century, enjoy professional acclaim; have been accepted in two AAT CVD hearings on the matter, and fully supported by several previous heads of the CASA aviation medical department. Conversely, some of the witnesses that CASA are intending to call have also campaigned, published and presented views that whilst diametrically opposed to those held by Dr Pape, **have not been tested by any acknowledged NAA medical department, court or appeal process.**

4) The AAT appeal applicant has more recently received correspondence from CASA Avmed indicating that there was a 'difficulty' in renewing his medical certificate. This due to his medical renewal becoming due midway through the current appeal process.

5) Effectively the letter from CASA intimates that continuation of his Class 1 medical certification may not be in the best interests of the safety of air navigation. The reason cited, 'he had not responded at the time to CASA Avmed expert evidence'. Given the sheer volume and complexity (including several thousand pages of combined witness statements and supporting publications) and the that the applicant is engaged in full time employment, as a pilot; providing any form of timely reply, would be 'difficult' for an expert, let alone from a layman.

6) It is noteworthy that the applicant has held the same medical restrictions now for over 15 years and has during this period has continued to demonstrate, on a regular, monitored basis an ability "**necessary for the safe performance of duties**", yet CASA Avmed give every appearance of pre-judging the AAT decision and acting on that assumption; this before the matter has even reached the hearing stage.

**N.B.** At the time of writing, it is unclear whether CASA will actually follow through on the proposed intimidating action, which could be construed as a threat, thinly disguised as a highly subjective, presumptive anticipation of the Tribunal decision.

(Refer Appendix 4).

9.0. In conclusion.

- 1) The battle CVD pilots are currently facing is just one of many examples, of the systemic problems pilots have faced in recent years, where attempting to deal with the Avmed section of CASA, without the need to resort to AAT or court proceedings. There are numerous supportive examples within the AAT records of similar examples.
- 2) Medical decisions which have a huge impact on pilots' livelihoods and family wellbeing are being made by a select few individuals, often based on nothing more than their own opinions against that of medical specialist advice and DAME opinion.
- 3) Avmed officers often appear to disregard opinions of other medical specialists and flight operations experts, including check & training pilots who are often in a better position to judge whether a medical condition such as CVD adversely affects the pilots ability "**necessary for the safe performance of duties**".
- 4) In the CVD argument, Avmed appear to be subverting and disregarding the findings of the AAT from the exhaustive Denison appeal.
- 5) By Avmed ignoring recommendations from other sources, pilots are faced with uncertainty at best; with no other option other than to appeal, through the AAT a bureaucratic decision. In the worst cases by doing so, they are often financially crippled attempting to balance the uneven the process against a regulator with unlimited access to resources.
- 6) A review of the many online pilot forums as well as anecdotal discussions with DAME, suggests that Australian pilots have, in no uncertain terms have lost confidence in the decision making abilities of the Avmed section of CASA.

---

END REPORT. P1.

---