RESPONSE TO NPRM 1304OS

Regulation of aeroplane and helicopter 'ambulance function' flights as Air Transport operations

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Do you consent to having your name published as a respondent to this NPRM?

YES [√] NO [ ]

Signed:  **Date:** **23 September 2013**

Key Proposal: Helicopter and aeroplane medical transport operations will be moved into the air transport classification and authorized by an AOC issued in accordance with Part 119 of CASR. Medical transport operations will be subject to the requirements of the applicable air transport regulation (i.e. Parts 121, 133 or 135 of CASR) and any overarching regulations from Part 91 of CASR, as applicable.

Recommend:

[ ] proposal is acceptable without change

[ ] proposal is not acceptable under any circumstances

[√] changes would make the proposal acceptable

Comments:

To invite comment on a proposal to align MT operations against CASR's 119, 121 and 135 (applicable in the case of Pel-Air) is confusing as these CASR's have not yet been promulgated and fully informed comment is therefore not possible. Comment is confined mainly to CASR's 119 and 135 which have progressed to the point where their contents are generally known. Some of the provisions of CAO 82.3 which would cause difficulty in MT operations have been removed in the draft form of CASR 135 and it is assumed that this will not change. Additional requirements that may or may not be incorporated into the new CASRs obviously cannot be commented upon.

Pel-Air supports the overall concept of aligning MT operations against AT operations and has already done so as far as practicable for its AMT operations. It agrees with CASA's preferred option 3 as the best mechanism for achieving this. Pel-Air conducts AMT operations with aircraft both below and above 8460kg and will therefore fall under the proposed CASR 121 and the proposed CASR 135.

Current procedures to add ports to an AOC for RPT operations (for those operators without an area AOC) are cumbersome and would not allow the flexibility needed in MT operations. Draft CASR 135.220 seemingly allows an operator to use an aerodrome provided it complies with relevant CASR 139 standards, without specific CASA approval and AOC issue for each port. This same system needs to be applied for MT operations conducted under CASR 121.

The current route and aerodrome qualification requirements for AT operations under CAR 218 would be totally impractical for MT operations where unexpected re-tasking can occur in flight. Draft CASR 135.975 will provide a practical solution to this and needs to be applied to MT operations conducted under CASR 121.

It is noted that the current prescribed pilot experience requirements for AT operations under CAO 82.3 are replaced by a more competency based system under draft CASR 135.960. Pel-Air fully endorses this change, particularly with regard to MT operations which can be highly specialised. Pel-Air assumes that similar provisions will be in CASR 121.

Pel-Air is not sure what the requirements will be for radio communication confirmation systems for AT operations in the new regulations but feels that these should not be required for MT operations which require more flexibility than normal AT operations.

Draft CASR 135.285 contains provision for the seating of able bodied passengers in seats adjacent to emergency exits. This will need to be excepted in the case of medical passengers.

In relation to the new CAO 48.1 Instrument (2013) and fatigue management generally, what approach could best manage fatigue risk in medical transport operations?

Recommend:

[ ] Work to the limits under the pertinent Public Transport Appendices of CAO 48.1, i.e. Appendix 2 (complex multi-pilot Public Transport), Appendix 3 (non-complex multi-pilot Public Transport) and Appendix 4 (single pilot Public Transport)

[ ] Work to a new set of fatigue management rules under Public Transport, which are tailored specifically for medical transport operations and capture appropriate sections of Appendix 5

[√] Work to a Fatigue Risk Management System under Appendix 7 to the new CAO 48.1

Pel-Air has MT operations that would come under both Appendix 2 and Appendix 4 of CAO 48.1. Pel-Air does not feel that these would suit the nature of MT operations which are often non-scheduled and require more flexibility than AT operations without compromising safety.

A modified Appendix 5 could be better but MT operations can vary widely between operators and it would be hard to formulate a 'one size fits all' set of prescriptive rules. Pel-Air does not favour this option.

Pel-Air is strongly in favour of a FRMS as per Appendix 7 of CAO 48.1. Whichever set of rules is adopted this should remain an option for MT operators as per the CAO.

General and specific comments.

Response to the Summary of Air Transport areas that have additional compliance or relief considerations.

A2 Operational Control

Flight following procedure and capability able to update the pilot on operational matters during flight.

Older aircraft do not have the sophisticated in flight communications systems of modern aircraft and to fit them can be prohibitively expensive. This requirement should allow for basic systems such as a sat phone which Pel-Air has used on remote and international flights with its older aircraft.

A.8.2 Experience

Pel-Air feels this is already covered by the draft CASR 135.960(1) and any additional experience requirements over those prescribed for AT operations are not necessary. In the past some operators have turned prescribed minimum experience requirements into a standard training syllabus rather than concentrate on the competency and standard of each individual pilot. Any minimum experience requirements should be imposed by the operator as per CASR 135.960(1). Operations and training systems may vary widely between operators and a blanket minimum experience requirement for a certain type of MT operation may not fit all operators.

A.8.5 Medical Crew Training

Pel-Air has in the past carried qualified medical personnel (doctors and/or nurses) on MT operations who may be considered as medical crew. These were often sourced from a hospital based pool of hundreds and it would not be possible to qualify them all for an annual proficiency check. Some flexibility may be needed to enable the operator to assign a qualified medical person as either medical crew or medical passenger, dependent on the training they have received, irrespective of the fact that they would be performing the same medical task in the aircraft.