

## **Professional Aviators Investigative Network.**

Supplementary submission to:

**Senate Standing Committee on Rural Affairs and Transport.**

### **Norfolk Island ditching.**

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## 0. Executive Summary.

1) The purpose of this supplementary document is to bring to the attention of the Senate Committee industry concerns emanating from the ATSB and CASA response to questions on notice from the enquiry into the ditching of a Pel Air medivac jet aircraft off Norfolk Island in 2009.

2) While the enquiry has raised many safety issues which must be addressed. It is the perception of subterranean machinations which leave a whiff of corruption in their wake to which the Senate Committee must now address their enquiry, if it is to have any lasting benefit for the Australian aviation industry. Obvious aberrations exist within the Pel Air matter, but they are not exclusive to the case.

3) The apparent cavalier attitude of both the ATSB and CASA toward due process, protocol and the constraints placed by Parliament on their activities raises alarms. The feckless, almost instant judgement, accusation and administrative punishment brought under the guise of the Civil Aviation Act 1988 for alleged reckless and negligent operations, of not being a fit and proper person, or of being a 'danger' to the safety of air navigation has long been a point of contention.

### For example:-

CASA attachment to Mr White's letter states: "*Section 20A of the Civil Aviation Act also makes it an offence to operate an aircraft being reckless as to whether the manner of operation could endanger the life of another person (or the pilot).*"

**Opinion.** - (or the pilot) in the CASA attachment, if so, that is a serious misstatement of S.20A, and reveals complete ignorance of the last amendment to S.20A, which removed the nonsense provision that you could be criminally liable for being negligent to yourself.

### For example:-

9. I am satisfied that your actions in conducting these manoeuvres during the flight in the helicopter were dangerous and contravened the following provisions:

#### **Civil Aviation Act [1988] Section 20A Reckless Operation of Aircraft.**

- (1) A person must not operate an aircraft being reckless as to whether the manner of operation could endanger the life of another person.
- (2) A person must not operate an aircraft being reckless as to whether the manner of operation could endanger the person or property of another person.

Penalty: Section 20A(1) - Imprisonment for 5 years

Section 20A(2) – Imprisonment for 2 years

#### **4) There are not, nor ever have been penalties stated with 20 A (1988 Act).**

**Opinion.** Note the indicating of penalties. This would appear to be in contravention of the version of the Act that was current at that time.

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5) The industry is being deprived of invaluable safety information and reform which should have resulted from a safety recommendation issued by the ATSB in response to what their investigators clearly identified as 'critical safety issues'. The delay in providing potentially life saving information is viewed as an aberration, produced by a culture of "strictly no liability" evidenced by:-

a) The selective use of 'suitable' parts of the Act and of regulations to manipulate a preordained outcome and the willingness of subordinate officers to comply with the edicts of the top echelon.

b) The patent disregard for the provisions and prescriptions of the Transport Safety Investigation Act (TSI).

c) The patent disregard for the provisions and prescriptions of the Freedom of Information Act (FOI).

6) The almost risible legal 'tap dancing' act around the extreme edges of the various Acts must stop with this Senate enquiry.

7) We respectfully suggest that the Senate enquiry, potentially could be viewed as incomplete without the testimony of the following individuals being heard, examined and duly considered in regard to the current Pel Air enquiry.

Mr. John Grima. CASA.

Mr. Michael White. CASA.

Mr. Roger Chambers. CASA.

Mr. Mike Watson. ATSB.

Mr. Joe Hattley. ATSB.

8) We believe that informed inquiry made of these officers statement and testimony, under oath could dismiss the notions which haunt the matter:-

a) The perception that the CASA ALIU team have breached s24 of the 1988 Act, within the parallel investigation in regard to radio transmission transcript, meteorological information and the proposed enforcement action against the pilot.

b) The perception that the CASA ALIU team have breached the AGIS 2003 Act and the CASA investigators manual within the parallel investigation.

c) The perception that the investigation was not instigated under the protocol and prescription set down by act of Parliament.

d) The perception that there was an accommodation reached between the ATSB and CASA to downgrade critical safety issue to a minor safety issue.

9) In order to disprove and allay the perceptions held by industry, all E-mails, letters, and communication logs between CASA (Grima, White, Chambers, Farquharson, McCormick and Anastassi); and, the ATSB (Dolan, Sangston, Hattley and Watson) be requested and independently examined with the record and minutes of meetings between ATSB and CASA before and after Grima became involved.

**1. Introduction.**

1) Prompted by the answers supplied to questions on notice, this supplementary submission is provided further to assist the Senate Inquiry into the ATSB treatment of Pel Air ditching incident off Norfolk Island. (ATSB AO- 2009-072-).

2) Research has revealed several areas of concern which relate directly to the involvement of CASA in the production of ATSB report, the officers who presented the CASA audit, special audit, investigation; and the management of that process.

- Pel Air Norfolk Island. ATSB-AO 2009-072.

3) To assist with a full understanding, we are obliged to draw your attention to two other analysis and investigations conducted by CASA officers which have direct relevance to the Pel Air enquiry. We have provided a short summary relating to the following matters which, we believe have a direct bearing on the manner in which the CASA and ATSB present answers, facts and circumstances to the Senate, the Judiciary and industry since the infamous Lockhart River enquiry. The perceived flaws appear to be common to the cases examined.

- Skymaster Canley Vale fatal. ATSB-AO 2010-043.
- John Quadrio. CASA investigation.

4) We believe that only a Judicial enquiry, assisted by an acceptable, appropriately qualified party into the legality of the CASA methods will resolve the issues. It is considered essential to examine CASA dealings with Coronial, Judicial, Tribunal and various Senate Committees. It is desirable that the outcome resolve conflict and remove the distrust that has developed between the CASA and the aviation community, at home and overseas.

5) We suggest that should even part of industry argument be proven, any aviation related court judgement or AAT ruling against an individual or company over the past four years, supported by CASA evidence must be considered suspect and probably legally unsafe.

## 2. Critical safety issues.

1) The ATSB has provided the Committee with a document -AQON\_2111112- in response to questions posed November 11, 2012. The information provided relates the internal management of the clearly defined 'critical safety issue' and the interaction between the ATSB and CASA.

2) The ATSB response provides a very clear understanding of the process by which a critical safety issue (CSI) status was maintained for 29 months before being significantly down graded just before the final report was published.

3) A time line analysis clearly shows the ATSB did not resile from the critical safety issue position until August 2012.

- 4 July 2012: The ATSB requested a copy of the CASA special audit report under a TSI section. A copy of the report was received by the ATSB on 9 July 2012.
- 16 August 2012: ATSB Commission approves the release of Final Report AO-2009-072 and officially reclassifies the long standing 'Critical safety issue' to a minor safety issue.

4) Until this point in time, the Norfolk incident was clearly defined as a critical safety issue by ATSB: all indications were that the ATSB intended the CSI to become a Safety Recommendation (SR).

**It is revealing that all reference to the CSI report and the proposed SR review was completely omitted from the 'Final Report'.**

5) Contained within the background section of ATSB report Appendix 2.

*"The ATSB may use its power to make a formal safety recommendation either during or at the end of an investigation, **depending on the level of risk associated with a safety issue and the extent of corrective action undertaken by the relevant organisation.**"*

6) Reading the offered correspondence between ATSB and CASA, it is reasonable to assume that the ATSB investigation team was acting wholly within the protocols and procedures of the Transport Safety Investigation Act (TSI). 'Attachment 1' was written in a manner which strongly suggests the ATSB team had every intention of translating the critical safety issue into a Safety Recommendation.

Refers - AO-2009-072 of 26 February 2010.

7) This would, under 'Division 2' of the TSI Act, to be a natural course for the ATSB team to take where a safety issue is listed as 'critical'. The report appears to have been written in the general format of a safety recommendation destined to be included in the 'Final Report' safety action section.

8) Should the critical safety issue have become a Safety Recommendation then the findings from the ATSB team would automatically become public forcing CASA to respond and institute remedial action in a timely manner, ensuring that the CASA actions and timing could be publicly documented and scrutinised.

### 3. Departmental communications.

1) The critical safety issue (CSI) report highlights several institutional, cultural and regulatory deficiencies within the administration of CASA; by revealing possible adverse implications from the findings of the Special Audit Team and subsequent administratively enforced actions inflicted on the Pel-Air pilot. Remember, several of the issued RCA were directly relevant to CASA, the Company and pertinent to the critical safety issue. Remember also that the RCA were issued after CASA accepted the MAP and that the CASA Special Audit Report was not sent to the ATSB until July 9, 2012.

16 December 2009: CASA accept the Pel-Air 'Management Action Plan' which consisted of three phases.
18 December 2009: Pel-Air successfully completed Phase 1 items and were able to recommence domestic operations.
23-24 December 2009: CASA overseeing FOI of Pel-Air Eric Demarco issues 14 RCA and a number of AOs. The RCAs needed to be acquitted by 28/01/2010.
24 December 2009: Pel-Air successfully completed Phase 2 items and were able to recommence international operations.
8 January 2010: CASA issue 7 more RCAs and several more AOs, all of which Roger Chambers the Audit Coordinator signed on behalf of several SAR team members.

2) We note ATSB -AQON\_211112- is devoid of any record of communications pertaining to one of two mentioned, criticals meeting between ATSB and Mr John Grima, CASA Acting 'Flight Operations & Licensing Standards Section Manager'.

**Hansard** 22/10/12: "**Mr Sangston:** *There was a second meeting whereby we met with a gentleman, John Grima, in CASA and we discussed the proposal again. If you peruse the letter that initially went to CASA, you will see that from our standpoint there was no proposal or intent to mandate any resolution. Indeed, the way we identify our safety issues is to identify the safety issue and then the owner, if you like—which in this case was CASA—would develop the response to the safety issue.*"

3) We note no documentation or minutes have to date been produced defining the agenda, context, minutes; or indeed any outline of the outcome of these crucial two meeting. Despite the Senators requesting that this information be made available.

**We believe the Senators need to insist that the details of this second meeting be produced and that John Grima be present to give evidence.**

4) From minutes of "Operational Standards Subcommittee Meeting" it is appears that the primary role Mr. Grima plays is to 'sell' the CASA regulatory reform program, changes to CAO 82 and to justify the CASA stance on the restrictions placed in the use Night Vision equipment by industry.

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5) It is noteworthy that ATSB also clearly indicate, at an early stage that the ATSB was not laying blame; directly or by inference on the pilot, but had correctly identified systemic operational and regulatory deficiencies.

Refers - Attachment One to ATSB letter AO-2009-072 of 26 February 2010.

6) CASA attachment to Mr White's letter states: "*Section 20A of the Civil Aviation Act also makes it an offence to operate an aircraft being reckless as to whether the manner of operation could endanger the life of another person (or the pilot).*"

7) This appears to indicate that initially CASA were considering a line of enforcement action under Section 20A of the Civil Aviation Act. It would appear that Mr White 'believed' or was persuaded that the documents provided by ATSB did not relate to the existence of a critical safety issue, but were actually part of a "Draft Safety Report". (Appendix 2 - TSI part 26).

Refers - Attachment to White's letter: "*Draft Transport Safety Report AO-2009-072.*"

8) It begs a question; whether this was a misconception or misdirection by the highly qualified Mr White. A full copy of the draft report would provide definitive answers. If it was part of a draft report, how is then possible that the 'Final Report AO-2009-072 ' took a further 29 months to complete?

8 January 2010: Audit Report completed.
3 February 2010: Video conference meeting between the ATSB and CASA to discuss critical safety issue.
12 February 2010: Mr R White ALIU Manager contacts Mr Michael Watson the ATSB 'investigator in charge' to request a supporting letter that described the critical safety issue.
26 February 2010: Mr Sangston Director of Aviation Safety Investigations writes to Mr White addressing the critical safety issue with the requested supporting documentation.
20 March 2010: CASA internal e-mail that highlighted a 50:50 split within the CASA inspectorate on when to divert to an alternate.
26 March 2010: Mr White and CASA initial response to critical safety issue.
15 June 2010: ATSB receive e-mail from Pel-Air detailing actions done in response to CASA Special Audit.
21 July 2010: CAIR 09/3 completed.
13 January 2012: ATSB issue preliminary report AO-2009-072
26 March 2012: Mr Sangston approves Final Report draft release to the directly involved parties (DIP) for comment on its factual accuracy. Comments were requested from DIPs by 23 April 2012.
4 July 2012: The ATSB requested a copy of the CASA special audit report under a section 32 notice. A copy of the report was received on 9 July 2012.
16 August 2012: ATSB Commission approve s25 release of Final Report AO-2009-072 and officially reclassify the 'safety issue' to minor.

#### 4. CASA investigation.

- 1) It is noteworthy that at the same time the CASA **Audit** team was deployed, the parallel **investigation** team were assigned.
- 2) The investigating audit team, appears to have been initially tasked with examining the potential for prosecuting the pilot under Section 20A of the Civil Aviation Act; a criminal offence.
- 3) As a federal enforcement agency CASA appear not to comply with the 'Australian Government Investigative Standard 2003'. (AGIS 2003).
- 4) The issuing of a Form 333 'Request for Investigation' or 'Recommendation for AIN' must be completed, submitted and approved to refer an investigator officially to the case. A CASA investigation team must comprise at least one Part IIIA delegated investigator.
- 5) Strict protocols and procedures are required to be completed. There is no evidence presented which justifies or proves that the "Investigation" was initiated according to the terms and conditions prescribed within the CASA document Investigators Manual (AGIS 2003).
- 6) We believe there exists reasonable doubt that due process and protocol were complied with; further this supports a notion that the investigation may have been both illegal and compromised, at the least by conflict of interest.
  - a) The early, precipitous unsubstantiated judgement that there had been 'intent' to breach Section 20A of the Civil Aviation Act may have been utilised as sufficient justification for an official 'investigation'. No evidence existed of intent during the audit, charges were never been laid, nor has CASA ever justified assigning a IIIA investigator.
- 7) We believe the Senate Committee should request the pertinent documentation approving an investigation, the terms of reference for the investigation, the reasoning which determined that parts of the Civil Aviation Act were intentionally breached, the name and qualification of the approved IIIA investigator, and the reasons why the bulk of the Pel Air investigation team was made up from the CASA team which audited Pel Air. One of whom was the FOI supervising Pel Air operations at that time.
- 8) We suggest the Committee request under FOI:-
  - a) A copy of the pro-form document '333', justifying the investigation, cost benefit analysis, authorisation for, approval of the investigation; and the formal appointment the IIIA investigator.
  - b) Request all documentation and evidence completed under the AGIS 2003 guidelines, which include the proper, documented control and presentation of all evidence gathered. We believe the Committee Chair requested this document be tabled. **Hansard** 22/10/12 pg 48:

**Mr. McCormick:** *"We are talking about the chief pilot. In actual fact, Mr Dominic James's training"—etc.*

**CHAIR:** *Can you table that?*

**Mr McCormick:** *I am not sure if you already have it or not, but I am quite happy to table it again." etc.*



## 5. CASA – ATSB understanding.

1) **Senator XENOPHON:** *"CASA has said, in relation to the AIP with respect to this, that they intend—emphasis on the word 'intend'—to change it in 2014. Given what has occurred, do you consider that time frame to be reasonable?"*

2) Although open-ended and not quite within the ATSB purview, the question still needs to be addressed. The question serves to highlight that because the critical safety issue was never 'formally' acknowledged or made a Safety Recommendation **there is no constraint on CASA to address the issue in a timely, accountable manner.**

Refers – Attachment One to ATSB letter AO-2009-072 of 26 February 2010.

3) Mr White was appointed to a new position created as a consequence of the Miller review and prior to the 2010 Memorandum Of Understanding. In this position White would have been totally cognisant of the MOU and the TSI Act 2003. It is reasonable to assume that White comprehensively understood all CASA obligations in relation to an ATSB accident investigation.

4) The correspondence between Mr. Sangston and Mr. White provides several points of interest:-

5) It appears that prior to the Feb 3<sup>rd</sup> meeting between the ATSB and CASA that White had been tasked to run a parallel 'investigation' to determine if CASA could reasonably pursue an enforcement action solely against the incident pilot under section 20A of the Civil Aviation Act.

a) We suggest the Feb 3<sup>rd</sup> meeting came as somewhat of a shock to White and may have forced a change in direction. The CSI identifying a need to defend against the implications contained within the SR, critical of CASA, should the safety recommendation be published.

b) We suggest the Feb 26<sup>th</sup> correspondence from the ATSB within the 'attachment' would have been a further shock to White. The correspondence clearly shows that the ATSB had factually researched and documented a very strong case for the critical safety issue (CSI) to be accepted and actioned by CASA. The next step in the process would be for the ATSB to promulgate a safety recommendation (SR). Stating that 'Attachment 1' was considered only a 'Draft Transport Safety Report' perhaps further highlights this.

Refers - AO-2009-072 of 26 February 2010.

6) The above all seems to indicate that at sometime during the CASA investigation it was decided to abandon the Section 20A line of possible enforcement action. If this is so, the abrupt change of tack should also be identified in the mandatory documentation, submitted by the 'investigation' team reporting to the branch manager Mr. Roger Chambers.

7) It would be of some interest to identify who instigated this directional change and whether it was due to CASA realising that a safety recommendation was imminent.

8) It would be of considerable interest to evaluate the entire document trail related to this about face, the minutes of the monthly briefings between the IIIA investigator and the MEPP, CI, RM and ALC (Appendix 2 - flowchart B) and any notes, emails or correspondence related to the matter.

## 6. White to Sangston.

1) It is unclear whether White was the author of, rather than the signatory to the response made to Sangston; the reply attachment presents a 'disjointed', almost inarticulate, totally unconvincing attempt to refute the ATSB critical safety issue (CSI) report and related correspondence. Refer to the attachment to White's letter: "*Draft Transport Safety Report AO-2009-072*."

2) It is interesting that White's reply to the ATSB did not occur for one month following the Feb 26<sup>th</sup> ATSB correspondence. It would be reasonable to enquire whether the critical safety issue matter was run through various sections of the CASA, in particular CASA Legal Services Division. It is a reasonable assumption that during the process, all possible implications of the critical safety issue becoming a safety recommendation were discussed: a plan of action developed; and Mr. Grima introduced into the equation.

a) If this was found to be the case the possibility of a direct contravention of TSI section 26 'Draft Reports' arises. (Appendix 2).

3) It would appear that White believed or was persuaded that the documents the ATSB sent to him regarding the critical safety issue were actually only part of a "*Draft Safety Report*": and could be treated as not yet affecting CASA.

4) From the available evidence it would appear that the ATSB and CASA have 'sat' on a 'critical safety issue' from the 26 March 2010 until the 16 August 2012. This is directly in conflicts with the following

*"Safety issues are broadly classified in terms of their level of risk. A critical safety issue is associated with an intolerable level of risk, **and generally leads to the immediate issue of a safety recommendation** unless corrective safety action has already been taken."*

Refers - "*Nature of the critical safety issue – ditching 3 NM south-west of Norfolk Island Aerodrome, 18 November 2010*" attachment:

5) Eventually, the ATSB elected not to issue a safety recommendation for the critical safety issue. Thus, the valuable, potentially life saving research faithfully generated by the ATSB investigation team was never formally recorded or placed on the ATSB database and is now lost to industry.

Refer - Attachment One to ATSB letter AO-2009-072 of 26 February 2010.

Quote from Hansard 21/11/2012 pg 19: **"Mr Dolan:** *"I would not have assessed, even at that stage, that it was a critical safety issue. I would have through that, prudently, we would have said it was significant.*

**However, the record shows unequivocally that it was clearly identified as a critical safety issue and not downgraded until 16 August 2012. All mention of this was omitted from the 'Final Report' safety action section.**

**7. Safety Recommendation impact.**

1) It is worth noting that had the ATSB made a formal Safety Recommendation then the CASA would have been legally obliged to respond and acquit the SR within a prescribed time frame. By delaying the finalisation of the ATSB final report, the potential for a clear breach of the TSI Act was only avoided by persisting with the argument which qualified the ATSB critical safety issue as "DRAFT" only.

***Quote** - "Safety action includes the steps taken or proposed to be taken by a person, organization or agency in response to a safety issue. The ATSB may use its power to make a formal safety recommendation either during or at the end of an investigation, depending on the level of risk associated with a safety issue and the extent of corrective action undertaken by the relevant organisation."*

Refers - Attachment One to ATSB letter AO-2009-072 of 26 February 2010:

2) Although the available documentation presents the impression of 'robust' debate between CASA and the ATSB, particularly in regard to the regulations and guidelines for in-flight decision-making; the published results do not remotely match the 'robust' rhetoric. All remained under the cover of "DRAFT" critical safety issue report rules.

**There is no formal denial by CASA that this was a critical safety issue.**

**There no formal acknowledgement by the ATSB that the matter had been acquitted or that the proposed corrective action plans by CASA were acceptable.**

Refers - Attachment One to ATSB letter AO-2009-072 of 26 February 2010 .

TSI - 26 "Draft reports" available Appendix 2.

**8. Canley Vale – Fatal.**

1) ATSB report -AO 2010-043- released on the Canley Vale fatal accident reflects the continuing downward trend in the independence, value and probity clearly visible in the Norfolk Island ditching report. This is clearly evidenced in the obfuscated, confused statements presented as fact, within the ATSB report from page 30 onwards.

2) The report presents as a pro forma document constructed to prevent any form of legal challenge to the CASA case against the closure of two Bankstown based operating companies. Apparently, it is now being seen as essential to abrogate all CASA responsibility rather than provide a factual, unbiased account of the incident.

a) Defined in industry terminology as the CASA "Strictly no liability" policy.

3) The following provides the supporting evidence for this statement and seeks to explain how the ATSB report is viewed as corrupt and why the entire matter should be subject to an independent Judicial enquiry.

4) To examine the Skymaster fatal it is necessary to understand the enforced closure of the sister company Airtex Aviation. Both companies were owned and directed by one individual. The companies were operated and managed in very different manners, as separate entities; each under the direct control of an independent chief pilot. The only direct operational link between the two entities was a common operations and flight following department.

a) Airtex operated two aircraft under an Air Operator Certificate designed to support medium weight, turbine powered aircraft, utilising a two pilot crew.

b) Skymaster operated approximately 20 smaller aircraft under an Air Operator Certificate designed to support light weight, reciprocating engine aircraft, crewed by one pilot.

5) CASA elected to pursue the closure of the Airtex operation through the AAT. The Skymaster Canley Vale fatal accident occurred during this period.

a) CASA pursued the Airtex matter using the testimony of Skymaster personnel in 'evidence' as part of the case against Airtex.

b) CASA pursued the matter using many Skymaster aircraft maintenance issues, incidents, and accidents as part of the case against Airtex.

c) CASA brought previously acquitted RCA in evidence. Many RCA were minor referring to administrative infractions of policy. Many of the charges could best be described as fanciful, at worst allegedly fabricated. These issues were presented as prima facie evidence of wrong doing, cynically manipulated to support the CASA argument under the relaxed rules of evidence in the AAT.

d) CASA was obliged to abandon approximately 30% of its voluminous 'evidence' (facts and circumstances) during the final days of the AAT hearing as unsupportable, and terminated the employment of a Flight Operation Inspector shortly afterwards.

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6) Under Parliamentary privilege, in camera there are upward of 12 independent witnesses who are prepared to provide their statements as were freely given to assist the ATSB. The sworn statements make a nonsense of the thinly disguised, manipulated conclusions drawn in the ATSB final report.

7) CASA was made aware of the serious concerns of two senior Check and Training pilots related to the training practices of the incumbent Skymaster chief pilot . One senior pilot made two written attempts to engage CASA, predicting a fatal accident if the matters raised in the report were not addressed. The prediction proved to be tragically accurate.

a) CASA dismissed the written reports offered by a senior Check and Training pilot, qualified and approved as an Approved Testing Officer.

b) CASA dismissed the written report provided to Skymaster management, highlighting deficiencies in both operational standards and the published company operating procedures manuals.

c) CASA suggested that the report be removed from the Safety system data base and that the matter be dealt with 'in house'.

d) CASA warned off the Airtex chief pilot and Head of Check Training, advising them not to interfere in the affairs of a separate' company. (Skymaster)

8) CASA and ATSB were made aware of the horrendous working hours imposed by the Operations Manger, enforced by the Skymaster chief pilot; related to length of duty period, the amount of sectors required to be operated and the fiscal penalties for not 'going along'.

9) CASA and ATSB were made aware of the marginal, cut-corner maintenance practices of the chief engineer. The generally poor, though 'legal' condition of the aged Skymaster aircraft fleet; and the unspoken law against complaining. The status quo was fully supported by the Skymaster chief pilot, who was an enforcer of the 'there are no maintenance issues' philosophy, also a repeat offender in the entrenched art of never, ever committing an aircraft fault to paper, unless there was no other option.

10) CASA and ATSB were made aware of the pressures on junior pilots, brought by a Skymaster major client, Heron Airlines; fully supported by the Operations manager and Skymaster chief pilot to carry 'heavy' loads over extensive distances, to the detriment of aircraft fuel planning and performance rules.

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Pilots who expressed concerns about being exhausted were 'sidelined' for a period of attitude adjustment.

Pilots who expressed concerns about operating aircraft not quite 100% operationally suitable and serviceable were 'sidelined' for a period of attitude adjustment.

Pilots who expressed concerns about being caught out, under-fuelled, over weight, with no escape should an engine fail at a critical point during the flight were 'sidelined' for a period of attitude adjustment.

**11) CASA and the ATSB were made fully aware that Wilson had dared to commit all of the above offences: and, no matter what Wilson did, right or wrong, it would end in some form of humiliating verbal abuse or fiscal penalty.**

12) CASA and the ATSB were made fully aware of the bullying and abuse Andrew Wilson was subjected to by the Skymaster chief pilot. Wilson was a constant target for 'jocular' derision, 'check rides' and other interesting humiliating events.

For example - the chief pilot Skymaster, a loudly and often self confessed 'Homophobe', believed Wilson to be 'homosexual'.

a) The question of Wilson's orientation was discussed with several pilots and suggested to many. Amusingly, the one pilot who absolutely rebutted the suggestion was the only homosexual pilot on the fleet; although this fact was not known the Skymaster chief pilot.

13) Andrew Wilson was to leave Skymaster and it's hated chief pilot the day after his last flight.

14) Perhaps Andrew made some wrong decisions the day he died, this we will never know from the ATSB report.

15) Was he cruelly deceived by a recalcitrant aircraft with a known history of 'difficult' engine management issues?, this we will never know from the ATSB report.

a) We do know he would dread having to endure yet another denigrating tirade from the Skymaster chief pilot on his return to Bankstown.

b) We do know that avoid the tirade he would have acted as instructed by the chief pilot on many other occasions, rather than risk a repeat performance of previous humiliations.

b) We do know that the damage the Skymaster chief pilot inflicted on the sound basic training Wilson had been given and the detrimental effect this had on his development of command confidence were a significant causal and contributing factor to this accident.

16) We will never know from the ATSB report. None of these issues, duly reported to CASA and the ATSB have been acknowledged within the final report, which is an insult to the death of young pilot, his family and friends, the public and the industry.

**9. Probity of CASA evidence.**

1) In support of the Pel Air inquiry, we beg leave to mention the case of Mr. John Quadrio. An average Australian who, until four years ago, earned a humble but satisfying living operating helicopter scenic flights over the Great Barrier Reef. As yet, Mr Quadrio's appeal case has not been presented to a court and may be discussed, with his express permission, herein.

**Bear in mind, the CASA actions were fully supported by and orchestrated with the knowledge of both the CASA legal department and the Director.**

2) PAIN conducted as one of many, an examination of the incident; and, our opinion agreed the Commonwealth Department of Public Prosecution (CDPP) summation that there was no case to answer. CASA persisted with the case in the Australian Administrative Appeals Tribunal (AAT). Four years later Mr Quadrio is still deemed 'not a fit and proper person' and remains firmly, administratively prevented from returning to industry.

a) PAIN presented a confidential briefing to the Queensland Police Service seeking advice as to whether there existed any breach of Queensland law in the physical evidence chain, sworn testimony or the methods used in the collection of evidence; and the manner in which the matter was presented to the AAT.

b) After the QPS briefing was provided two CASA corroborating witnesses made signed affidavits which recant statements made under oath. They have provided sworn statements alleging coercion, threats and physical fear being used to acquire their signatures on prefabricated statements; contrary to their original interview statements. Under threat of up to eight years goal, their support of manipulated or manufactured evidence was 'requested and required'.

c) Since the QPS briefing was provided a further two independent, unheard witnesses have agreed to provide sworn statements which further corroborate Mr Quadrio's original unchanged testimony.

d) The Air Operator who employed, suspended and subsequently dispensed with Mr Quadrio's services has since made a statement which not only supports Mr Quadrio, but explains, amongst other matters, that the company was forced to take the action under threat of the business being closed down by the CASA.

3) We are informed by Council for Quadrio that these matters will be brought to trial and thoughts of compensation or recompense, settled out of court will not be contemplated. A judgement against CASA will be vigorously sought; fully and proudly supported by the Australian aviation industry.

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**End of report:**

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