Professional Aviators Investigative Network.
(PAIN).

Commentary.

Canley Vale Fatal.

ATSB-AO 2010-043-

Overview.

The 'technical' aspects of an air accident investigation present one of the more difficult areas for non industry participants to come to terms with. It is however considered essential that the Senate Committee be offered a report which avoids confusing terminology, endless series of meaningless data and presents as succinctly as possible, identified problematic areas which require further examination.

The short commentary following is presented with the aim of achieving two objectives:-

a) To define, as clearly as possible, some of the basic problem areas raising concerns within the ranks of industry experts. These issues are not solely restricted to the Pel Air ditching event. The concerns are chronic; initially becoming noticeable after the Lockhart River tragedy, becoming endemic, almost the 'norm' for the preceding five years.

b) To further assist the Committee in reaching, for what many in the aviation industry believe is a landmark report, a conclusion to the Pel-Air event which will assist in curtailing the growing budgetary costs of sustaining the current reporting system, from which no definable, useful benefit is gained.

The following commentary is not presented as a complete analysis, nor should it be treated as such. The construct is abridged and represents the opinions and comments of senior industry personnel.

PAIN editors.

BKC 8. Canley Vale – Fatal.

1) ATSB released report -AO 2010-043- focusing on the Canley Vale fatal accident clearly reflects the continuing downward trend in investigation quality, the dependence on CASA conclusions and opinions, further degradation in the value and probity of reports, visible in the Norfolk Island ditching event. This is clearly evidenced in the obfuscated, confused statements presented as fact, within the ATSB Canley Vale report, from page 30 onwards.

2) The report presents as a pro forma document, which, in our opinion is 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 a supporting construct for this statement and seeks to explain how the ATSB report is viewed as flawed and why the entire Canley Vale 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 a very different manner, 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 Canely Vale fatal accident occurred during this period.

a) CASA pursued the Airtex matter using much Skymaster personnel testimony and '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 into evidence. Many RCA were minor, administrative infractions of policy; many of the charges which could best be described as fanciful, at worst alleged to be fabricated; 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 it's voluminous 'evidence' during the final days of the AAT hearing as unsupportable, and terminated the employment of a Flight Operation Inspector shortly afterwards.

*Request for Corrective Action (RCA); later replaced by the Non Compliance Notice (NCN).

BKC 8../Cont:

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. Refer 'Cheese' page 11.

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 insisted 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' although sister 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.

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

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

c) Pilots, 'under contract' 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 brought into discussion 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, certainly not 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, certainly not 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.

Analysis.

0. Introduction.

The guiding principles of an engineering report are that it should analyse data, present results, conclusions and make recommendations in a precise and accessible manner. The report should be transparent in its presentation of data so that it facilitates peer review.

The ATSB investigation document AO-2010-043 (Collision with Terrain Piper PA-31P-350 Mojave VH-PGW) fails as an engineering report and one would question whether the author has sufficient technical understanding. Interestingly, it has a range of human factors texts cited in full Harvard referencing discipline. However there is no reference to technical and measurement equipment used, its calibration, nor a discussion on the limits of accuracy.

The report seems to indulge in gratuitous criticism of the operator and its operating discipline that is not germane to the accident. If this is an accident investigation, it should remain focussed on factors relating to the incident only.

The reports inclusion of an un-named pilot's opinion of the VH-PGW pilots flying ability is nothing better than reporting on gossip and has no place in a professional report. If the ATSB saw value in collecting opinions of the pilots ability, beyond that of those tasked with doing so by the CASA regulations (i.e. Chief Pilot, Approved Testing Officer, etc) then the correct way is to conduct structured interviews, disclose the position of the interviewees, append the list of questions and cite quotations from individuals and: or, conclusions while keeping the identity of those questioned confidential. This is easy, routine and practiced by the market research industry the techniques for this are well known to authors of psychology reports.

There are a number of factors that may have contributed to the accident. These are:

	ATSB report	**Discussion**
Incorrect fuel	Effectively discounted	
Shutdown of incorrect engine	Effectively discounted	
Correctness of diversion choice	Accepted as appropriate	
Pilot training	Questioned	
Pilot fitness to fly	Accepted as appropriate	
Pilot currency	Accepted as appropriate	
Pilot qualifications	Questioned	
Weather conditions	Accepted as good	
Reason for the inability of the aircraft to maintain altitude on the LH engine	Not investigated	This is the key issue for this accident. If the aircraft had maintained altitude according to the manufacturer's specification, there would have been no accident. The pilot is not reported to have expressed any alarm about not being able to maintain altitude until 0803:41 some 11 minutes after the mechanical problem with the RH engine. This supports an alternate view to that put by the ATSB which is that the aircraft was descending according to an ATC direction.
RH engine CSU problem	Not investigated	If this was a CSU issue and not an engine issue, it would have a number of ramifications. (A) It would raise maintenance questions since this aircraft had registered previous complaints, (B) It would mean that the pilot would have been better NOT to have shut down the RH engine.
Direction of ATC to descend	Not investigated	**Once descended, this aircraft had no capacity to regain altitude.** The directions to descend given by ATC and their appropriateness is germane to the accident, yet has been treated in a trivial manner by the ATSB who have indulged in changes in wording or interpretation throughout the report.
Psychological effect of gear warning horn	Pilot criticised for not silencing a distraction.	

1. Specific concerns.

1) The references to surging RPM* and engine roughness through "uneven fuel distribution" are prima facie contradictory. It is possible that the author does not understand the operation of a CSU**. If the statement that the Right Hand engine was exceeding the maximum permissible RPM is correct, then this points to a CSU issue, not an engine issue. The engine should not be able to make the propeller go faster than the 'redline' limit. This also fits the history of that aeroplane (which is glossed over by the ATSB). The ATSB had the opportunity to investigate this with the test flight in the exemplar aircraft, but did not.

2) There would have been useful information derived from empirical evidence on the manifold pressures required to re-create the RPM fluctuations evident on the radio recordings. The data may have provided information of the severity of the engine problem, or it may have provided evidence supporting a CSU issue rather than an engine issue.

* RPM – Revolutions per Minute.

** CSU – Constant Speed Unit (propeller RPM control).

3) The report does not define "Derived Airspeed" at all, which frankly is a novice mistake. It is believed that the ATSB meant this to indicate KTAS*, but it could equally refer to KIAS** or KCAS. However, it makes no sense.

** KIAS – the speed reading from the aircraft Air Speed Indicator.

* KTAS – True Air Speed (indicated air speed) corrected for temperature and altitude.

4) According to the preliminary & final report the Bankstown METAR Wind 340°@ 4 knots, the METAR for Richmond was calm. However at the final fix, 6nm from YSBK at 500 feet the ATSB are using an 11 knot tailwind component.

5) No meteorological data for winds aloft has been tabled. The Preliminary report quotes speed as Groundspeed derived solely from radar to aircraft transponder returns. There are not many data points that correlate between the two reports, but there are nine. Just before Top Of Climb over Richmond flying pretty much North, the ATSB calculations show a **19 knot tailwind**. Four minutes later having turned through slightly more than 180 degrees (reversed course) at the same altitude (after having climbed further, then descended) ATSB are using a **16 knot tailwind**. This is mutually exclusive.

6) None of the "derived airspeeds" can be relied upon, at all. This further to completely undermine the ATSB report's conclusion that the pilot was not managing airspeed.

7) At 0755:13 the pilot reports that PGW is on a "slow descent". This is used by the ATSB to support the thesis that the aircraft was not able to maintain height due to the pilots poor control of airspeed. However, if this was a response that follows a direction to descend, then it is an appropriate response and takes on a different meaning.

8) In paragraph 3 of p 47 the ATSB write: *When queried by ATC as to his ability to maintain height, the pilot reported being on a "slow descent"*. This statement is in conflict with the radio call described by the ATSB on page 6 at time 0755:13. How is this explained?

9) The radio transmissions appear to have been modified in their wording (and by inference, meaning) for the report. There is also a marked discrepancy in the language between the preliminary & final reports. The radio transmission transcripts are not appended, nor quoted in any meaningful manner.

a) If there had been an initial instruction to descend to 5,000 feet, followed by a further instruction to descend to 2,500 feet, (as intimated by the preliminary report) then this whole incident takes on a completely different flavour.

b) For instance, the preliminary report says "ATC **instructed** the pilot to descend to 2,500 feet". The final report does not cite the ATC transmission, but says "The pilot read back an ATC **clearance** to descend to 2,500 feet". There is a significant difference between being cleared & being instructed, which may have a significant influence on the pilot's actions.

c) If the pilot were descending under ATC instructions, then an airspeed above VYSE* is appropriate. Once again making undermining the basis on which the ATSB has criticised the pilot.

* VYSE – An airspeed which produces the best **climbing** rate for an aircraft with One Engine Inoperative (OEI). Please note this is a speed for CLIMBING on one engine, not a descent speed.

10) A graph drawn of the aircraft's vertical flight profile (from the ATSB timeline), demonstrates the flight lasted approximately 760 seconds from first altitude loss to loss of radar return (about 300 feet Above Ground Level). The flight profile can be dived into three segments.

a) An initial loss of altitude to 5,000 feet which occurred at about 1200 feet/min and lasted about 100 seconds.

b) Then a period of approximately 300 seconds where the speed was stabilised at about 140 knot Ground Speed at a descent rate of about 740 feet/min.

c) The final 360 seconds was marked by a reduced rate of descent (about 320 feet/min) with reducing airspeed (140 knots < 95 knots).

11) The aircraft descends to 2,500 within about 3 nautical miles of the 2500 CTA* step. Anecdotally, there are reports of a Sydney ATC practice of descending IFR charter aircraft below the controlled airspace steps down to 2,500 feet to make traffic handling at Sydney Airport easier. This descent profile seems consistent with an ATC direction.

* CTA step – a defined (distance and height) boundary between non controlled and radar controlled airspace.

12) If this supposition is correct then it means that (without consciously disobeying an ATC direction) the pilot would have not known that the aircraft would not maintain height until the aircraft was below 2,500ft AMSL (approx. 2,000ft AGL*). * AMSL - Above Mean Sea Level.

13) The ATSB criticises the pilot for the initial altitude loss. (p 46 last paragraph). ATSB had the opportunity to investigate the height loss during the process of identifying an engine fault then securing (feathering) an engine, but did not. **Why not?**

2. Questions:

RE: ATC

1. Why was the ATC wording (regarding the instruction to descend) changed between the preliminary report and the final report?
2. Why was the transcript not published?
3. Was the pilot of PGW instructed to descend to 2,500 feet to remain OCTA?
4. Is there a common practice for YSBK IFR aircraft to be descended below OCTA which would automatically cause the pilot of VH-PGW to treat this descent profile as normal without questioning its appropriateness?
5. How is the discrepancy of the ATSB reporting of the radio call at 0755:13 explained (see p 6 vs p 47).

Re: Engines

6. Why was there no consideration that the "engine surging" symptoms might have been the result of a propeller CSU malfunction rather than an engine malfunction?
7. Within limits, a variation in engine power caused by uneven fuel distribution should cause fluctuating manifold pressure while the RPM remains constant. Why was this not acknowledged or discussed?
8. Why was the relationship between manifold pressure (i.e. throttle opening & power) and RPM not explored?
9. Why was there no effort to reproduce the RPM fluctuations heard in the radio transmissions?
10. Anecdotally, there is discussion of maintenance organisations purposefully adjusting the engine controls on this aircraft type to limit the power (manifold pressure) in an effort to preserve engines from over boosting. Why was this not investigated?

Re: "Derived Airspeed"

11. How was the "derived airspeed" calculated?
12. Were the "derived airspeeds" adjusted for density (height and temperature) altitude?
13. What winds were used for this calculation?
14. Why were the en route wind observations or area forecast winds not tabled in the report?
15. Can the ATSB explain why they appear to have applied a tailwind to the aircraft while it was flying both northbound and Southbound?

Re: Training

16. Is dealing with a CSU malfunction part of the CASA type endorsement guidelines?

Re: Emergency Procedures

17. The ATSB report criticises the pilot for poor airspeed management, blaming high airspeeds on the lack of ability of the aircraft to maintain altitude. However, in the final stages of the flight the aircraft spent some time at VYSE, but still did not maintain height. This was not discussed in the report. How does the ATSB justify not discussing this and how does it explain the aircrafts lack of ability to maintain altitude?

18. Why didn't the ATSB take the opportunity to investigate altitude loss during the process of investigating the engine fault and securing an engine using its flight with the exemplar aircraft? This is significant because the initial height loss was criticised and the spectral analysis of the radio transmissions gives a good record of the pilots actions.

This file contains two separate letters which attempt to redress the concerns of senior company pilots, related to the perceived risks as noted brought to their attention.

18 Feb. 2009.

24 March, 2009.

18 Feb. 2009.

Email - To:-

Mr Dieter Siewart, CEO Avtex Aviation.

Mr Steven Donoghue, GM Avtex Aviation.

Mr Steven Donoghue, Chief Pilot, Avtex Aviation.

Mr Malcolm Campbell, Acting Team Leader, CASA Field Office, Bankstown, NSW.

Mr Eric De Marco, FOI, CASA Field Office, Bankstown, NSW.

Mr James Wallace, FOI, CASA Field Office, Bankstown, NSW.

Mr Ken Lewis, Independent Auditor (Flight Standards) Avtex Aviation.

Capt. (Ret). William Hamilton. Chairman, Safety and Standards committee, Tradewinds Interline.

Capt. David Grant, Chief Pilot, Skypac Aviation.

0) To the recipients.

a) Gentlemen; please be aware that the report presented is "anecdotal", based on second hand or repeated information and although is, to the best of my knowledge accurate, may in fact be proven not be so.

b) Having held a Chief Pilot approval for almost 25 of the 35 years I have been a professional pilot; and having spent many of those years associated with General Aviation (GA) in a flying capacity and as Check and Training pilot, I feel obliged to bring the following report to your attention, as industry professionals and safety administrators.

c) Had, as I initially believed, the report was "Pilot gossip" and "Junior pilot speak" I would not have gone to the trouble of writing and editing this report.

d) I apologise in advance for the writing style; I have attempted to recreate the spirit, intent and, the general humour and manner in which the information was delivered.

e) I accept that on an individual basis the items may seem, at first glance, trivial and so they do until an accounting is made. Add any of the presented items, individually to any other item and even reduced by 50%, there is serious reason for an aviation professional to become alarmed.

f) It is essential to realise that the pilots being dealt with are the residual "first job" pilots, hired under the previous Airtex Chief Pilot system; and that the current Metro 3 first officers were not.

g) It is also important to note that the only point of contact between both companies is that, in order to earn a living, Airtex Metro pilots "moonlight" as Sky Master pilots. It is through this source that most of the available information has been gathered.

h) This report is not intended to decry, minimise or cast doubt on the qualification, or integrity of the Chief Pilot of Sky Master Aviation, or of the process through which the appointment was made.

i) It is solely my wish to ensure that junior pilots, inducted into a difficult and demanding area of GA operations are provided with suitable supervision, monitoring, guidance and education. It is fitting to ensure that the majority proceed into more difficult and demanding roles with a sound, if slightly robust knowledge of the basics of commercial air operations.

1) Hand slapping.

a) I have now been informed by three individual company pilots that their hands have been slapped during "training" operations, conducted by their Chief Pilot.

b) Apart from the legal aspects of "assaulting" a pilot in flight, the humiliation of being treated like a 3 year old and the potential for distracting a pilot during a critical flight period, the practice is not an approved (or documented) training procedure.

c) The most alarming thing is, I believe that the event is occurring during landing, which in itself is alarming, however, the reasons for the procedure are even more so.

2) Power off.

a) I have been reliably informed that pilots are "slapped" for maintaining contact with the throttles during the last 50 feet of a landing. They are instructed to close the throttles at 50 and await contact with runway. I will not elaborate here the sheer, purblind folly and illegality of this practice. It has been demonstrated, with serious consequences, on several occasions in the past.

3) Propeller management.

a) I have been reliably informed that pilots are "slapped" for placing the propeller levers at "Climb" RPM prior to landing. In short, the aircraft is not configured for a missed approach.

b) Again, I will not elaborate here the sheer, purblind folly of this practice, the disregard for AFM procedures or the requirements of sensible operating practice. It has been demonstrated, with serious consequences, on several occasions in the past.

4) Unsafe practices.

a) I have personally heard once, and been informed several times of pilots being instructed to perform operations in a manner which defies most of the sensible and legitimate tenets of sound practice.

b) The most recent was a serious lecture, given, thankfully, post flight to one of the most sensible, intelligent pilots we have on staff. The pilot requested a meeting with me and, told me of the event.

c) In short; the pilot was tasked to Lismore NSW, after a second attempt at the approach, the aircraft was visual at the minima, but, on top of a very low deck of Stratus (lifting fog) which obscured the aerodrome and prevented a landing. The aircraft was diverted to Ballina.

d) This individual later responded to a general question related to the days operation with a sketch of the days events. He was then taken aside and briefed on how it should be done, not to labour the issue the essential points where:-

(i) Slow the aircraft (PA 31-350) to less than 120 knots,

(ii) Stooge about until you identify a roadway which leads toward the aerodrome,

(iii) Get below the cloud and follow the road through the hills until the runway is sighted.

6) Fuel system questions.

a) Apparently, during a supposed "check flight", pilots have been seriously chastised (not slapped) because, they had no idea that PA 31 series aircraft engines could, despite AFM requirements, be cross fed whilst both engines are operational.

(i) The question runs like this, " OK mate, you look out of the window and notice fuel leaking (how ??) from the right main (which "main" is a mystery, we call the outboard main tanks "Auxies"). Question ?. How can you recover (and use) this fuel.

b) The sensible answer is land at the nearest suitable. WRONG. (Hand smack following).

c) The right answer, apparently, is some unbelievable rubbish, not related to the actual fuel system, by which, despite the manufacturer AFM warnings, this can be achieved.

d) When a sensible pilot was asked this question, he diplomatically ventured the idea that if fuel was sighted, then the leak is severe, and the source indefinable. The best answer is to close down the engine, and land at the nearest suitable, (engine and/or wing fires etc). WRONG.

e) When the pilot produced a fuel schematic and illustrated why the manufacturer disallowed the practice, and further pointed out the complex series of circuits to be managed (from the aircraft schematic) and stated that all control was behind the cross feed line, only then, reluctantly, was it was acknowledged that, well perhaps the question "could" be rephrased; but it is still achievable. QED.

f) Could be !. Could be a junior pilot, in trouble one day does exactly what the correct answer is (according to the "training pilot" and burst into flames, 10, 000 feet above a suitable airport).

7) Summary.

a) The holes in that famous cheese are slowly, but inevitably lining up.

b) I have noted that a lack of respect within the pilot body for the edicts of the individual mentioned has had a serious, negative impact on SOP. The pilots are, to all intents and purposes, now "making it up" as they go along. They are informing each other, through the "drums" of how they do things, Basically, the individual has essentially lost control of the pilot body.

b) Some of the junior pilots will (i) do as they are told, to impress and (ii) are highly susceptible to "senior" pilot influence, for right or wrong.

c) For the record, one day (or night) some junior pilot is going to get trapped beneath a cloud layer, and will not have the very slow aircraft in a configuration which will assist with an attempted extrication. At best we have over boosted engines and reduced climb power, at worst a CFIT. All very real possibilities.

d) It is difficult enough to prevent the "kids" from "having a go". The very least we can do is ensure that sensible operating practices will at least assist them on the inevitable day when a pilot looses "immortality".

Head Check and training.

Airtex Aviation.

Second attempt :- 24 March 2009.

Mr Dieter Siewart, CEO Avtex Aviation.

Mr Steven Donoghue, Chief Pilot, Avtex Aviation.

a) Gentlemen; please be aware that the report presented is "anecdotal", based on information provided to me by the individuals concerned, and from my own investigation into the facts. It is, to the best of my knowledge accurate.

b) Having held a Chief Pilot approval for almost 25 of the 35 years I have been a professional pilot; and having spent many of those years associated with General Aviation (GA) in a flying capacity and as Check and Training pilot, I feel obliged to bring the following report to your attention.

c) Had, as I initially believed, the reports were "Pilot gossip" or "Junior pilot speak" I would not have gone to the trouble of writing and editing this report.

d) Regrettably, this is not so. I cannot, in good conscience, allow the existing situation to continue. It is inevitable that sooner or later, the CP Sky Master is going to be the root cause of an accident or serious incident.

e) I have attempted to recreate the spirit, intent, humour and manner in which the information was delivered. Although there is nothing remotely humorous here.

f) I accept that on an individual basis the items may seem, at first glance, trivial. Individually, each item provides concern, collectively there is real cause for alarm.

Summary.

a) The holes in that famous cheese are slowly, but inevitably lining up. It is no longer a matter of if there will be an accident, but when.

b) For the record, one day (or night) some junior pilot is going to get trapped in bad weather, in a bad situation. The procedures and methodology employed will directly reflect training.

c) I have noted that a lack of respect within the pilot body for the edicts of the individual mentioned has had a serious, negative impact on SOP. Essentially this individual has lost control of the pilot body.

d) The pilots are, to all intents and purposes, now "making it up" as they go along in the absence of creditable guidance . They are informing each other, through the "drums" of how they do things.

e) Some of the junior pilots will (i) do exactly as they are told, to impress and (ii) are highly susceptible to "senior" pilot influence, for right or wrong.

f) The amount of time and money wasted are serious. For example for ESIR pilots are grounded, no remedial training is offered and then a "Check flight" is conducted. There have been 4 events this week. ESIR require a briefing if they were serious, but for minor infractions, a "chat" would achieve more than an aircraft and two pilots out of the system for a period of time.

1) Hand slapping.

a) I have now been informed by three individual company pilots that their hands have been slapped during "training" operations, conducted by the Chief Pilot at Sky Master.

b) Quite apart from the legal aspects of "assaulting" and interfering with a pilot in flight. The humiliation of being treated like a 3 year old and the potential for distraction both physical and mental during a critical flight period is dangerous. The practice is not an approved (or documented) training procedure.

c) The most alarming thing is, I believe that the events are occurring during landing, which in itself is alarming, however, the reasons for the procedure are even more so.

d) Pilots are "slapped" for maintaining contact with the throttles during the last 50 feet of a landing. They are instructed to close the throttles at 50 and await contact with runway.

e) Recently a very Junior pilot was instructed to ensure that every landing was made on the "piano keys", literally at the very beginning of the runway. He is the only pilot to be so instructed. During the tirade against his poor landing technique, he was also informed that "Navajo fuel gauges are 100% accurate, all of the time".

f) I have been reliably informed that pilots are "slapped" for placing the propeller levers at "Climb" RPM prior to landing. In short, the aircraft is not configured for a missed approach.

g) I will not elaborate here the sheer, purblind folly of these practices, the disregard for AFM procedures or the requirements of sensible operating practice. This has all been demonstrated, with serious consequences, on several occasions in the past.

2) Unsafe practices.

a) I have personally heard once, and been informed several times of pilots being instructed to perform operations in a manner which defies most of the sensible and legitimate tenets of sound practice.

b) The most recent was a serious lecture, given, thankfully, post flight to one of the most sensible, intelligent pilots we have on staff. The pilot requested a meeting with me and, told me of the event. It is one of three similar stories.

c) In short; the pilot was tasked to Lismore NSW, after a second attempt at the instrument approach, the aircraft was visual at the minima, but, on top of a very low deck of Stratus (lifting fog) which obscured the aerodrome and prevented a landing. The aircraft was diverted to Ballina.

d) This individual later responded to a general question related to the days operation with a sketch of the days events. He was then taken aside and briefed on how it should be done, not to labour the issue the essential points where:-

(i) Slow the aircraft (PA 31-350) to less than 120 knots,

(ii) Stooge about until you identify a roadway which leads toward the aerodrome,

(iii) Get below the cloud and follow the road through the hills until the runway is sighted. Enough said.

3) Fuel system questions.

a) Apparently, during a supposed "check flight", pilots have been seriously chastised (not slapped) because, they had no idea that PA 31 series aircraft engines could, (despite AFM prohibition), be cross fed whilst both engines are operational.

(i) The question runs like this, " OK mate, you look out of the window and notice fuel leaking (how ??) from the right main (which "main" tank is a mystery). Question ?. How can you recover (and use) this fuel.

b) The sensible answer is land at the nearest suitable. WRONG !!. (Hand smack following).

c) The right answer, apparently, is some unbelievable rubbish, not related to the actual fuel system, by which, despite the manufacturer AFM warnings, this can be achieved.

d) When a sensible pilot was asked this question, he diplomatically ventured the idea that if fuel was sighted, then the leak is severe, and the source indefinable. The best answer is to close down the engine, and land at the nearest suitable, (engine and/or wing fires etc). WRONG !!.

e) When the pilot produced a fuel schematic and illustrated why the manufacturer disallowed the practice, and further pointed out the complex series of circuits to be managed (from the aircraft schematic) and stated that all control was behind the cross feed line, only then, reluctantly, was it was acknowledged that, well perhaps the question "could" be rephrased; but it is still achievable. QED.

f) Could be !. Could be a junior pilot, in trouble one day does exactly what the correct answer is (according to the "training pilot") and bursts into flames, 10, 000 feet above a suitable airport).

4) Engine Failure.

a) Currently under investigation (CASA/ATSB) is a series of turbo charger failures, traced to a manufacturing fault.

b) What is not being examined is the inconsistent chief pilot response and the total absence of any training material, course or general discussion relating to the incidents. There have been at least eight (8) return to land and a couple of unscheduled occurrences.

c) The unbelievable part is that despite correct technique and, a couple of very level headed decisions being made, several pilots have been the recipient of a serious dressing down, for doing the right thing. I know this because, it's usually me that gets asked the questions afterwards, by confused, offended pilots.

d) On one occasion, a LAME pilot had a partial failure on take off with a full load of passengers. During the verifying procedure it was noted that when the throttle was retarded, the yaw increased. He surmised that by not securing the engine, and leaning the mixture, he could retain 60% power on the engine. The return to land was made safely. The pilot almost resigned after being told that he was "basically useless".

5) Check flights.

a) The most recent horror story occurred very recently. It is the latest in a long litany of similar events. Please keep in mind the following points.

(i) this occurred during a commercial operation, with a flight nurse and patient in the back.

(ii) the CP has no formal training or qualification to act as either a training pilot or check airman.

(iii) the pilot involved is a 'journey man' pilot, although well respected and capable, for the experience level.

b) The pilot was informed that there was to be a "Check flight" to qualify him to conduct patient transport operations. There is no formal statement in the Operations Manual relating to this, no formal training procedure set down and no "pass/fail' benchmarks.

c) Pre flight the pilot was asked if he could conduct a DGA approach, the correct answer was offered. WRONG. The check pilot clearly has some confused ideas about the use of GPS as DME.

d) The pre take off (ground time) for briefing with engines running was spent in a lecture, delivered by the "Check pilot" of approximately a 30 minutes. The talk went on during runway entry, take off clearance delivery, line up and take off role, ("non stop natter") the pilot, distracted, in an unfamiliar aircraft type omitted to turn the transponder on.

e) The route was KAT – ORG, at top of descent the pilot still being chastised for the transponder, was instructed to conduct a DGA arrival. Half way through the GPS was turned OFF, the pilot was informed that he was a fool, acting illegally and told to overshoot (despite being visual) and join the NDB approach. No problem until an opposite direction Citation informed them that he was entering the overshoot procedure and was climbing to holding altitude.

(i) Imagine, the radio is taken over, there is no distance guidance and suddenly you need to find 1000 feet to avoid a mid air, no clear briefing, no instruction and absolutely no idea of who has command of the flight.

f) The remainder of the flight was similar, no clear definition of whether it was training or checking. Needless to say the kid has been completely grounded, severely chastised and is completely demoralised.

g) The number of real live serious safety issues raised in this matter alone should at least be grounds for CASA investigation. This gentleman should not be allowed to conduct training or checking until he has at least a rough ides of how to set about the

6) Maintenance Issues.

a) I have now confirmed that the CP Sky Master has, on two occasions, failed to report aircraft un serviceability's.

b) On one occasion, the follow on pilot grounded the aircraft, pre departure, citing at least 10 separate items, of which 4 were MEL covered and not noted. The previous pilot had completed 5 sectors, one of which was a purported "line check + ICUS", services were all commercial, over approximately 7 hours of flying. The aircraft was returned to and signed off as being serviceable.

7) Useable Fuel.

a) Two individual pilots report that the flight planning data for the PA 31 series aircraft has been altered to reflect that the capacity (fuel calibration card) indicated for each individual aircraft has now become the fuel useable for flight planning.

b) Insanity, when it was pointed out that the AFM is clear and specific as to the amount of useable fuel, the CP then declared that engineering had incorrectly conducted the calibration checks and it was still acceptable to plan a flight against the placard capacity. CAO 108 was referred to, it took a meeting of the GM, HAM and CE to attempt a correction. To date, the flight planning data still reflects the total capacity as useable fuel.

c) This is as good an indication of absolute incompetence as I have ever witnessed. A few seconds of thought produces several lethal practices and identifies complete and utter incompetence.

8) A last word.

a) The person in question has lately taken to simulating engine failures, the latest was, as usual not briefed, and conducted at Tumut with a junior pilot at the controls, at high speed during the take off roll.

Just slightly short of criminal. What next I wonder.

Head Check and training.

Airtex Aviation.