
AUSTRALIAN SOCIETY OF
AIR SAFETY INVESTIGATORS
Air Safety
Investigators
Winter News Journal

ASASI Winter News Journal

August 2026

In this journal you can expect:

Welcome to the Winter edition of the ASASI News Journal!

In this edition we cover recent and future ASASI events, membership updates, as well as topical safety issues.

The Asia Pacific Cabin Safety Group continues its important safety work and updates on their work and related issues are included.

Recent events at Sydney Airport have illustrated that “Safety” should never be taken for granted.

The investigations will discover several factors which led to the near miss (reference James Reason) but the fundamental task of safety professionals is to consider “minor” events in order to prevent more serious outcomes. It is interesting to compare the rail investigation involving a collision between two passenger trains in England which is summarised in this edition. The parallels in aviation and rail investigations are evident.

The ASASI website is the main avenue for our society’s information: asasi.org

We welcome feedback and suggestions for improvement both for the website and for future News Journals.

The Executive Report

The past few months have reminded us that resilience is one of the defining qualities of the aviation safety profession. The cancellation of the ANZSASI 2026 Conference in Wellington - driven by global fuel pressures and wider economic uncertainty - was disappointing for all of us. As NZSASI noted, 'ongoing global and economic pressures have affected the ability to deliver the event to the standard our community expects."

Yet the response across our trans-Tasman community has been nothing short of outstanding. NZSASI's decision reflected responsible stewardship, and ASASI fully supported their long-term view.

We now turn our collective energy toward delivering an exceptional ANZSASI 2027 Conference in Canberra, ACT and momentum is already building.

Welcoming New Members & Strengthening Our Community

I am delighted to welcome two new ASASI members since our last newsletter:

- **Ms Sally-Anne Balharry**, an event and investigation specialist with Boeing, Brisbane; and
- **Mr Usman Khalid**, currently completing the final year of his Master of Aviation (Griffith Uni), Brisbane.

Both bring enthusiasm and a genuine commitment to aviation safety. Usman has already connected with our new **Student Ambassador**, Mr Chirag Mehrotra, and expressed interest in mentoring. Thanks to the excellent coordination between Chirag and our **Mentor Coordinator** Ms Hope Rigby, Usman is now matched with Hope - a Brisbane-based mentor with strong investigative and safety credentials.

With this, all ASASI coordinator positions are now active/re-activated and contributing, except for one:

- We are still seeking a volunteer to serve as ASASI's **Scholarship Coordinator**.

If you have a passion for supporting emerging investigators, we would love to hear from you.

ASASI WAI Australia Scholarship — Celebrating Christine Campbell

On the 10th of July, I had the pleasure of representing ASASI at the WAI Australia Awards Announcement (a 'black-tie' affair over TEAMS — I don't think anyone saw my trackie pants). This year's ASASI Scholarship recipient is Ms Christine Campbell, an Essendon-based air traffic controller with nearly 25 years of experience.

As noted in the announcement, 'As the **Check and Standards Supervisor** at **Essendon Tower**, she reviews every **CIRRIS incident report**—work that demands judgement, discipline and a strong safety mindset. Christine has consistently shown that safety is not just a requirement of the job; it's a professional value. What impressed us most is her desire to deepen her involvement in safety and investigations, both to grow personally and to support others. Her commitment to safety, her desire to deepen her investigative skills, and her leadership at Essendon Tower made her a standout candidate.

Christine received a **one-year full ASASI membership** and an **all expenses paid** Registration, travel and accommodation to join us at **ANZSASI 2027** in Canberra (up to the Scholarship cap of $2,000).

Christine, on behalf of ASASI, congratulations. We look forward to welcoming you into the Society, supporting your development, and connecting you with investigators across Australia, New Zealand and beyond.

Our partnership with WAI Australia continues to be one of many meaningful ways we support professional growth, and the next generation of investigators.

ANZSASI 2027 — Canberra, 15–17 June 2027

After site inspections by both Paul Mayes and myself, the Executive has selected the QT Hotel Canberra as the venue for ANZSASI 2027 — and it is a very clear winner on many fronts.

Why QT Canberra?

- **Suites with balconies** — ideal for delegates who appreciate space to decompress after full conference days.
- **Excellent conference facilities** — modern, flexible rooms with strong AV capability.
- **Central location** — walking distance to Canberra's civic centre, restaurants, and transport (new Canberra Light Rail should be good-to-go by June 2027).
- **Stunning 15th-floor reception room** — the venue for our Welcome Reception, offering sweeping views of Lake Burley Griffin, Black Mountain, and the Canberra skyline.
- **A superb bar and dining area** — perfect for networking, informal discussions, and reconnecting with colleagues.

The Executive Report

Mark your calendars now for **ANZSASI 2027** — 15 to 17 June 2027:

- QT Canberra, ACT
- Tuesday 15 June 2027 — APCSWG + Welcome Reception
- Wednesday 16 to Thursday 17 June 2027 — Main Conference

With 11 months to go, the ASASI Executive would love to hear from members interested in assisting with planning, paper selection, logistics, or session coordination.

After the disappointment of 2026, **ANZSASI 2027** is shaping up to be a milestone event - a chance to reconnect, share lessons, and strengthen our trans-Tasman, Australasian and Pacific partnerships.

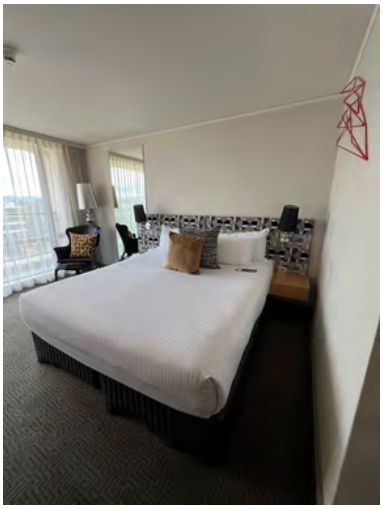
Looking Ahead

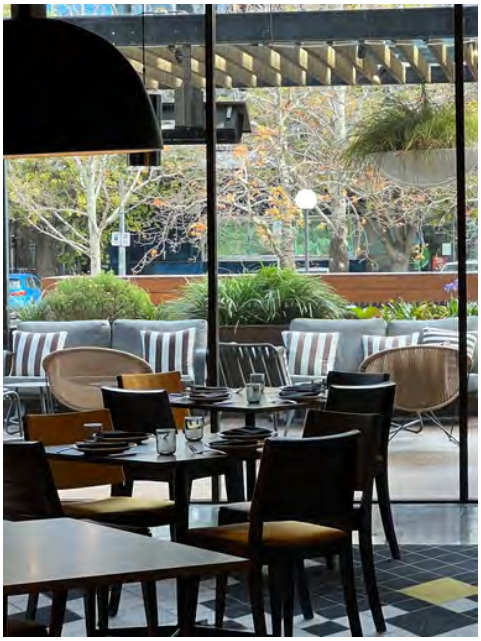
Despite global turbulence, ASASI continues to grow, adapt, and deliver value to its members. Our mentoring program is active, our Student Ambassador is engaged, our partnerships are strong, and preparations for ANZSASI 2027 are well underway.

Thank you for your continued support, professionalism, and commitment to aviation safety. Together, we are building a stronger, more connected investigative community across Australia and New Zealand.
I look forward to seeing many of you in Canberra in June 2027.

Best regards,

Alf Jonas
President, ASASI
13 July 2026





Photos provided by Lori - Thanks Lori!

IATA's Cabin Operations Safety Guide provides a central reference source for industry best practices, sample policies and procedures as well as recommended practices and regulations such as ICAO's Annex 6 relating to the delivery of safe and efficient cabin operations, according to IATA. The latest version of the guide, edition 7 published in 2022, provides updates to existing procedures, and new guidance for root cause analysis for cabin safety-related incidents and reports; accessibility and passengers with disabilities, to align with other IATA activities; and accountability and authority definitions to align with the IATA Operational Safety Audit (IOSA), which is required of all member carriers".

In light that the IATA role is to also educate and guide airline operators it is commendable to see this development of a clear and firm message:

"Every second counts, save a life not a bag"

This recent IATA video has been released learn more here.

Containing the same information, a pamphlet (see page 8)

It is some time since CASA worked on and released some animated videos of their own, they covered a number of cabin safety and passenger related behaviours. This video is in line with the IATA video released this year, and covers a number of cabin safety related issues.

Not the least of which is "leave bags behind" when evacuating.

This article below comes from Mr Nicholas Butcher FRAeS, of the Royal Aeronautical Society in the United Kingdom. He provides a comprehensive history of accident survival and also discusses possible contributing factors to why passengers take their cabin baggage in an evacuation.

Also, see here a recent Australian perspective on the subject. Found on social media – a site called 'Starts at 60', nonetheless a commercial view but it is out there, how many passengers have read this and think it is a reasonable way to look at the topic? In fact, how accurate is it? Is it a cynical move by airlines to add more $$$$'s to their bottom line? Or, could it possibly encourage passengers to reduce the weight in their in-cabin bags? Either way, no discrimination, each Australian airline gets a mention and the overall message seems to be that of how much money the airlines can 'get' from passengers.

On a more positive note - The TSA video embedded in the link is informative and should prove helpful if people are prepared to see it all the way through and adopt some of the recommendations:
https://startsat60.com/media/the-great-airline-baggage-shakedown-why-your-carry-on-bag-is-now-their-most-profitable-piece-of-real-estate?utm_campaign=709441_Saturday%2C%20June%2020&utm_medium=email&utm_source=Starts%20at%2060%20Pty%20Ltd&dm_i=6T9R,F7EP,1QGHEL,29HQ9,1,0,0,0

The notion of leaving cabin bags behind in an evacuation appears to be one of the biggest issues for passengers to come to terms with. Within the survival factors section of an accident report this will invariably be acknowledged. And, there are a variety of reasons for this – again, not the least of which could be cultural and or societal. Oft times the contents of the bag, and the significance it has to that individual is more than anyone else is able to understand.

Within the industry we do not need to convince ourselves of the potential issues, we need to find new and inventive ways to provide information to the travelling public. Commercial considerations have proven to be an obstacle to this notion so perhaps the time is drawing nearer for more open and factual information sharing.

In conclusion, there appears to be a long way to go in the education of the travelling public. There has been progress, but there is room for an increase in the dissemination of greater factual and meaningful information as it relates to Cabin Baggage.

IATA Information Brief

We are all aware of evacuation situations where passengers attempt to retrieve their carry-on baggage, despite clear instructions from cabin crew not to do so.

To better understand this behavior, IATA has conducted passenger research to assess what travellers believe they already know, as well as to identify opportunities to positively influence their actions during an evacuation. In addition, we have reviewed multiple evacuation incidents, video footage, investigation reports, and research studies to better understand the underlying causes of this behavior.

Recognizing that there is no single solution to fully address this issue, IATA has developed and launched, at its recently held AGM, a video campaign to support airlines in reinforcing that such behavior is unacceptable and can put lives at risk.

The campaign is aimed at the general public and will be shared across social media platforms, with the intention of encouraging widespread sharing among friends and family. While the tone is non-confrontational, it delivers a clear and firm message: **“Every second counts, save a life, NOT a bag”**

The campaign comprises of one video including several key messages, and several shorter videos focusing on each specific issue:

Pay attention to crew instructions

1. Leave all baggage behind
2. Don't film, move
3. Keep aisles and exits clear
4. Don't take bags down slides
5. Be prepared

Download the videos here

Download the passenger leaflet here

Call to action

Rail Investigations

The Australian Transport Safety Bureau is “multi modal” with rail and marine investigators. Several other countries have similar safety investigation responsibilities. However, in the UK rail accident investigations are carried out by the Rail Accident Investigation Branch.

It is interesting to see the complexity of modern rail operations and the role of automated safety devices. There are many similarities with aviation accident investigations and the depth and scope of the safety investigations.

Collision

On 19 June 2026, two East Midlands Railway trains collided on the Midland Main Line south of Elstow, near Bedford, England. One train driver was killed and over 160 people injured. An initial examination stated the accident occurred after one train stopped on the line unexpectedly due to an Automatic Warning System fault causing it to automatically brake. It was then hit from behind by the second train that had passed a red signal protecting the train in front.

Two passenger trains operated by East Midlands Railway collided at Elstow, near Bedford, at 17:15 on 19 June 2026. The first train to stop on the line was the 15:50 Nottingham to London St Pancras service 1B67, a five-car Class 810 *Aurora* unit; the second train was the 16:40 Corby to St Pancras service 1H46, operated by a four-car Class 360 *Desiro* unit.

Both the British Transport Police and Bedfordshire Police attended the scene of the collision as part of the emergency response, with inspectors from the Rail Accident Investigation Branch (RAIB) and the Office of Rail and Road arriving shortly afterwards. Whilst a full RAIB investigation into the accident remains underway, a preliminary report was published on 24 June.

In its preliminary report released on 24 June 2026, the RAIB identified the likely contributing factors. Due to a fault with the AWS which caused the brakes to apply, the Nottingham service had stopped unexpectedly on the up fast line where it was struck from the rear by the Corby service. The report stated that the Corby service passed a signal at danger (SPAD), which was protecting the Nottingham service. The Corby service had just crossed over to the up fast line as scheduled after stopping at Bedford, and would have received yellow caution signals. The Corby service made a brake application just nine seconds before the collision, with the train travelling at approximately 76 miles per hour (122 km/h). The Corby service was still travelling at 49 miles per hour (79 km/h) at the time of the collision.

The full investigation will consider:

- the actions of those involved and any factors that may have influenced them · the status and performance of the braking, Automatic Warning System (AWS) and other safety systems on train 1H46
- the reason train 1B67 stopped
- the status of signal WH154 and its AWS equipment, as well as its positioning, visibility, and conspicuity
- the crashworthiness performance of both trains during the collision
- the emergency response to the accident
- the processes used to assess the risk of overrun at this location, and the effectiveness of any control measures intended to address this
- any relevant underlying factors, including any actions taken in response to previous relevant safety recommendations.

How Compounding Risks Drive Runway Excursions

By Advanced Aircrew Academy
Source: https://sm4.global-aero.com

Runway excursions rarely result from a single factor. More often, they develop when several manageable risks combine into a situation that leaves little margin for error.

FAA Advisory Circular 91-79B emphasizes the "compounding effect" of operational hazards, and runway excursion accidents in business aviation repeatedly demonstrate how tailwinds, unstable approaches and contaminated runways can align to overwhelm crews who fail to recognize the deteriorating picture early enough.

The Anatomy of a Compounding Accident

A Learjet 35 runway excursion in San Marcos, Texas, provides a textbook example. The NTSB investigation found the crew landed with a 15-knot tailwind on a wet runway after an unstable approach in gusty weather conditions. The airplane touched down halfway down the runway at 124 knots with only about 2,600 feet remaining and subsequently hydroplaned off the departure end. Together, these conditions created an accident chain.

The flight crew initially received weather information that was approximately one hour old and reported winds favoring Runway 13. However, convective activity near the airport caused the wind to shift significantly before arrival. By landing time, there was an approximate 15-knot tailwind for Runway 13.

Managing Dynamic Wind Conditions

Dynamic wind conditions are a major runway excursion hazard because they often evolve faster than crews anticipate. A preflight risk assessment should not only identify the forecast winds but also evaluate the likelihood of changing conditions at the estimated time of arrival, especially when convective weather or frontal activity could significantly alter runway conditions before landing. Thunderstorms, gust fronts and frontal boundaries should immediately raise concern for runway changes or rapidly shifting winds.

AC 91-79B stresses the importance of continuously reassessing operational conditions during the approach phase. That means crews cannot rely solely on the METAR received earlier in the flight. Staying ahead of changing conditions requires an active strategy.

Crews should brief how they will monitor winds during their arrival by requesting updated tower wind checks, listening for AWOS or ATIS updates, monitoring FMS wind indications and tasking the pilot monitoring with visually checking the windsock on final approach.

The Perils of Unstable Approaches

In the San Marcos accident, changing winds were only one piece of the problem. The NTSB found the approach itself was unstable. Recorded flight data showed descent rates exceeding 2,000 feet per minute shortly before landing, beyond the operator's stabilized approach criteria.

An unstable approach, combined with a tailwind, almost always results in a long touchdown. That is exactly what occurred here. The airplane touched down halfway down the runway, eliminating much of the stopping distance needed for a wet runway landing.

This highlights one of the most important principles in runway excursion prevention: A go-around is not a failure. It is often the safest and most professional decision a crew can make. AC 91-79B and the NTSB both emphasize that crews should not attempt to "salvage" an unstable approach. The accident first officer later stated that a go-around should have been initiated before landing.

Summer Convective Hazards and Runway Contamination

The final hazard in this accident was runway contamination. Many pilots primarily associate contaminated runway operations with winter weather, but summer convective weather creates hazards as well.

The San Marcos runway was reported wet, and the first officer stated the airplane appeared to hydroplane after touchdown. The challenge with convective weather is that runway conditions can deteriorate faster than airport reporting systems can update. Standing water from a passing rain shower may develop within minutes, while braking action reports lag behind actual conditions.

How Compounding Risks Drive Runway Excursions

By Advanced Aircrew Academy

This is why crews should maintain a conservative mindset anytime rain showers are near the airport environment. Even if runway condition codes appear acceptable, pilots should recognize that heavy rain and standing water can significantly increase stopping distances and reduce braking effectiveness. Combining those conditions with a tailwind or long touchdown can quickly erase all available safety margins.

Final Thoughts

Business aviation runway excursion data continues to show the same recurring pattern: Accidents are rarely caused by a single issue. Instead, they result from multiple operational threats combining during the approach and landing phase. The safest crews are the ones who identify those threats early, continuously reassess changing conditions and are willing to execute a go-around before a manageable situation becomes an accident.

Safety Management Systems in Aviation Maintenance

By Jim Lara, Principal and Founder, Gray Stone Advisors, and Steve Brechter, Senior Advisor of Operations, Gray Stone Advisors
Source: https://sm4.global-aero.com

There has been "much ado" about Safety Management Systems (SMSs) in aviation since their debut many years ago. A great deal of the attention has gone to SMS implementation in the Flight Operations arena, and it's been a positive story.

But what has the experience been in implementing SMS systems in aviation Maintenance departments? Is the picture in Maintenance as bright? What results have been achieved? Has SMS had an impact in Maintenance?

The SMS Change

An SMS is nothing new. In the past, however, safety management was not usually considered until after an accident or incident occurred and would accordingly be reactionary.

The difference that SMS systems introduce is a proactive safety culture in which all employees are engaged in reviewing everything they do with the objective of improving safety.

It's about prevention rather than reaction. It's about anticipating safety hazards and taking action to preclude them, not waiting until they happen. At that point, it's too late.

What They're Saying

To find out the impact that SMS systems are having in Maintenance, we went to the source and spoke with a group of front-line Maintenance professionals in some of the most respected business aviation organizations in the industry.

Here's what they had to say about the impact SMS is having in their Maintenance operations.

Improved Communication

Communication emerged "loud and clear" as one of the primary benefits of SMS implementation. SMS systems have almost universally brought forth formal pre- and post-flight briefings where none had been done before or were performed only "when convenient." One director of maintenance reported that "the briefings evolved on their own to include all issues related to the flight, including catering and ground transportation, not just technical issues."

Another maintenance manager reported that their SMS system "improved Operations Manual updates by creating an environment of questioning the status quo and openly discussing new and more efficient ways of doing things across all functional lines."

In another instance, a director of maintenance told us that their parent company takes safety so seriously that all employees have an app on their phone that can send a safety alert immediately when a hazard is seen.

Culture Shift

Many maintenance organizations reported a shift from safety "compliance" to "commitment" after implementing an SMS system. One maintenance manager relayed the story of "a complex technical problem in our rotary-wing operation involving the brief loss of all navigational information during a WAAS approach in IFR conditions. The problem was extremely difficult to troubleshoot and provided the opportunity for flight crews to blame Maintenance for not being able to find the problem and for Maintenance to accuse flight crews of not using the onboard equipment correctly."

But none of that happened. The problem took significant time and attention to resolve, but both groups collaborated in ways not experienced before, due to their SMS experience.

Another maintenance manager told us that "a pilot visiting an FBO sent back photos of the FBO line crews performing unsafe actions on the ramp, beaming with pride over his own Maintenance organization's shop/line practices."

You know that the safety culture in that organization runs deep.

Focus on Process

Process thinking emerged as a powerful benefit of SMS implementation. One maintenance manager reported a reduction in "Ouch, I won't do that again!" instances, where an error is kept under wraps and nobody is informed.

Safety Management Systems in Aviation Maintenance

By Jim Lara, Principal and Founder, Gray Stone Advisors, and Steve Brechter, Senior Advisor of Operations, Gray Stone Advisors

Their SMS system brings these types of experiences out into the open without repercussion. Another manager reported a drop in “cowboy fixes” on the road by flight crews. Such instances are now freely discussed.

One manager shared that the focus brought about by their SMS system “is now transferable to others because our processes and procedures are not just something one person started on their own and disappeared when he retired.”

Another reported that the process focus fostered by their SMS stretched the organization to new ways of thinking.

The Maintenance team “created a change management process that evaluates the operational, technical and human factors impact that the introduction of a new aircraft type would bring.” That had not been done before.

A Few Surprises

There were a few unexpected benefits of SMS implementation reported by the survey group.

One maintenance manager reported “while we do not yet use a formal Maintenance Risk Assessment Tool (MRAT), an informal assessment process is now being used every day without prompting from me or anyone else.”

Another reported that the techniques of SMS have made their way into the Maintenance organization’s supply base, including the OEMs, parts suppliers and regulatory agencies, addressing issues such as recurrent unscheduled component removals, publication problems, overpriced parts, lack of support, etc.

He indicated that “once the SMS culture is engaged, problems get addressed wherever they occur or the system loses value.”

The Outcome

As one maintenance manager put it, “Before SMS, there was a lot of talk, but no action. SMS added the structure and the needed fuel to the fire to get the problems fixed, once and for all.”

That sure sounds like an A+ to us.

ANZSASI 2027 Bulletin 1

June 15 to 17 2027

We are pleased to announce that we have arranged with the QT hotel Canberra to hold the ANZSASI 2027 conference June 15 to 17 2027.

ANZSASI 2027 *Conference*

QT Hotel 1 London Circuit Canberra

The QT Hotel is ideally suited being centrally located in Canberra, and adjacent to public transport. The Conference will follow our usual format with the Cabin Safety Working Group meeting on Tuesday, a welcome reception on the Tuesday evening, followed by two full days of presentations on Wednesday and Thursday and the awards dinner on the Thursday evening. For partners, the QT is close to the central shopping area, with easy access to all the Canberra attractions.

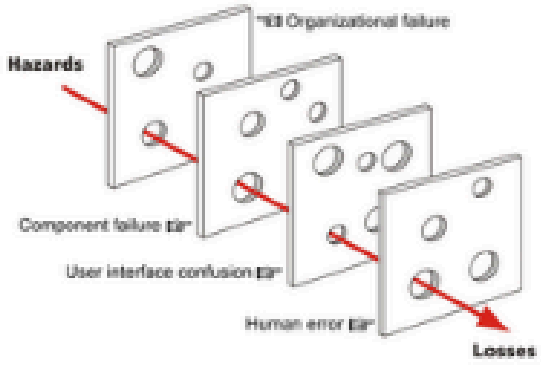
The success of our annual ANZSASI Seminar is always measured by the quality of the papers and associated presentations provided. The conference will cover a range of quality papers will address all aspects of transport safety, safety training and education, human factors and technical developments.

It will be interesting to return to this hotel. In 1991 it was the Lakeside Hotel. And subsequently has been extensively modernised and has become part of QT hotel chain.

In 1991 the Australian Society hosted, for the first time, the International Society's annual international conference at the Lakeside Hotel in Canberra.

It was rememberable for two events in particular. Firstly, we decided to give our visitors from interstate and overseas a touch of the "real" Australia. For the "casual dinner "we bused the delegates and partners to the Colonial Inn at Gundaroo (about 30 minutes) for an Australian BBQ and folklore evening. Entertainment was provided on the buses as well during the trip. The feedback was very positive and helped to promote the **Australian** experience.

The second notable event was the Keynote presenter: Professor James Reason. This was our first introduction to his accident causative model, colloquial referred to as his "Swiss Cheese Model". To experience his presentation of this defining model for safety analysis was unforgettable. It became the basic tool of many accident investigators around the world.

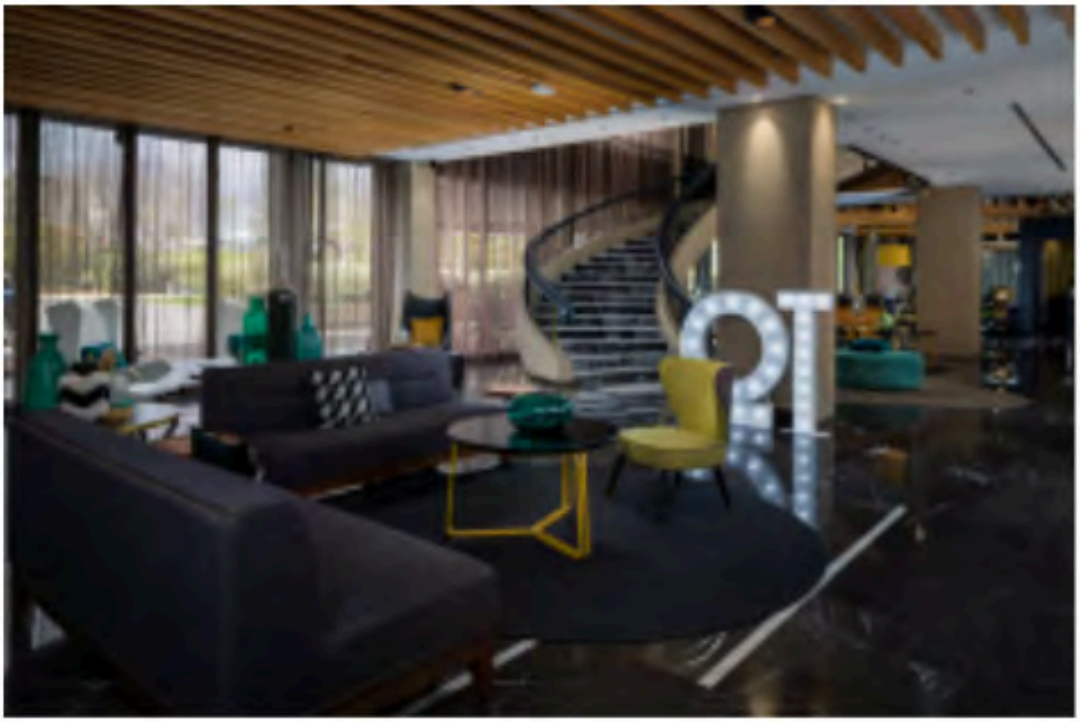


Swiss cheese model of accident causation with example barrier layers

The Swiss cheese model, a conceptual framework for the description of accidents based on the notion that accidents will happen only if multiple barriers fail, thus creating a path from an initiating cause to the ultimate, unwanted consequences, such as harm to people, assets, the environment, etc. Reason also described the first fully developed theory of a just culture in his 1997 book, *Managing the Risks of Organizational Accidents*.

Reason wrote books on human error, including absent-mindedness, aviation human factors, maintenance errors, and risk management for organizational accidents. In 2003, he was awarded an honorary DSc by the University of Aberdeen. He was a Fellow of the British Academy, the British Psychological Society, the Royal Aeronautical Society, and the Royal College of General Practitioners. He was appointed a Commander of the Order of the British Empire (CBE) in the 2003 New Year Honours "for services to Reducing the Risk in Healthcare." In 2011, he was elected an honorary Safety and Reliability Society fellow.

He died from pneumonia at a Slough hospital, on 4 February 2025, at the age of 86.



CANBERRA

Canberra has a number of interesting attractions for visitors, ranging from Museums to world class Art Centres, to the Federal Triangle with Parliament House and the National Library, to the ACT War Memorial and ANZAC Avenue. There are also several large shopping centres and numerous cafes and restaurants. So, there are lots of possibilities for partners (delegates before or after the conference).

Welcome to Canberra
https://canberra.com.au/

Welcome to New Members

So far this year we have had 2 new members who Joined ISASI and, as they are from Australasia, they automatically join our ASASI team. We are very pleased to grow our membership and welcome the new members. They have a wide range of backgrounds and experience which illustrates the scope of contemporary aviation safety and investigation. Details of a new member follows and we plan to introduce other new members in future editions.

Usman Khalid

I am an Aviation Management postgraduate at Griffith University in Brisbane, currently near completion of my Master's degree, with a focus on airport planning, aviation economics, and strategic leadership. I hold a First-Class Honours Bachelor's degree in Airline and Airport Management from Buckinghamshire New University, alongside a dual degree from the University College of Aviation Malaysia. My academic research background includes smart airport biometric integration. As a member of the Australian Society of Air Safety Investigators (ASASI), my core professional focus and technical interests center directly on Safety Management Systems (SMS) and air crash investigation.

Positions Vacant - Volunteers Needed

To support our ‘recharge’ initiative and strengthen our engagement with the next generation, I’m calling for volunteers for an important role:

· Scholarship Coordinator – to oversee our evolving scholarship model

This role doesn’t require a huge time commitment —but it will have a huge impact. Indeed, if any of the members have any other ideas or wish to assist in a voluntary capacity the Executive are more than happy to hear from you.

If you’re interested, please speak with any of the Executive team members

The History File

One of many members of ASASI who has been a keen supporter and promoter of our operations is Dr. Geoff Dell. His involvement in ASASI dates back to the 1970s.

Dr Geoff Dell, PhD, MISASI
Head of Aviation Safety,
AMDA Foundation Ltd.

Dr Dell has been working in aviation safety and air safety investigation for the last 45 years. He joined ASASI in 1979 as an Associate. Ian Smith was the ASASI President and 108 Londsdale St was still the ASIB headquarters and Frank Yeend was just about to retire with Paul Choquenot taking over. It took Geoff nearly 2 years to accumulate the required number of investigations before he achieved full membership grade in May 1981. He has had senior safety appointments in multiple airlines; TAA,
Australian Airlines, Qantas, Cobham, Nauru Airlines and has conducted many freelance air safety and other investigations, including many expert witness investigations and reports for Coronial, Civil and Criminal Courts in Australia. From 2010 to 2020 he held a professorial position at CQUniversity to develop and implement the unique Bachelor of Accident Forensics and Masters of Air Safety Investigation programs. By the time the COVID Pandemic hiatus caused the University to close all its non-core programs, there were over 500 student enrolments across the accident forensics and investigation program suite. Dr Dell has been Head of Aviation Safety for the AMDA Foundation for the past nine biennial
Avalon International Airshows and has been full time in the role since mid-2024.

Thank you for reading!

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