Mr Alan Wilson

2 March 2010

Committee Secretary
Senate Standing Committees on Rural Affairs & Transport
PO Box 6100
Parliament House
CANBERRA ACT 2600

Dear Lauren,

Re: Pilot training and airline safety including consideration of the *Transport Safety Investigation Amendment (Incident Reports) Bill 2010*

I and Mr Grant Burley welcome the opportunity to address the Senate Enquiry into Pilot Training and Airline Safety. We believe we have a valuable and meaningful contribution to make to your enquiry.

My son, Andrew Wilson, was recently killed on the 15th June 2010 when his Piper Chieftain PA-31 registered VH-PGW crashed in Canley Vale NSW killing him and a Nurse, Ms Kathryn Sheppard.

I believe that this accident was caused by poor maintenance and lack of adequate training by his employer.

Attached are:

1. a copy of the AAT decision on this accident;

2. a summary of AAT which is a case study of the need for reforms to the powers and resources of CASA and the recommendations of the Tribunal; and

3. a letter to the Civil Aviation Safety Authority ("**CASA**") that Mr Burley wrote shortly following the accident. Mr Burley is a close family friend, an experienced pilot and was a mentor for Andrew.

In brief, I would like to make a number of points for consideration of the Senate Enquiry. Both Mr Burley and I would welcome the opportunity to speak in further detail about these at the Enquiry.

What has become clear through our detailed investigation process is, many gaps in training, compliance and poor culture in some GA operations, which leads to not only this, but other events of this nature. Whilst it is acknowledged your review is centered at the

larger operators one must acknowledge that pilots who control the larger jets have usually undertaken their training in the smaller operations, such as the one in question. This being the case, the future of airline safety has to be focused right back to the predominant source of initial training.

Please consider:

1. Pilot Experience

In Australia it is very difficult for young pilots to forge their way into the major airlines. They need experience on single, twin engine and turbine engine aircraft.

One curious observation is the industries current focus upon hours achieved rather than his/her actual experience and ability levels. Seemingly, the more flying hours completed, the better the chance of obtaining their desired job. Our view is actual flying experience in all types of conditions and a variety of aircraft should play a far greater role.

Invariably, operators take advantage of these young pilots. They have to travel to remote parts of Australia to obtain experience, receive low pay, and work for operators who sometimes leave a lot to be desired in the way they maintain the aircraft and try and pressure pilots to fly in unsavory conditions.

Pilots are often placed in conditions outside their relevant ability and assume risks to themselves and others all to fulfill the desires of their employer. *Please also read the tribunal findings on the recent Skymaster/Airtex case as attached, see the link above.*

2. Pilot recruitment

Currently there appears to be less opportunities in General Aviation for young pilots. The Defense Force and Major Airlines only employ a small amount of young people who seek to have a career flying. The balance of young pilots need to find work with private operators. Many of these private operators are operating on limited funds, which make it difficult for young pilots to obtain the necessary training and advancement in their flying careers. It is common that a young pilot will obtain many hours in the one type of plane flying in the same conditions all the time.

3. CASA

CASA needs to be given more power and resources to investigate and stop the below par operators from flying at an early juncture.

In Andrew's case CASA had given a "*Just Cause*" notice to Skymaster Pty Ltd, his employer on the 28th May 2010, some 2 weeks before he died in the accident. CASA has been trying to stop this company from flying for 4 years, but just did not have enough power or resources, despite repeated incidents and crashes.

It is clear to me that if CASA did have the power and resources to stop Andrew's employer, then Andrew would still be alive today.

It has been proven that Andrew's employer did not take pilot training seriously, encouraged pilots not to officially report safety incidents, encouraged pilots not to record defects in the planes and preferred them to write defects on a "*snag sheet*" so the planes could keep flying, (which puts pilots and passengers at risk). They also encouraged pilots to fly in poor

weather without the appropriate training or equipment on the planes, humiliated pilots if they did not "*toe the line*" and much more. **This organisation has a NSW State Government medical contract to carry sick and injured people, accompanied a nurse. One would expect from a Government contract that a patient, nurse and pilot should be able to travel safely.**

We refer to another incident on 18 May 2005. The sister plane of the one in question was the subject of a catastrophic engine failure on 18 May 2005. The incident is the subject of an ATSB report:
http://www.atsb.gov.au/publications/investigation_reports/2005/AAIR/pdf/aair200502331_001.pdf

The pilot maintains that the reason he continued with the flight from Young to Bankstown was he thought everything was "*OK*".

No twin engine aircraft is performing "*normally*" in the event of engine failure and the pilot (in our view) should have landed as soon as practicable and NOT continued with the flight to satisfy the Operator's whims by landing the stricken plane at the Operators home base. Assuming the aircraft was at Young it flew around 140 nautical miles which would have been an hour or more of flight, sometimes over high terrain. Had the plane encountered any issues with the second engine at a further stage of the flight the time interval between this and facing ground terrain at critical periods would have been less than 3 minutes and with little or no opportunities for landing safely. If for whatever reason Young was unavailable for landing then the next practicable solution was Goulburn and/or Cowra, both nearer and without the necessity to fly over high terrain.

And making matters worse is that this flight had a flight nurse and patient on board.

Noticeably absent from the ATSB report of the incident was comment upon the pilot's decision to continue with the flight in favour of landing. The point is it highlights a deficiency in training, procedure and possibly even in the investigation. We put it that the delay to make decisions to land as soon as possible may well unfold to be a contributing factor as to the flight in question.

The regulations are clear on this issue:
http://casa.gov.au/wcmswr/_assets/main/download/orders/cao20/2006.pdf

CASA has had a very difficult time in trying to stop this operator, and other similar operators, due to lack of power and funding.

Many of this companies former employees now fly for the major airlines!

4. Reporting of Incidents

Under the current system, pilots are reluctant to report incidents of safety etc to CASA. They fear that their careers will be cut short, they could loose their job from their employers or be vilified by their employers, they could be "black banned" by the industry, all for speaking up and trying to make the industry better.

We need to have a safe system in place where pilots and crew can safely approach CASA and advise their concerns. They need protection. CASA is not the enemy. If a safe system of reporting was introduced, this would improve airline safety.

5. Air crash Investigations

Since Andrew's accident I have seen how the industry works. There are a lot of good people, but the system is flawed.

Following an incident the following occurs:

5.1 The Australian Transport Safety Bureau ("**ATSB**") heads up the investigation. This body is a no blame body and finds the cause of the accident. No material obtained by the ATSB is available to outsiders for use with the incident. The members of the ATSB do not give evidence.

5.2 CASA is a regulatory body. They do not investigate the accident. Their role is to check and see if any breaches of air regulations have occurred. Their powers are restricted and they cannot rely upon ATSB reports for prosecution they must identify and confirm evidence independent of the ATSB.

5.3 Workcover is available for employees in the aviation industry, but they do not investigate the accident. They believe that the ATSB and CASA will investigate the accident and make charges against the operators where they see fit. This is wrong. If an accident happened on a construction site, then workcover would complete and full investigation and then possibly charge the owner if they found breaches. Workcover believe that in the aviation industry ATSB and CASA will enforce breaches and penalties, which is clearly wrong. I am trying to address this with the NSW Workcover presently.

5.4 The Police are the only people with power to charge after the accident. This is difficult for them as they are not aviation experts and do not understand the aviation industry. In Andrew's case it is very difficult for the Police to obtain the necessary experience for them to investigate his accident properly.

Currently the system is flawed.

6. The Andrew Wilson Foundation

Looking at Andrew's career and after his accident we have seen just how difficult it is for young pilots to obtain experience and training in the General Aviation field. As a result we have established "**The Andrew Wilson Foundation**" which is a charitable trust. Donations are tax deductible. We will have a voluntary board and hopefully work with the major airlines.

The aim of the foundation is to offer scholarships each year to young pilots for the advancement of their careers. These scholarships will be used in training and hopefully help the aviation industry make better pilots in Australia.

This is only a small way that we can help the industry, but we believe that it will make a difference and also honor Andrew.

7. Tribunal Recommendations

Senior Member Fice of the AAT, in the *Avtex* decision, raises the issue of legislative reform in relation to the position of HAAMC.[1]

Understandably, the decision does not explicitly recommend a conclusion on law reform, but we recommend there should be law reform to deal with the issues that Senior Member Fice identifies, specifically:

- the position of HAAMC should be occupied by a Licensed Aircraft Maintenance Engineer (LAME); and
- the position of HAAMC – like Chief Pilot – should be subject to the approval of CASA.

We refer to the attached chronology which sets out significant dates in the history of the matter, as set out in the *Avtex* decision. That chronology inevitably involves some degree of selection of significant dates – it does, however, show two factors that we consider significant:

- the length of time that it took matters to be dealt with – CASA will of course be able to give its own analysis of this, but to us it indicates that CASA should be supported with additional resources so that it can deal faster and more intensely with a problem such as that shown in the Avtex case; and
- the importance of anonymous tips – the chronology identifies that anonymous reports were made to CASA on several occasions.

Conclusion

The issues are far and wide, but the general points which we would like to address the Senate upon:

(a) General training issues as they relate to various craft/ conditions and recommend some enhancements.

(b) CASA role, resources and powers. A review needs to be taken as to the tasks, priorities and powers of CASA, with particular emphasis upon establishing suitable resource/regulatory allocations to ensure that the authorities lack of resources and power does not play a significant role in its self for poor air safety.

(c) The Investigation process and matters that arise.

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[1] At paragraph 374, Fice SM states as follows: *"Mr Newberry's role as HAAMC for Avtex and Skymaster and also of the certificate of approval section of Avtex, places him in a pivotal position regarding the airworthiness of aircraft operated by the AOC holder. With respect to Mr Newberry, and I mean no criticism of him at all, that position should be occupied by a LAME. My concern is that a person without engineering qualifications placed in such a position will almost invariably be influenced and possibly controlled by the engineer who heads up the engineering operation of the AOC holder, if it has one. As the legislation currently stands, there is no formal qualification required for a person in this position. In fact, CASA approval for the appointment of the HAAMC is not required, unlike that for the chief pilot. It may be that CASA should examine this issue with a view to making appointments to this position subject to its approval."*

(d) The Government, State and Federal role in pushing GA service prices down and the impact upon Aviation safety. A review of all these procedures needs to take place.

Yours faithfully

Alan Wilson

Avtex Air Services Pty Ltd v Civil Aviation Safety Authority **[2011] AATA 61 – A case study of the need for reforms to the powers and resources of CASA.**

What was the *Avtex* case about, and why is it relevant?

1. The *Avtex* decision of the Adminsitrative Appeals Tribunal ("***AAT***") – confirming the cancellation of Avtex's Air Operators Certificate ("***AOC***") – is an important document for this inquiry. The decision raises a specific issue for legislative reform in relation to the position of Head of Aircraft Airworthiness and Maintenance Control ("***HAAMC***").

2. Sadly, the *Avtex* case shows that a company which had a "*poor safety culture*"[1] could operate, despite nearly four years of efforts by the Civil Aviation Safety Authority ("***CASA***") to control it. In that time, three people died in two fatal accidents. The hope must be that this decision – which documents Avtex's failings in great detail – will serve as a document that prevents such things recurring.

3. On 20 August 2010, CASA cancelled the AOCs of both Avtex and Skymaster. This AAT decision concerned Avtex's challenge to CASA's cancellation of its AOC. Although Skymaster also made an application to the AAT to challenge its cancellation, that appears not to have been proceeded with – it was not the subject of the present case.[2]

4. Avtex Air Services Pty Ltd ("***Avtex***"), was an associated company of Skymaster Air Services Pty Ltd ("***Skymaster***"). There was considerable overlap in terms of facilities, and key personnel including the Chief Executive Officer, Mr Dieter Siewert, and the Head of Aircraft Airworthiness and Maintenance Control ("***HAAMC***"), Mr Graham Newberry.[3]

5. Alan Wilson's son Andrew Wilson ("***Andrew***") was piloting a Piper Mojave PA-31P-350 ("***PA-31P***") aircraft operated by Skymaster on 15 June 2010 when it crashed on Canley Vale Road near Bankstown Airport, killing Andrew and a flight nurse, Ms Kathryn Shepherd.[4] The Australian Transport Safety Bureau ("***ATSB***") is continuing its investigation into this accident – it has, however, noted that the accident occurred following a reported in-flight engine shutdown.[5]

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1 As Senior Member Fice concluded in relation to Avtex: *Avtex* [2011] AATA 61 at paragraph 386.
2 See *Avtex* [2011] AATA 61 at paragraph 12.
3 See *Avtex* [2011] AATA 61 at paragraphs 1-4 and 15.
4 See *Avtex* [2011] AATA 61 at paragraph 5.
5 ATSB website accessed 1 March 2010, http://www.atsb.gov.au/publications/investigation_reports/2010/aair/ao-2010-043.aspx .

6. This was the second fatal accident involving the Skymaster/Avtex companies – on 9 April 2008, a Metro III aircraft operated by Avtex crashed into Botany Bay killing the pilot Mr John Hamilton; the cause of that accident remains unknown and it also is the subject of ATSB investigation.[6]

7. The *Avtex* decision followed a sixteen day hearing, and the decision provides a set of findings that are relevant to the current Senate inquiry into *Pilot training and airline safety including consideration of the Transport Safety Investigation Amendment (Incident Reports) Bill 2010* "***the Inquiry***". The case is especially relevant to Terms of Reference (f), (g) and (h):

> *"(f) the capacity of the Civil Aviation Safety Authority to appropriately oversee and update safety regulations given the ongoing and rapid development of new technologies and skills shortages in the aviation sector;*
>
> *(g) the need to provide legislative immunity to pilots and other flight crew who report on safety matters and whether the United States and European approaches would be appropriate in the Australian aviation environment;*
>
> *(h) reporting of incidents to aviation authorities by pilots, crew and operators and the handling of those reports by the authorities ..."*

8. Senior Member Fice of the AAT, in the *Avtex* decision, raises the issue of legislative reform in relation to the position of HAAMC.[7] Understandably, the decision does not explicitly recommend a conclusion on law reform, but we recommend there should be law reform to deal with the issues that Senior Member Fice identifies, specifically:

- the position of HAAMC should be occupied by a Licensed Aircraft Maintenance Engineer (LAME); and
- the position of HAAMC – like Chief Pilot – should be subject to the approval of CASA.

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6 See *Avtex* [2011] AATA 61 at paragraph 45.

7 At paragraph 374, Fice SM states as follows: *"Mr Newberry's role as HAAMC for Avtex and Skymaster and also of the certificate of approval section of Avtex, places him in a pivotal position regarding the airworthiness of aircraft operated by the AOC holder. With respect to Mr Newberry, and I mean no criticism of him at all, that position should be occupied by a LAME. My concern is that a person without engineering qualifications placed in such a position will almost invariably be influenced and possibly controlled by the engineer who heads up the engineering operation of the AOC holder, if it has one. As the legislation currently stands, there is no formal qualification required for a person in this position. In fact, CASA approval for the appointment of the HAAMC is not required, unlike that for the chief pilot. It may be that CASA should examine this issue with a view to making appointments to this position subject to its approval."*

Summary of problems identified with Avtex

9. We attach a chronology which sets out significant dates in the history of the matter, as set out in the *Avtex* decision. That chronology inevitably involves some degree of selection of significant dates – it does, however, show two factors that we consider significant:

- the length of time that it took matters to be dealt with – CASA will of course be able to give its own analysis of this, but to us it indicates that CASA should be supported with additional resources so that it can deal faster and more intensely with a problem such as that shown in the *Avtex* case; and

- the importance of anonymous tips – the chronology identifies that anonymous reports were made to CASA on several occasions.

10. The *Avtex* decision demands to be read in its entirety. It sets out a litany of problems which we summarise here so that the systemic failure of Avtex's operations can be comprehended[8]:

- **Defective endorsement training** (paragraphs 76-120). We draw attention to the conclusion at paragraph 120

  "*Avtex's failure to deal in a systematic and safe way with the deficiencies identified by CASA is seriously disturbing. While many of the responses to CASA's requests about endorsement training certainly seem appropriate* on paper, *when one examines the underlying actions taken, the response was anything but adequate. This appears to be a case of* say one thing *and* do another [all emphasis in original]"

- **Avtex training and checking organisation** (paragraphs 121 – 155). Numerous deficiencies are identified in the June 2008 special audit (see paragraphs 121-122).

- **Overweight takeoffs and landings** (paragraphs 156-162, and also at paragraph 369). Avtex's use of out of date charts for the purpose of calculating appropriate takeoff weights is identified at paragraphs 158-159.

  Senior Member Fice concludes at paragraph 161 that: "*Avtex continued to operate aircraft in excess of their RTOWSs* [Regulated Takeoff Weights] *after that matter had been brought to its attention in 2008. It*

[8] Paragraph references are all to *Avtex* [2011] AATA 61.

seems to me that if the company had been intent on making its operations as safe as possible, such errors would not have been repeated." – at paragraph 161.

- **Safety Management Systems** (paragraphs 162-185, and at paragraph 371). We draw attention to the comment at paragraph 184 by Senior Member Fice: "*The problem for Avtex, as I see it, is that there is evidence of safety problems having arisen on a number of occasions while the SMS was supposedly functioning, and yet incidents and accidents nevertheless occurred.*" And we also note that he considered the issues regarding the development of the SMS are "*a significant factor in determining whether Avtex has an adequate safety culture throughout its organisation*" (paragraph 185).

- **Culture of Safety** (paragraphs 186-194 and also at paragraphs 385-386) – the conclusion is that Avtex had a "*poor safety culture*" (at paragraph 386). At paragraph 385, Senior Member Fice concluded that "*the operations of both Skymaster and Avtex were unsafe*", and that the CEO Mr Siewert had a pervasive influence over Avtex, and said: "*While that* [Mr Siewert's pervasive influence], *from the commercial perspective, comes as no surprise, it does become a problem when commercial imperatives override safety considerations. In my opinion this is what was happening in Avtex and Skymaster.*"

- **Defect Recording** (paragraphs 195-252, 355, 359-360, 372). Allegations of putting pressure on pilots to discouraging reports of defects are set out. Attention is drawn to the allegation of Mr Siewert threatening a CASA officer at paragraph 221 – this was accepted by Senior Member Fice, at paragraph 355. In relation to putting of indirect pressure on pilots, see further about Mr Siewert's role at paragraphs 359-360.

- **Flying in adverse weather conditions – icing and thunderstorms** (paragraphs 253-292, and see also 354 and 356) – especially at paragraphs 280-281 in relation to the practice of encouraging pilots to fly to "*go and have a look*" at icing conditions, which Senior Member Fice identified (at paragraph 280) as "*unacceptable from a safety perspective and it is in breach of CAR 238*".

- **Fatigue** (paragraphs 293-327) – includes evidence of pressure placed on pilots to fly when they felt fatigued, and see at paragraph 356 at sub-paragraphs (e)-(g), which indicate acceptance by Senior Member Fice of evidence of the pilots there set out.

- **Airworthiness** (paragraphs 328-346 and paragraphs 374-378). Airworthiness is identified as a serious concern at paragraph 375, and Senior Member Fice concluded at paragraph 375 that: "*the evidence also discloses a significantly large number of serious mechanical failures which cannot be attributed to causes outside the maintenance organisation*". The issue of legislative reform has been identified above.

Conclusion

11. The *Avtex* decision should be an impetus to law reform in relation to the role of the HAAMC. It also demonstrates the difficulties for a regulator in dealing with a company such as Avtex, which is clearly shown by the decision to have had systemic failures in safety over a continuing period – and a company in which the CEO attempted to threaten a CASA officer. We consider that the decision would support CASA in having additional resources to deal more intensely with problems of this magnitude. We also consider that this case demonstrates the importance of anonymous reporting, and that anonymous reporting should be protected under any new legislative measures.

CHRONOLOGY

Date	Event
18 May 2005	Sister plane subject of catastrophic engine failure. The incident is subsequently the subject of an ATSB report.
2006	Civil Aviation Safety Authority ("**CASA**") receives a number of anonymous industry complaints about maintenance practices.
November 2006	CASA issues a maintenance direction under CAR (**Civil Aviation Regulations 1988**) 38 to Avtex directing it to cease conducting engine overahauls – this is subsequently lifted after Avtex employs a suitably qualified engineer.
November 2006	Incident involving Avtex aircraft.
December 2006	CASA issues an audit observation to Avtex to update its Fatigue Risk Management System ("**FRMS**").
July 2007	Following an anonymous complaint about engine failures, CASA issues directions to Avtex under CAR 38 and CAR 53 requiring the production of maintenance documents and to allow CASA to inspect engines.
July 2007	Incident involving Avtex aircraft.
October 2007	CASA refuses to issue Avtex an FRMS exemption (Avtex had failed to respond to the audit observation in December 2006) – CASA instead issues a standard industry exemption against Civil Aviation Order 48 in lieu of the FRMS.
January 2008 – March 2008	Incidents involving Avtex aircraft
9 April 2008	Death of Mr John Hamilton in Metro III accident at Botany Bay
Post-9 April 2008	Following the Metro III accident, CASA received anonymous reports through the ICC indicating there were serious deficiencies in the training of Avtex pilots, including Mr

Date	Event
	Hamilton
11 April 2008	Mr Weeks (Manager of CASA Flying Standards Branch) notes in a memorandum prepared that Avtex had not responded to the audit observation issued in December 2006 to completely update its FRMS.
11-24 June 2008	CASA audit reveals a large number of safety deficiencies in the systems and work practices within Avtex, including inadequate endorsement training by Mr Myles, inadequate training and checking of pilots engaged in Metro III operations, permitting a pilot to fly a Metro III aircraft without sufficient experience, inadequate emergency procedures, proficiency training and assessment of flight crew, and overweight operations in Metro III aircraft
Post-24 June 2008	As a result of the CASA Audit, CASA issues 2 Safety Alerts ("**SAs**") for corrective action which must be addressed immediately, and a number of Requests for Corrective Action ("**RCAs**") referring to deficiencies involving non-compliance with legislation that must be addressed As a result of the CASA Audit, Mr Weeks formed the view that CASA should take serious and imminent risk action against Avtex. However, CASA abandoned the idea of taking serious and imminent risk action as it had seen some improvement in the company in terms of management structure, and the deficiencies identified related essentially to the chief pilot.
July 2008	Meeting with CASA regarding conditions to be placed on Avtex's AOC, following which Avtex accepted those conditions and nominated Mr Donoghue to be the chief pilor of Avtex.
29 August 2008 – 1 September 2008	First audit by independent audit provider ACS.
23 October 2008	CASA receives application from Avtex to have condition no. 2 removed from its AOC. CASA rejects that application
26 October 2008	Pilots meeting, which discussed the issue of flying in icing conditions.
26-27 March 2009	Second ACS audit

Date	Event
15-16 September 2009	Third ACS audit
10-16 February 2010	CASA officers conduct risk based audit of Avtex to determine whether the systems Avtex had put in place would enable CASA to remove the conditions on its AOC. Although Avtex had told CASA that its operations would involve only the utilisation of turbine powered SA226 and SA227 aircraft and the audit focussed primarily on those aircraft and their use, it became apparent during the audit that Avtex continued to use the Piper PA-31 piston engine aircraft. The auditors also noted that the majority of scheduled and unscheduled maintenance on the turbine powered aircraft was carried out by ANA and that Avtex, under its COA, only occasionally certified for completion of minor maintenance work. The auditors also found that many of the issues raised in the June 2008 risk based audit remained. As a consequence of the audit, one SA and 24 RCAs were issued. Five of those RCAs were issued regarding the airworthiness of aircraft used in the AOC operation.
11 February 2010	Avtex ceases flying operations.
15 February 2010	CASA arranges for Mr Couch (Head of Training and Checking) to undergo a proficiency check under the supervision of Mr Worthington. This proficiency check was assessed the proficiency check as a fail and that the effort by Mr Couch was well below the standard for a HOTC position. The audit report also noted that Mr Couch arrived 1½ hours late and that he appeared to be suffering from the effects of alcohol.
28 May 2010	CASA issue Avtex first show cause notice .
15 June 2010	Death of Andrew Wilson and Kathryn Shepherd in PA-31P at Canley Vale Road
22-29 June 2010	CASA conducts special audit of Skymaster. The audit reveals a large number of safety deficiencies in the systems and work practices in place within the Skymaster AOC organisation. The audit resulted in three SAs and a number of RCAs being issued by CASA.

Date	Event
25 June 2010	Avtex responds to first show cause notice by its solicitors, Norton White.
12 July 2010	CASA issues audit report, together with separate audit reports of the Drug and Alcohol Management Plan and the SMS.
23 July 2010	CASA suspends AOCs of Avtex and Skymaster pursuant to sub-section 30DC(1) of the *Civil Aviation Act 1988*.
3 August 2010	Moore J of FCA makes order under sub-section 30DE(2) of the CA Act prohibiting Avtex and Skymaster from doing anything authorised by their AOCs until 5 pm on 4 August 2010.
12 August 2010	Norton White, solicitors for Avtex and Skymaster, responds to second show cause notice (to both Avtex and Skymaster).
20 August 2010	CASA cancels AOCs of both Avtex and Skymaster
4 February 2011	Administrative Appeal Tribunal affirms cancellation of Avtex AOC

Grant Burley

26 July 2010

Mr. John McCormick
Director of Aviation Safety
Civil Aviation Safety Authority
GPO Box 2005
CANBERRA ACT 2601

Via facsimile: 02 6217 1444

Dear Mr. McCormick,

RE: AIRCRAFT ACCIDENT VH PGW
DATE OF ACCIDENT 15 JUNE 2010
DECEASED: ANDREW WILSON – PILOT
KATHY SHEPPARD – FLIGHT NURSE

On 15 June 2010, Andrew Wilson, a Pilot and good friend of mine and a young man I had assumed a mentoring role with was killed along with Kathy Sheppard, a flight nurse, in an accident that occurred at Canley Vale, NSW.

The accident has of course created a permanent change to the lives of the families of the deceased and left many, particularly in the aviation industry, and including myself distressed and in the need of answers to the circumstances leading to the event, the accident and the investigation proceeding at this time.

This letter is written to you on behalf of the Wilson family, the family of the deceased Pilot as well as by me. The Wilson family and I will follow the investigation to the full extent possible and provide any assistance to your Authority.

We are aware that your Authority, the ATSB and NSW Police Services are carrying out extensive investigations. We are also aware that you have now suspended the Operator of the aircraft and its related companies, Skymaster Air Services and Avtex Air Services ("the Operator") from flying. We greatly appreciate the efforts to date. The purpose for this letter is to put to you, as the regulator of air safety, material that we believe should be considered and investigated and indeed acted upon so that the likelihood of repeat incidents are significantly reduced. We also believe that there is an urgent need to address a number of what we believe are serious shortcomings in the regulatory framework, pilot training processes and incidents that continue to arise with the operator.

By way of example I am aware that one of the Operators aircrafts suffered an engine malfunction on Friday, 2 July 2010. While the aircraft was successfully returned to Bankstown Airport the aircraft had limited time to fly before that engine would have become totally inoperative. I am also aware of another recent incident involving an undercarriage failure where an aircraft nose wheel collapsed on landing. It's almost inconceivable that one operator could be the subject of such misfortune. It is indeed more likely that a number of factors are contributing to the continuation of such events.

Because of the extraordinarily high incidence of failures with the Operator's aircraft we believe your Authority should move immediately to extend the order on the Operator for the full 40 day period available under the law so that your Authority has the time within which to complete its investigations and act upon its findings. Further, we are not of the view given all that has transpired that the operator is fit to hold such privileges beyond that period.

Background

Andrew Wilson's father has been associated with me for over 20 years and I was provided opportunity to assist Andrew with the long and arduous process of procuring experience to be a suitable candidate for airline operators. Andrew was well liked and others more experienced that I also assisted Andrew with that quest. It should therefore come as no surprise that this accident has sent shock waves through the aviation community.

In 2007 Andrew relocated from Darwin to Bankstown and set about building his hours. He first worked with Skypac and then the Operator. I spent considerable time flying with Andrew in Cessna 310 aircraft and my Cheyenne 400 LS turbine aircraft. He was well organised, risk adverse and in my view presented as sound, professional and competent airline material.

A number of my close associates spent time with Andrew over his time at Bankstown. I had numerous discussions with him where he aired his concerns about the Operator, including, but not limited to, aircraft maintenance, the apparent disregard of adverse weather conditions and the Operator's expectation that pilots would perform certain Instrument Flight Procedures without necessary and required equipment. In these discussions Andrew also raised his concerns to me as to aircraft performance levels even when both engines were operating. Andrew advised me on a number of occasions that when he complained to the Operator about his concerns, it was clear that his complaints were not welcomed. Andrew advised me that his flying duties appeared directly linked to him airing his complaints to the staff and responsible officers of the Operator. Andrew was seemingly ostracised for complaining and for operating within the rules.

The concerning side of such a culture is that low time impressionable pilots may be pressured into conducting flights that are not only outside the rules but most likely beyond their ability. After a while of course they treat these flights as ` Normal` flights which of course they are not and one should also acknowledge that these pilots are indeed future airline operatives.

It is hard to lay any blame on the pilots as they are inducted into the Operator with minimal training and then left with unsuspecting passengers, all with the blessing of the Chief Pilot and Management. We have documentary evidence in our possession clearly confirming training deficiencies, and will make copies available on request.

A further revelation as to the very nature of these medical flights is that it may arise that flight nurses are another pressure point for pilots to complete flights of this nature.

On the morning of the 15 June 2010 I was about to depart from Alice Springs for Bankstown when I received a call from a close colleague who told me about that morning's accident and that Andrew had been killed.

Shortly after being advised of the accident I learned that the Operator had made calls to Andrew's fellow pilots in an endeavour to see that the earlier failed medical flight to Queensland was fulfilled. Whilst I will deal with this serious issue shortly any reasonable person cannot ignore the distaste that proposition presents .This is especially relevant when I discovered that Andrew's immediate family were not informed of the accident by the Operator, but rather by me. This departure from protocols in dealing with a catastrophe of this magnitude defies belief and serves to exacerbate my suspicion that the Operator's management are deeply misguided.

Specific Areas of Concern

We acknowledge that it is too soon to make assumptions on the events leading up to the accident and accept many items are the subject of ongoing investigation.

However, right now there are a number of known facts and they link to apparent gaps in regulation and procedure which go to the heart of airman training and the basis upon which the Operator has operated. In fact the more one delves into the situation the more issues arise.

We realise that your authority as taken action notwithstanding that the ASTB has not finally reported and we are grateful for that action. We seek to raise the following points.

It is beyond belief that within hours of the accident the Operator was soliciting pilots to conduct the same flight that the stricken aircraft was to complete earlier. We have accounts from one pilot that within 1.5 hours he was asked to conduct the flight which he refused .Shortly thereafter the flight was conducted.

At the time the second flight was being arranged and right up until this day tampering with of the Operators aircraft in the period prior to flight is subject to ongoing investigation .Even leaving aside the obvious regulatory responsibilities of the Head of Maintenance and/or Chief Pilot no reasonable person would embark on such a flight unless all such possibilities could be completely ruled out. It is inconceivable that such events could have been dismissed at the time of the flight and at the time substitute crew were sought.

Trauma due to stress has been identified and well documented as a major contributing factor to accidents. This is true in motor, aviation and other vocations where operating complex machinery. It is our contention that any crew who manned the subsequent flight could not be immune from the events which had occurred earlier and this placed the passenger(s), aircrew and public at further risk quite unnecessarily.

Training records we have in our possession show alleged deficiencies in some elements of Andrew's operating. Despite recommendations shown on the document it would seem the remedial procedures were never carried out. If those records are not already held by your authority we will provide copies on your request.

Issues arising:

We ask that you advise the steps your authority has taken in relation to investigate these issues and specifically:

1) Referring to the replacement flight that took place what maintenance checks were carried out on the Operator's entire fleet that were housed next to each other at the Operators Bankstown location and specifically whether they were conducted to a satisfactory level given the earlier incident;

2) How those checks were (if they were done at all) completed to a satisfactory standard prior to:

   a) the request for alternate pilots; and

   b) When the actual flight took place?

3) What motivation the Operator had for conducting the second flight at all? The decision, in our view, just confirms a clear conflict between revenue procurement and safety. We cannot imagine any conceivable reason as to why this flight took place other than revenue raising given everything that had unfolded earlier.

4) What steps the Operator and specifically the Chief Pilot took to ensure the line pilots were fit for flight. We are of the view that no responsible officer could have allowed such an event to occur.

5) Why are check flights occurring and yet the recommended remedial recommendations not being carried out?

General operation of the AOC Holder

As previously mentioned, Andrew repeatedly raised his concerns as to the flight operations of the Operator with me and with his friends and family. Even if it is established that Andrew made an error of judgement, one thing he would not do is undertake flights into known icing conditions, thunderstorms or undertake breaches of regulations.

At times Andrews flying appeared to dry up: "no flights available" etc as was quoted to me. However, there appeared to be a link between these events and the refusal to undertake flights of the nature outlined or after events when Andrew wrote defect reports on the aircraft maintenance release(s).If this is true it reflects poorly upon the Operator.

We have in our possession written accounts from Andrew of just some of the matters and will on request provide copies to you.

As you are aware and as has been reported in the media, the Operator has experienced a high number of aircraft accidents and/or incidents. The unexplained loss of a Metro in 2007, a number of engine failures and another partial one since the flight in question and a recent gear failure, are more in line with a third world aircraft operator rather than one that operates daily out Australia's main GA airport.

It is our opinion based upon information to hand and accounts from Andrew that the continuation of the Operator presents a real and unacceptable risk to innocent passengers and General Aviation. At its very simplest the accident/incident data, training records we have along with Andrews accounts all point to a very serious and dangerous environment.

The sister plane of the one in question was the subject of a catastrophic engine failure 18 may 2005 the incident is the subject of an ATSB report.
http://www.atsb.gov.au/publications/investigation_reports/2005/AAIR/pdf/aair200502231_001.pdf

The pilot maintains that the reason he continued with the flight from Young to Bankstown was he thought everything was "OK".

No twin engine aircraft is performing "normally" in the event of engine failure and the pilot (in our view) should have landed as soon as practicable NOT continued with the flight to satisfy the Operator's whims by landing the stricken plane at the Operators home base. Assuming the aircraft was at Young it flew around 140 nautical miles which would have been an hour or more flight, sometimes over high terrain. Had the plane encountered any issues with the second engine at a further stage of the flight the time interval between this and facing ground terrain at critical periods would have been less than 3 minutes and with little or no opportunities for landing safely. If for what ever reason Young was unavailable for landing then the next practicable solution was Goulburn and/or Cowra both nearer and without the necessity to fly over high terrain.

And making matters worse is that this flight had a flight nurse and patient on board.

Noticeably absent from the ASTB report of the incident was comment upon the pilot's decision to continue with the flight in favour of landing. The point is it highlights a deficiency in training, procedure and possibly even in the investigation. What did your Authority have to say about such a procedure and what training took place with the Operator since this event? We put it that the delay to make decisions to land as soon as possible may well unfold to be a contributing factor as to the flight in question.

The regulations are clear on this issue:
http://casa.gov.au/wcmswr/_assets/main/download/orders/cao20/2006.pdf

And specifically 3.2 D) & H) which refer to the likely risks should a second engine fail and H) the terrain associated for future flight.

Issues arising

Based on information we have in our possession and accounts from Andrew we submit that a careful review of the flight operations needs to be undertaken including:

1) The pattern between Andrew's flying and the maintenance issues he documented upon aircraft;

2) Weather patterns with a careful review of flights, lower safe altitudes and freezing levels. We do not believe that the Operator's aircraft are certified for known icing conditions.

3) Periods where instrument approaches have been necessary at Bankstown involving incoming Operator flights and the equipment in the aircraft. Specifically, are the aircraft fitted with Serviceable Distant Measuring equipment (DME) or TSO approved and current GPS and are the pilots are trained and certified in the use of such equipment?

4) Consistent with 3) the navigation equipment utilised for flights which as we understand is predominantly GPS, BUT are pilots trained and certified for the use of such equipment and are they TSO GPS units with regular data base updates? Even en route GPS as a Nav aid requires the equipment to be TSO Certified for the nature of flights the Operator is undertaking.

5) Referring to ***CAO 20.18 4.1 A)-C)*** None of these aircraft can legally fly without the provision of a serviceable autopilot system which is operative and possesses the functions as outlined in these sections without a second pilot. Our understanding is that on numerous occasions this has not been the case and that it may not be the case now.

6) Details of training and especially that relating to single engine procedures and those relating to company procedures.

Air regulations/Training

Quite aside from any areas that might arise with the Operator are the various issues that have surfaced with the very nature of these flights.

We were amazed to learn that the aircraft being used for such flights were being operated in the Air Work and not Charter category .The nature of these flights is often Med 2 Patient transfer. Those patients' expectations would be to be flying in the safest aircraft possible.

While it is accepted that the category in its self is not a predetermining factor of how aircraft maybe maintained it does mean that certain maintenance issues do not need to be attended to at the same intervals for example hydraulic hoses, calendar engine life etc.

Most training manuals that refer to multi engine training in the single engine state drum in: "full power, gear up, flaps up, dead leg, dead engine etc." The one critical item seemingly missed is what we will refer to as confirmation of the aircraft state that is after the drills are completed what is the state of the aircraft. Is the aircraft maintaining altitude? If not, what is the distance to nearest airport reference ground speed, elevation of airport and descent speed? If one cannot make the airport what is the next course of action whilst some altitude still exists?

We note that the deficiencies don't stop there. Flight manuals seem to neglect the decline in performance that maybe experienced if a propeller is not capable of being feathered or flaps/gear become inoperable. We do not for a minute propose that the amending of flight manuals be taken on BUT these key issues ought be dealt with in far more detail than they are with performance expectations in multi engine aircraft in the case of engine failure .

We have spent some time reviewing the regulations relating to not only the procedures for multi engine asymmetric flight condition but also the recommended training syllabus:
CAAP 5.23-2(0) : Muli-engine aero plane Operations and Training

We can see NO reference in that and other documents suggesting procedures in the event

a) The aircraft is not performing to manufacturer specification on the non failed engine; nor

b) Training in relation to the circumstance whereby the aircraft is incapable of being placed in a safe state i.e. flaps/gear inoperative or propeller is incapable of being feathered and specifically further likely events that might unfold and immediate decisions that these events would then entail.

It may well be found that this very subtle absent factor was also a major contributing factor to the 15 June 2010 accident.

When Andrew accepted the descent to 2500 feet with still 20 odd track miles to Bankstown a descent of anything around 200fpm would mean the aircraft was not capable of reaching the designated airport, but the descent until Prospect Reservoir was in fact much greater than that. So, to the extent the aircraft arrived at Prospect at 1000ft with a descent of 200FPM or thereabouts meant that the aircraft could not make the designated aerodrome. We believe this contributing factor to the accident remains an issue that needs to be addressed in all multi engine training.

On the basis of an engine failure (if it is found this is the root cause) the question remains open as to why level flight was not apparently available to the pilot on what was an ISA day, with the aircraft below maximum takeoff weight .

Issues arising:

Clearly many of these issues are already well known to your Authority and as such there would be plans afoot to remedy what seem to be regulatory gaps certainly in respect to the category of aircraft used in such critical medical related flights.

We ask that your Authority:

1) Regulate to prevent Air Work aircraft carrying out what are essentially medical flights?

2) Advise what it sees as its role in improving multi engine training and in this regard in relation to aircraft state after engine failure, landing soon as practicable after engine failure and other related issues?

The Investigation

Access to parties involved in this investigation to date has been excellent and for this we thank your Authority, the ATSB and NSW Police Service.

As we understand (briefly) the role of the parties they are:

ATSB

Accident investigation, fact finding and report upon the sequence of events leading to the loss .We understand the complexity, the many aspects needing to be considered and the significant time this process will take.

It appears though the ATSB has NO powers in relation to any action that may be taken against operators or indeed the capacity to enact criminal proceedings should the scope for which arise.

Police CIB

The local Canley Vale Police will investigate the circumstances of the fatalities and whether there are any criminal aspects.

Police Air wing Accident investigation unit

As we understand this department will in the end provide a report to the NSW Coroner's office and following receipt of ATSB report and report and whether there are criminal aspects of the accident and if appropriate enact those proceedings.

CASA

Controller and manager of aircraft regulation, breaches of such and the administrator of aircraft operators.

Issues arising:

1) We see the role of your Authority and the role of the ATSB as quite different and believe that there should be a full and transparent passing of data between the departments. We have been advised that this freedom of data is not necessarily available or indeed the way these investigations unfold. It goes without saying that the freedom and ease upon which data flows would significantly enhance all authorities' capacity to get to the truth and in the contrary any withholding of critical data will significantly undermine investigations of this nature and the quality of the final outcome given the risk passing of time poses.

2) In our view your Authority needs to be exercising its full delegated authority now and over the ensuing period to seek and receive all necessary reference material as it sees fit and this would include the cross referencing of pilot log books, Maintenance releases, flight and duty times and the broader operations of the operator as outlined. We acknowledge that this maybe occurring right now.

3) As well the interviewing of all line pilots, inspection of equipment in aircraft, specifically in relation to some of the issues raised needs to be undertaken rigorously and as a matter of urgency. We accept that this may already be happening but we need that comfort and do not possess a suitable level at this time.

We appreciate that there are many issues raised in this letter. We seek some assurance that these issues are being or will be fully investigated. Specifically could you advise:

1) What steps your Authority has taken to date to each and every one of the issues rose.

2) What key actions will be adopted and the timelines associated with those actions. To be clear we believe that your Authority should review all flight records, conduct interviews with responsible office bearers and pilots of the Operator now. This process would include the cross referencing of pilot log books, Maintenance Releases, flight and duty times and the broader operations of the Operator. Training records of ALL pilots should be reviewed.

3) Any limiting factor as to why it is your view that your Authority may not be able to investigate each and every issue raised.

4) Any assistance your Authority may require in terms of resources to ensure the quality and detail of this investigation is not compromised in anyway.

Conclusion

We are available to assist in any way we can. Our objective is to ensure we arrest the cause and contributing factors associated with this event and to see that a number of sensible actions are taken to improve safety aspects for all concerned. From the families and my perspective it is important that as difficult as they may be serious and expeditious steps be taken in a raft of areas.

We await a considered response in due course and once again thankyou for efforts assumed to date.

Yours truly,

GRANT BURLEY

CC Alan Wilson

Administrative Appeals Tribunal of Australia

Avtex Air Services Pty Ltd and Civil Aviation Safety Authority [2011] AATA 61 (4 February 2011)

Last Updated: 4 February 2011

Administrative Appeals Tribunal

DECISION AND REASONS FOR DECISION [2011] AATA 61

ADMINISTRATIVE APPEALS TRIBUNAL)

) No 2010/3553

GENERAL ADMINISTRATIVE DIVISION)

Re AVTEX AIR SERVICES PTY LTD

Applicant

And CIVIL AVIATION SAFETY AUTHORITY

Respondent

DECISION

Tribunal Mr Egon Fice, Senior Member

Date 4 February 2011

Place Sydney

Decision The Tribunal affirms the decision made by the Civil Aviation Safety Authority on 20 August 2010

. . . . . [sgd] Egon Fice . . . . . .

Senior Member

CIVIL AVIATION – cancellation of AOC – serious and imminent risk to air safety – key personnel – inexact proofs, indefinite testimony or indirect inferences – concurrent hearing of applications – special risk based audits – defective endorsement training – CASA instrument of delegation and approval – asymmetric

flight training – training and checking organisation – proficiency checking – amending training and checking manual – in command requirements for charter work – distinction between class and type of aircraft – regulated take-off weights – safety management system – safety culture – defect recording – flight in icing conditions – flight around thunderstorm activity – pilot fatigue and pressure to conduct flight – fatigue management system – airworthiness of aircraft used in AOC operations

Administrative Appeals Tribunal Act 1975 ss 3, 33(1), 41(2), 43(1)

Acts Interpretation Act 1901 s 13

Civil Aviation Act 1988 ss 20AA(3), 27(2A), 28, 28(1)(a), 28(1)(b), 28(3), 28BA, 28BA(3), 28BD, 28BE, 28BE(1), 28BE(2), 28BF, 28BF(1), 28BH, 28BI, 28BAA, 30DB, 30DC, 30DC(1), 30DC(3), 30DD(1), 30DE, 30DE(2), 30DG, 30DH, 30DI, 30DI(2), 31, 31A, 98(4A),

Civil Aviation Regulations 1988 – 2, 5.13, 5.14(2), 5.19(3), 5.20(1), 5.20(2), 5.21(1), 5.23(2), 7(1), 30, 38, 42R, 47, 50, 53, 217, 217(2), 235(2), 238, 249,

Civil Aviation Safety Regulations 1998 – 99.050

Civil Aviation Order – 20.11 (paragraph 12.1), 20.7.1B, 40, 41.1.0, 40.1.5, 40.1.7 (paragraph 9.1, 9.1(a), 9.1.1), 40.2.1, 40.2.2, 48, 82.0, 82.1 (paragraph 4, 6.2)

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Glossary of Terms

NOTE: These abbreviations are referred to throughout the Reasons for Decision

AGL	Above ground level
AAT Act	Administrative Appeals Tribunal Act 1975
ACS	Aviation Compliance Solutions Pty Ltd
AH	Artificial Horizon

ANA	Australian National Aviation Pty Ltd
AOC	Air Operators Certificate
APG	Aircraft Performance Group
ASR	Aircraft Survey Report
ATIS	Aerodrome Terminal Information Service
ATO	Approved Testing Officer
ATSB	Australian Transport Safety Bureau
Avtex	Avtex Air Services Pty Ltd, trading as Airtex Aviation
CA Act	Civil Aviation Act 1988
CAO	Civil Aviation Order
CAR	Civil Aviation Regulations 1988
CASA	Civil Aviation Safety Authority
CASR	Civil Aviation Safety Regulations 1998
CEO	Chief Executive Officer
CIR	Command Instrument Rating
COA	Certificate of Approval
DAMP	Drug and Alcohol Management Plan
EGT	Exhaust Gas Temperature
ERSA	En route Supplement Australia
FAID Score	Fatigue Audit InterDyne Score
FMS	Fatigue Management System
FOI	Flying Operations Inspector
FRMS	Fatigue Risk Management System
GSMS	Group Safety Management System
HAAMC	Head of Aircraft Airworthiness and Maintenance Control
Heron	Heron Airlines Travel Pty Ltd
HOTC	Head of Training and Checking
ICAO	International Civil Aviation Organisation
ICC	Industry Complaints Commissioner
ICUS	In command under supervision
IFR	Instrument Flight Rules
ILS	Instrument Landing System
IMC	Instrument Metrological Conditions
LAME	Licensed Aircraft Maintenance Engineer
Metro III	Fairchild Metro III
NDB	Non Directional Beacon
NLG	Nose Landing Gear
NOTAM	Notices to Airmen
PA-31	PA-31 Navajo Chieftain
PA-31P	Piper Mojave PA-31P-350
PIC	Pilot in Command
RCA	Request for Corrective Action
RFDS	Royal Flying Doctor Service
RPT	Regular Public Transport

	Regulated Takeoff Weight
SA	Safety Alert
SAS	Stall Avoidance System
Skymaster	Skymaster Air Services Pty Ltd
SMG	Safety Management Group
SMS	Safety Management System
TBO	Time between overhaul
TCM	Training and Checking Manual
TCO	Training and Checking Organisation
USA	United States of America
VFR	Visual Flight Rules
Wingaway	Wingaway Air Pty Ltd

REASONS FOR DECISION

4 February 2011 Mr Egon Fice, Senior Member

1. Avtex was the holder of an AOC. The current directors of Avtex are Dieter Siewert and Lieselotte Siewert. They are also shareholders in that company.
2. Mr and Mrs Siewert are also involved in a number of associated companies. Skymaster was also the holder of an AOC prior to its recent cancellation. Mrs Siewert is the sole director and secretary of that company. Its shares are held by Mr and Mrs Siewert.
3. There are two associated companies involved in the aviation businesses but which do not hold AOCs. They are Wingaway and Heron. Mr and Mrs Siewert are both directors of each of those companies and also their shareholders.
4. Mr Siewert is the CEO of Avtex and Skymaster. Mr Graham Newberry is the HAAMC for Skymaster and for Avtex (including the CAR 30 organisation). Skymaster and Avtex share a common facility at Bankstown Airport in New South Wales. Prior to their cancellation, the AOCs of Avtex and Skymaster authorised charter and aerial work operations. Avtex's AOC authorised its holder to operate piston engine and turbine engine aircraft in its operations. The Skymaster AOC authorised charter and aerial work operations using only specified types of piston engine aircraft. Although Skymaster is not the registered operator of any aircraft, it operates aircraft which are registered to Avtex, Wingaway and Mr Siewert. Also, after June 2008, Skymaster almost exclusively used the piston engine aircraft in its air operations while turbine engine aircraft operations were conducted by Avtex. Most of the pilots used in the operations of both companies were hired on a casual basis, conducting operations for both entities.
5. On 28 May 2010 CASA issued to Avtex a notice of proposed action to vary, suspend or cancel its AOC (the first show cause notice). On 25 June 2010, Avtex's solicitors, Norton White, provided to CASA a response to its first show cause notice. However, between those two dates, on 15 June 2010, a PA-31P aircraft registration VH-PGW operated by Skymaster crashed on Canley Vale Road near Bankstown Airport when attempting to make an emergency landing. The pilot of the aircraft and a flight nurse were killed in that crash. That accident resulted in CASA conducting a special audit of Skymaster between 22 and 29 June 2010. Following the special audit, CASA concluded that if Skymaster were to continue its operations under its AOC, that would result in a serious and imminent risk to air safety. CASA also formed the view that because of the close relationship between Avtex and Skymaster, and the joint resources shared by those companies, if Avtex continued its operations under its AOC, that would also result in a serious and imminent risk to air safety.
6. On 23 July 2010 CASA suspended the AOCs of Avtex and Skymaster pursuant to s 30DC(1) of the CA Act. Section 30DC of the CA Act provides that:

(1) Where CASA has reason to believe that the holder of a civil aviation authorisation has engaged in, is engaging in, or is likely to engage in, conduct that contravenes section 30DB, CASA may suspend the authorisation by giving written notice to the holder.
Note: CASA is not required to give the holder a show cause notice before making a decision under this subsection.

Section 30DB provides that:

The holder of a civil aviation authorisation must not engage in conduct that constitutes, contributes to or results in a serious and imminent risk to air safety.

7. Unless CASA makes an application to the Federal Court under s 30DE of the CA Act within five business days of notifying the holder of the suspension, the suspension ends (s 30DC(3)). Section 30DD(1) provides that:

(1) CASA may make a decision under section 30DC in relation to a civil aviation authorisation even if CASA has given the holder of the authorisation the show cause notice required before making a decision under another provision of this Act or the regulations.

The Regulations referred to in s 30DD(1) include the CARs and the CASRs. A suspension under s 30DC has effect irrespective of whether there is a Stay Order in place under s31A of the CA Act.

8. On 3 August 2010, Moore J of the Federal Court of Australia made an Order under s 30DE(2) of the CA Act, prohibiting Avtex and Skymaster from doing anything which was authorised by their respective AOCs until 5.00pm on 4 August 2010. Section 30DE(2) provides that:

(2) If the Federal Court is satisfied that there are reasonable grounds to believe that the holder has engaged in, is engaging in, or is likely to engage in, conduct that contravenes section 30DB, the Court must make an order that prohibits the holder from doing anything that is authorised by the authorisation but that, without the authorisation, would be unlawful.

9. Under s 30DG of the CA Act, if the Federal Court has made an Order under s 30DE, CASA is required to complete an investigation into the circumstances that gave rise to CASA's decision to suspend the authorisation by the end of the period that the Order is in force. After making the investigations required by s 30DG of the CA Act, where CASA has reason to believe that a serious and imminent risk to air safety would exist if the civil aviation authorisation in question was not varied, suspended or cancelled, and the grounds for CASA's belief are related to the circumstances that gave rise to CASA's original decision to suspend the authorisation under s 30DC, it may give the holder of the authorisation a show cause notice within five business days after the last day on which the Order is in force.
10. In accordance with s 30DH of the CA Act, CASA gave Avtex and Skymaster a show cause notice. CASA allowed Avtex and Skymaster 28 days from the date of the notice to provide it with reasons why CASA should not recommend that each entity's AOC be varied, suspended or cancelled.
11. On 12 August 2010 Norton White (solicitors) provided CASA with a written response to the show cause notices issued to Avtex and Skymaster. After considering Norton White's responses, on 20 August 2010, CASA made a decision in respect of both entities under s 30DI(2) of the CA Act, cancelling both AOCs. Section 30DI of the CA Act provides:

CASA may vary, suspend or cancel an authorisation within 5 days after end of show cause period
(1) This section applies if, after the end of the period specified in a show cause notice given under section 30DH:

(a) CASA is satisfied that a serious and imminent risk to air safety would exist if the civil aviation authorisation were not varied, suspended or cancelled; and
(b) the grounds for CASA's belief are related to the circumstances that gave rise to CASA's decision to suspend the authorisation under section 30DC.
(2) CASA may vary, suspend or cancel the authorisation, by written notice given to the holder of the authorisation within 5 business days after the end of the period specified in the show cause notice.

12. Within 28 days of that decision, Avtex lodged an application with the Tribunal for a review of CASA's decision to cancel its AOC. It also lodged with the Tribunal an application for a Stay pursuant to s 41 (2) of the AAT Act. Although Skymaster also lodged an application for review of CASA's decision to cancel its AOC, that application is not the subject of this review. Mr H.J. Langmead SC, who appeared for Avtex, said that application had only been lodged to enable Skymaster to proceed if it subsequently believed it needed to.
13. I heard Avtex's stay application on 27 August 2010 and declined to grant a Stay. This matter was given an accelerated path to a concluded hearing which was conducted over some 16 sitting days.
14. Because this application before the Tribunal is only in respect of the cancellation of Avtex's AOC, Mr Langmead firmly submitted that any issues relating to the cancellation of Skymaster's AOC were irrelevant for the purposes of this proceeding. CASA disagreed. Mr I. Harvey of counsel, who appeared on behalf of CASA, referred to the fact that prior to the audit conducted by CASA in July 2008 following a fatal accident involving an Avtex operated Metro III aircraft, Avtex operated both the piston engine and turbine engine aircraft. After the audit, piston engine aircraft operations were transferred to Skymaster. Avtex then operated almost exclusively turbine engine aircraft, predominantly the Metro III. This of course was possible due to the controlling interest of the Siewert family in both companies.
15. Mr Harvey submitted that if I were minded to set aside CASA's decision to cancel Avtex's AOC, Avtex would again resume the piston engine operations formerly conducted by Skymaster. According to Mr Harvey, and these facts were not disputed, the overlap between the operations of Avtex and Skymaster includes:
    - (a) operations out of the same hangar;
    - (b) the same CEO;
    - (c) the same HAAMC;
    - (d) the piston engine aircraft serviced by Avtex under a COA held by it, which is also controlled by Mr Siewert;
    - (e) sharing a common operations department;
    - (f) ownership and control by the Siewert family; and
    - (g) access to a common pool of pilots employed on a casual basis so that appropriately qualified pilots within the pool may be tasked to conduct flying operations for either or both companies.
16. Section 28 of the CA Act, which deals with the issue of AOCs, requires CASA to be satisfied that the key personnel in the organisation to which the AOC is granted have appropriate experience in air operations to conduct or to carry out the AOC operations safely. The expression *key personnel* is defined under s 28(3) of the CA Act and it means the people, however described, that hold, or carry out the duties of the following positions in the AOC holder's organisation:

    . . .
    (a) the chief executive officer;
    (b) the head of the flying operations part of the organisation;
    (c) the head of the aircraft airworthiness and maintenance control part (if any) of the organisation;
    (d) the head of the training and checking part (if any) of the organisation;
    (e) any other position prescribed by the regulations.
    . . .

17. As Mr Harvey submitted, the key personnel in both organisations are identical except for the fact that

each organisation has its own chief pilot, who is the head of flying operations. Also, because Avtex is required to have a TCO under CAR 217, it also has a HOTC. This is not the case for Skymaster which is not required to have a TCO.

18. Mr Harvey submitted that the rationale for the suspension and ultimate cancellation of the Avtex AOC concurrently with the Skymaster AOC emanated from operational problems experienced by Skymaster which, according to CASA, resulted in the fatal accident of the PA-31P Mojave aircraft on 15 June 2010. Mr Harvey submitted that had the Avtex AOC not been suspended and then subsequently cancelled concurrently with the Skymaster AOC, the operations of Skymaster would have immediately been transferred to Avtex.
19. I did not understand Avtex to dispute the fact that if its AOC were reinstated, it would immediately commence operations using the piston engine aircraft formerly operated by Skymaster. It follows, in my opinion, at least to the extent that the key personnel under Avtex's AOC will remain the same as they were prior to the cancellation of the AOC, that there is some force in CASA's submissions. Although there will be some changes to key personnel if I decide to set aside CASA's decision to cancel Avtex's AOC, I am of the view that I should carefully examine CASA's concerns about the safety of the operations of both AOC holders. At the same time, I should bear in mind the fact that the cancellation of the Avtex AOC was principally motivated by concern with Skymaster's operation following the fatal accident on Canley Vale Road; and that the head of the flying operations of Skymaster and Avtex are not the same person.
20. The real issue, as I see it, is the influence the common key personnel have on the safety of air charter and air work operations of both entities. To only examine the influence of those persons on Avtex would, in my opinion, result in excluding evidence which is likely to be significant in coming to the preferable decision in this matter. In fact, although Mr Langmead strenuously resisted the concurrent hearing of the Avtex and Skymaster applications, he nevertheless relied on evidence from the chief pilot of Skymaster in support of Avtex's claim.
21. Although CASA applied to have the Skymaster and Avtex's applications heard together, I declined that application. That is because, in my view, the Tribunal does not have the power under the AAT Act to compel an applicant to have multiple applications lodged with the Tribunal heard concurrently.
22. While I appreciate the Tribunal is given broad procedural powers which are set out in s 33(1) of the AAT Act, those powers clearly relate to procedure in a proceeding. Matters are frequently heard concurrently by the Tribunal but that is generally with the consent of the parties. I agree with Mr Langmead's submissions that save for an order made by the Tribunal that the discrete applications be heard together, each applicant and the respondent in each case is entitled to a separate hearing. While Mr Langmead accepted that there is a risk of inconsistent findings in separate proceedings, that may well be unavoidable given the different circumstances in which each entity operates. However, if the dominant influence over the operations comes from the same key personnel, then such inconsistent findings are unlikely.
23. That is not to say that Skymaster is not entitled to an independent adjudication of the cancellation of its AOC based on its merits. However, in this case, it seems inevitable that there will be some overlap of the two operations because of common key personnel. This is despite the fact that both entities had, at the relevant time, different chief pilots. I accept, as is set out in CAO 82.0 Appendix 1 at cl 2.2(a), that it is the responsibility of the chief pilot to ensure that the operator's air operations are conducted in compliance with the CA Act, CARs, CASRs, and CAOs. Nevertheless, it is not impermissible, in my opinion, to examine whether other key personnel may have had some negative influence on the chief pilot. If there is evidence of such influence, then it must necessarily be relevant to take that into account when determining whether CASA's decision to cancel Avtex's AOC was the preferable decision.

BASIS FOR REVIEW

24. CASA's decision to cancel Avtex's AOC was based on s 30DI of the CA Act. After receiving Avtex's response to its show cause notice of 10 August 2010, CASA nevertheless remained satisfied that a serious and imminent risk to air safety would exist if the AOC were not cancelled. That is why it acted on 20 August 2010 to cancel the AOC.
25. There was no dispute about the fact that this Tribunal has jurisdiction to review decisions made by

CASA which are described as *reviewable decisions*. That expression is defined in s 31 of the CA Act. A reviewable decision includes cancellation of a certificate granted or issued under the CA Act. An AOC is issued under s 28 of the CA Act. Therefore, as Mr Harvey submitted, the first question for me to determine is whether Avtex's operations would present a serious and imminent risk to air safety, if they were to continue.

26. Mr Harvey submitted that if the jurisdictional facts, that is, those facts which would support a serious and imminent risk to air safety finding, no longer existed, then I should exercise other powers or discretions open to me and in particular those set out in s 28BA(3) of the CA Act. That section provides:

> ***28BA General conditions***
> *(3) If a condition of an AOC is breached, CASA may, by written notice given to its holder, suspend or cancel:*
> *(a) the AOC; or*
> *(b) any specified authorisation contained in the AOC;*
> *whether or not the breach is continuing.*

27. In fact, in the show cause notice issued to Avtex on 28 May 2010, CASA relied on s 28BA(3) of the CA Act when considering whether to vary, suspend or cancel Avtex's AOC. Although Avtex responded to that show cause notice, CASA did not in fact make a decision under s 28BA(3) of the CA Act as subsequent events, namely the Canley Vale Road accident, heightened CASA's concerns to the extent that it proceeded under Division 3A of the CA Act on the grounds of serious and imminent risk to air safety. Regardless, Mr Harvey submitted that if minded to do so, I could nevertheless affirm CASA's decision if I were to find that Avtex's conduct in the course of its air operations was such that s 28BA (3) of the CA Act was enlivened.
28. Mr Harvey relied on the decision of Hill J in *Secretary, Department of Social Security v Hodgson* [1992] FCA 338; (1992) 108 ALR 322. That case involved a decision by the Secretary of the Department of Social Security to recover an overpayment of social security although he had not considered whether recovery of that debt to the Commonwealth should be waived. Although the issue of waiver was first raised before the Tribunal, his Honour did not think that prevented the Tribunal from exercising the power to waive the debt. His Honour specifically relied on the power granted to the Tribunal under s 43(1) of the AAT Act. That section empowers the Tribunal to exercise all the powers and discretions conferred upon the original decision maker provided it does so for the purpose of reviewing a decision. Hill J said, at 330:

> *Of course there must be an association between the power to be exercised by the tribunal and the decision under review, but that association is to be found in the restriction of the grant of power in s 43(1) to the purpose of the tribunal's review. The test is one of relevance rather than dependence. Where the exercise of a power or discretion is relevant to the making of the decision under review then, if requested, the tribunal may exercise the discretion. . . . Where its jurisdiction is enlivened by an application to review an administrative decision it exists to do again, within the limits of the review, that which the decision-maker was entrusted to do.*

29. In my opinion, there clearly is an association between the power which could have been exercised under s 28BA(3) of the CA Act and the decision under review to cancel Avtex's AOC. In fact, until the intervention of the Canley Vale Road accident on 15 June 2010, CASA was proceeding towards a possible cancellation of Avtex's AOC under that section of the CA Act. I am of the view that in exercising all the powers and discretions conferred upon the original decision-maker for the purposes of reviewing the cancellation decision, as an alternative to finding a serious and imminent risk to air safety, I should also examine whether conditions of Avtex's AOC were breached and whether those breaches, if found, should result in a cancellation decision.
30. Unless I have misunderstood the submissions made by Mr Langmead, he did not appear to dispute this alternative proposition made by CASA. In fact, Mr Langmead submitted that Avtex's AOC should be

reinstated because it satisfied the criteria set out in s 28 of the CA Act for the issue of an AOC and it has done so for a long time. The criterion set out in s 28(1)(a) is that CASA be satisfied that an applicant has complied with, or is capable of complying with, the provisions of the CA Act, the Regulations and CAOs that relate to safety.

31. Mr Harvey submitted that the statutory conditions which may have been breached include those set out in s 28BD, s 28BE, s 28BF, s 28BH, s 28BI and, importantly, s 28BAA which in effect requires CASA to remain satisfied of the matters set out in s 28(1)(a) and (b).

32. Mr Harvey conceded that the expression *serious and imminent risk* was not settled in its application to matters such as this before me. He referred to the analysis of that expression by Madgwick J in *Civil Aviation Safety Authority v Graeme Boatman* [2006] FCA 460 . While his Honour said the expression was difficult to comprehend fully in relation to all possible circumstances in which it might fall for consideration, he nevertheless agreed it was a composite phrase and that it was not appropriate to see *serious* as only referring to the risk of harm occurring. He said, in the context in which it appears in the CA Act, *serious* means something like *really significant*. He also agreed that the level of risk is a product of a number of factors including the probability or likelihood of its occurring, the degree of exposure and the potential consequences. Nevertheless, he suggested *that in most cases attention would focus on the degree of likelihood that a risk to air safety would eventuate [45]*. While his Honour agreed that flying involves inevitable risks which do not fall within the purview of the expression *serious and imminent risk*, in his opinion, as far as the matter before him was concerned, the test was:

> *[55]. . . given appropriate meaning by asking: was there a really significant prospect that such risks of serious considerable harm as actually existed, in relation to the conduct complained of, would materialise?*

33. In his opening address, Mr Langmead submitted that the principles stated by Dixon J in *Briginshaw v Briginshaw* [1938] HCA 34; (1938) 60 CLR 336 should guide my consideration of the evidence. Dixon J said, at 362:

> *But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences.*

34. His Honour explained that where the law required the proof of any fact, the Tribunal must feel an actual persuasion of its occurrence or existence before it can be found. It could not be found as a result of mere mechanical comparison of probabilities independently of any belief in its reality. However, Mansfield J said this in *Boatman*, at [62], when *Briginshaw's* case was referred to him by Mr Langmead:

> *As to the ease with which the Court should be satisfied of matters adverse to them, the respondents submitted that, given the seriousness of the consequences for their reputation and livelihood of adverse findings, the evidentiary principles in Briginshaw at 361-3 are applicable. I disagree. The proceedings are primarily protective of the public, notwithstanding that fairness to impugned authorisation holders is an important part of the process. Further, any adverse finding that the Court might make is provisional only: it would merely assert that there are reasonable grounds for believing that some conduct had been in contravention of the statutory requirement. It would be inconsistent with the statutory commands to the Court to consider 'reasonable grounds to believe' and to give safety the primary emphasis to require that the Court only act on proofs which are not 'inexact',*

testimony which is not 'indefinite' and inferences which are not 'indirect' (see Briginshaw at 362).

35. Of course I appreciate that Mansfield J was referring to the provisions in s 30DE(2) of the CA Act, where the Federal Court is required to be satisfied that there are reasonable grounds to believe the holder is engaging, or is likely to engage in, conduct that constitutes, contributes or results in serious or imminent risk to air safety. The basis upon which I am required to make my decision is whether I am satisfied that a serious and imminent risk to air safety would exist. Although that is a different consideration, it nevertheless primarily involves the protection of the public. It also appears to me that use of the expression *is satisfied* might mean something less than reasonable satisfaction, although I consider that I should find all material facts on the balance of probabilities when exercising the discretion of the original decision-maker in accordance with the CA Act, the CARs, the CASRs and the CAOs.

RISKS TO AIR SAFETY

36. Mr Siewert testified that Avtex was established in 1986 and has now been operating for some 25 years. He said that Avtex had held an AOC continuously since 1986 until its cancellation in August 2010. Mr Langmead submitted that prior to the imposition of the conditions placed on Avtex's AOC in 2008 following the fatal accident involving a Metro III, no adverse administrative action had been taken against Avtex. It had been audited by CASA regularly throughout that period. It operated more than 20 types of aircraft including a Lear Jet. At the time of ceasing its operations in February 2010, Avtex was operating both nationally and internationally.
37. However, as was deposed to by Mr Roger Weeks, the manager of CASA's Flying Standards Branch based at Bankstown Airport, Avtex came to the attention of CASA in an adverse way in 2006. CASA had received a number of anonymous industry complaints regarding the poor maintenance practices of the maintenance organisation which is a part of Avtex and which holds a COA under CAR 30. In November 2006 CASA issued a maintenance direction to Avtex under CAR 38, directing that it cease conducting engine overhauls. The maintenance direction was required because CASA investigations revealed that Avtex had employed an inappropriately trained engineer. The direction was lifted after Avtex employed a suitably qualified engineer.
38. Up until this time, both the AOC and COA holders were on a three year routine or scheduled audit cycle. However, following that incident, the company was placed under additional risk based surveillance. This was because of the number of incidents and industry intelligence as well as the complaints made to the ICC.
39. In July 2007, CASA issued a further direction under CAR 38 and a direction under CAR 53 requiring the production of maintenance documents and to allow CASA to inspect engines. This action resulted from an anonymous complaint relating to engine failures then experienced by Avtex. CASA discovered that one engine failure was attributed to an incorrectly installed counterweight during maintenance carried out by Avtex personnel. Mr Weeks convened a meeting which was attended by Mr Stephen Donoghue, who was then the General Manager of Avtex, as well as a CASA airworthiness team leader, Mr Paul Simpson, from the Sydney region. As a result of that meeting, Avtex grounded and inspected all affected aircraft. Although Mr Langmead objected to this evidence going in on the basis that it was not relevant to the AOC holder, but rather only reflected on the maintenance organisation or the COA holder, I indicated at the time that there was an overlap between the maintenance of aircraft operated by Avtex and its AOC because Mr Newberry was the HAAMC of both parts of Avtex. In my opinion, where the AOC holder is also at the same time a COA holder under CAR 30, and there is a common HAAMC, it is simply not possible to distinguish the activities because the AOC holder is required to ensure that the aircraft used under its AOC are satisfactorily maintained. Furthermore, although Mr Harvey agreed that CASA took no action against the COA held by Avtex at that stage, he indicated that investigations into the maintenance aspects of Avtex were continuing by CASA.
40. In October 2007 CASA refused to issue an exemption to Avtex from duty time requirements by issuing a FRMS. According to a memorandum prepared by Mr Weeks on 11 April 2008, Avtex had not responded to an audit observation issued in December 2006 to completely update its FRMS. This remained outstanding at the time of CASA's refusal to re-issue the FRMS exemption. Instead, Mr

Weeks issued a standard industry exemption against CAO 48 in lieu of the FRMS.

41. Using the investigation powers contained in Part IIIA of the CA Act, CASA also conducted an investigation into the conduct of a contract pilot used by Avtex, Mr Robert Couch. This investigation occurred after it was reported that Mr Couch, as the pilot in command of a Piper Mojave PA-31P operated by Avtex with seven passengers onboard, taxied the aircraft onto an active runway and then backtracked for departure while another aircraft was on final approach for landing. The approaching aircraft aborted its landing. However the CASA investigators were unable to find sufficient evidence to support an offence and no further action was taken.
42. On the same flight referred to in the preceding paragraph, allegations were made by passengers onboard that flight that Mr Couch was intoxicated when reporting for duty one morning. They refused to fly with Mr Couch on that day because they claimed he looked *scruffy* and *worse for wear*. They observed him drinking in the hotel on the prior evening. Although the local police attempted to breathalyse Mr Couch, they were unable to do so because they were without power. Avtex flew another pilot and aeroplane to Bourke to transport the passengers. Because it was not possible to determine whether Mr Couch had breached the regulations, no formal investigation report issued.
43. Avtex also had a number of incidents involving its aircraft in November 2006, July 2007 and between January and March 2008. Two of those incidents involved landing gear problems and three involved aircraft engines, including an engine failure in flight. Three of those incidents were caused by pilots not following correct procedures for the operation of their respective aircraft. No incidents were attributed to maintenance conducted by Avtex under its COA. It is noteworthy that on one occasion, where the pilot experienced a rough running engine during a pre-flight engine run up, the engine was repaired by a LAME but the maintenance release was not signed off. This is contrary to a number of the CARs and is a dangerous practice.
44. On 11 April 2008 Mr Weeks prepared a memorandum for Mr Bruce Byron, the then CEO of CASA, setting out the background of CASA's dealings with Avtex over the previous couple of years. Mr Weeks concluded with the following statement:

> *A discernable improvement in management safety attitude and proactive engagement with CASA has been observed over the last 18-24 months. The new management team appear to be making genuine improvements in the operation of the organisation. The communication between the operator and CASA is sound.*

45. On 9 April 2008 a Metro III aircraft operated by Avtex crashed into Botany Bay shortly after takeoff killing the pilot. The ATSB has not completed its investigation into that accident and its cause remains unknown. The pilot who died in that accident, Mr John Hamilton, was an experienced pilot with approximately 4,500 hours flying time recorded. He had approximately 500 hours on the Metro III aircraft. He was also the chief pilot of Skymaster at that time.
46. Following the Metro III accident, CASA received anonymous reports through the ICC indicating there were serious deficiencies in the training of Avtex pilots, including Mr Hamilton. As a result of those reports, CASA instituted a special risk based audit of Avtex. This was conducted between 11 and 24 June 2008. According to Mr Weeks' statement dated 2 September 2010, the audit revealed a large number of safety deficiencies in the systems and work practices within Avtex. He identified the most serious systemic deficiencies as:
    - (a) inadequate endorsement training by the then chief pilot, Mr Steven Myles, including his failure to conduct any or adequate asymmetric training in the course of many Piper Chieftain aircraft endorsements and conducting pressurisation endorsements without taking the aircraft to flight levels which would be sufficient to ensure adequate exposure to emergency procedures following depressurisation;
    - (b) inadequate training and checking of pilots engaged in Metro III operations;
    - (c) permitting a pilot to fly a Metro III aircraft as pilot in command without sufficient experience as pilot in command under supervision;
    - (d) inadequate emergency procedures proficiency training and assessment of flight crew; and
    - (e) overweight operations in Metro III aircraft.
47. As a result of the audit, CASA issued two SAs and a number of RCAs. As Mr Weeks explained in his oral evidence, a SA is a request for corrective action which must be addressed immediately. A RCA is

the next tier down from a SA and, as is explained in the instructions attached to the aviation safety audit report, RCAs refer to deficiencies involving non-compliance with legislation that must be addressed. Ordinarily, the operator is given some time to comply and must record the remedial and corrective action taken in respect of the RCA by the due date set out on that document. If the operator or recipient of a RCA is unable to carry out the corrective action by the due date, it is required to indicate the date by which the corrective action will be completed. There is also a third tier document referred to as an audit observation. That document is used to draw attention to latent conditions or minor deficiencies in a system which cannot be attributed to breaches of current legislative requirements. Its purpose is to raise awareness with a view to avoiding problems in the future. It is also important to bear in mind the fact that CASA may issue a number of RCAs in relation to a single incident which gave rise to CASA's concerns. Therefore the number of RCAs issued is not necessarily indicative of the number of problems observed by CASA.

48. The two SAs which CASA issued related to the endorsement training conducted by Mr Myles and the requirement for pilots in command on Metro III aircraft to have the required 50 hours flight time ICUS.

49. Mr Weeks testified that the issue of a SA is a relatively rare event. He said that to have two SAs issued in a single audit was particularly significant. As a result of the audit, Mr Weeks formed the view that CASA should take serious and imminent risk action against Avtex. That is, action pursuant to s 30DC of the CA Act. However, CASA abandoned the idea of taking serious and imminent risk action because, according to Mr Weeks, it had seen some improvement in the company in terms of management structure and the deficiencies identified related essentially to the chief pilot. CASA felt that there was an opportunity to give Avtex a second chance. CASA had discussions with Mr Siewert and Mr Donoghue expressing its serious concerns about the safety of Avtex's operations. Mr Weeks said he discussed the possibility of attaching conditions to Avtex's AOC in order to alleviate CASA's concerns regarding safety. As a consequence of that meeting, Mr Siewert applied to have those conditions attached to Avtex's AOC. The conditions were as follows:

    1. *No passengers carrying charter or aerial work operations are to be conducted whilst Steve Myles is the chief pilot. Such operations are only permitted to resume upon CASA approval of a new chief pilot;*
    2. *The company must develop multi-crew procedures for and crew Metro aircraft with two qualified pilots when carrying passengers. These procedures to be in place prior to such operations;*
    3. *Implements, by 25 July 2008, a confidential reporting system to provide the Chief Executive Officer (CEO) with information relating to poor operational standards or hazards and risks within the companies operations;*
    4. *Develops a comprehensive, company wide, safety management system, which is fully supported by the CEO, to be implemented by 30 September 2008;*
    5. *Duplicates, via a secure back-up process, all computerised company records and keeps these back-ups in a secure place, such a system to be in place by 31 July 2008;*
    6. *Implements a system of printing pilot flight and duty time records to ensure a permanent record is kept, such process to be in place by 18 July 2008;*
    7. *Employ an appropriately qualified, independent auditor acceptable to CASA. The auditor must conduct comprehensive quality and aviation safety systems audits on a six monthly schedule, commencing no later than 31 August 2008. The company is to provide CASA with a copy of each audit report within three weeks of completion of the audit; and*
    8. *Reviews and where required, amend the company operations manual with such amendments submitted to CASA for acceptance by 30 September 2008.*

50. Shortly thereafter CASA issued a show cause notice to Mr Myles, stating it proposed to suspend or cancel his approval as chief pilot and check pilot of Avtex. CASA also notified Mr Myles of its proposal to cancel, suspend or vary his instructor rating and to revoke the Instrument of Delegation which was issued to him in respect of the endorsement and conversion training of pilots. After considering a response from Mr Myles, CASA cancelled Mr Myles' chief pilot approval, suspended his instructor rating and revoked the Instrument of Delegation.

51. Following the meeting with CASA in July 2008 regarding the conditions to be placed on Avtex's AOC, Avtex accepted the conditions and nominated Mr Donoghue to be the chief pilot of Avtex. While Mr Peter Telling had been approved as HOTC in May 2004, after Mr Myles became the chief pilot of

Avtex, he indicated that although he was HOTC, he said *I haven't done much lately.* Mr Telling was under the impression that Mr Myles had assumed responsibility for the role although it had not been formalised. Also, in a letter dated 8 July 2008, Mr Siewert wrote to Mr Malcolm Campbell of CASA stating that Avtex continued to view Mr Myles as an excellent chief pilot *even though there has been some alleged inconsistency in his training methods* ... . Mr Siewert said that there was a shortage of experienced pilots to meet the requirements of chief pilot and Avtex wished to continue to employ Mr Myles as chief pilot. Also, on 29 August 2008, Mr Couch was approved as HOTC for Avtex.

52. Mr Donoghue's oral evidence was that he accepted the Avtex chief pilot position on the basis that it operated solely the turbine powered aircraft. He was not prepared to act as chief pilot if Avtex continued to operate piston engine aircraft as well as the turbine engine aircraft. According to Mr Weeks, that resulted in a business decision to transfer the piston engine aircraft operations to Skymaster under its AOC. Of course Mr Hamilton had been the chief pilot of Skymaster and, following his death, Skymaster could not operate under its AOC without a chief pilot. Mr Peter Hanley was duly appointed as its chief pilot.
53. On 23 October 2008, CASA received an application from Avtex to have condition number two (referred to above) removed from its AOC. CASA rejected that application. Mr Weeks expressed surprise that Avtex, some two months after CASA almost cancelled its AOC, sought to have conditions which it agreed should be imposed on its AOC, altered or removed. Mr Weeks agreed that Avtex had met the timelines for implementation where they are set out in the conditions, but he noted that this was in its infancy and the conditions needed to remain to ensure that there was never a repeat of the situation which led to the conditions being imposed.
54. Between the time of the Metro III accident on 9 April 2008 and the Canley Vale Road accident on 15 June 2010, there were a number of significant events which need to be briefly stated.
55. To enable Avtex to continue operations under its AOC, CASA attached eight conditions. One of those conditions required Avtex to engage an independent auditor to conduct quality and aviation safety systems audits on a six monthly schedule. Avtex engaged the services of ACS to satisfy that condition. The first audit by ACS took place between 29 August 2008 and 1 September 2008. Following that audit, ACS provided a very brief, five page audit report. The report is undated.
56. The persons present or contacted during the audit included Mr Siewert, Mr Donoghue, Mr Myles and Mr Couch. The assessment objective was said to be to establish whether Avtex had an organisational structure to satisfy the safe and secure operations defined in lines of authority and responsibility throughout its organisation. The assessor was said to be Mr Ken Lewis. Mr Lewis was not called to give evidence at the hearing of this matter. The significant findings and recommendations were:
    - (a) the company had produced a new operating manual which was yet to be approved by CASA;
    - (b) a single copy of a safety policy signed by the CEO was found hanging on an obscure wall;
    - (c) although some job descriptions were in the proposed operating manual, ACS suggested those should be in a discrete chapter; furthermore, Mr Lewis could not find a job description for the CEO;
    - (d) communications to aircrew and staff did not appear to be robust as operational requirements were readily accessible and they were taped to computer modules in the pilot's crew room;
    - (e) Mr Lewis recommended that a formal management review committee be formed and that it meet not less than once every 12 months with records of the meeting to be kept and held on file;
    - (f) Avtex needed to put into place a document control system covering all of its manuals including engineering and maintenance and a separate manual needed to be produced which enlarged on the existing material in the proposed company operations manual;
    - (g) although a chapter dealing with risk management existed in the proposed company operations manual, Mr Lewis did not consider it to be satisfactory and management staff needed to receive training in risk analysis;
    - (h) Mr Lewis recommended that a formal quality assurance audit program be introduced with selected company personnel receiving auditor training from an approved organisation;
    - (i) Avtex should appoint a flight safety officer with the proposed operations manual outlining the duties and responsibilities of that position; and
    - (j) Mr Lewis recommended that Avtex put in place a confidential incident reporting system.
57. ACS completed a second audit between 26-27 March 2009. It produced another brief report, six pages in length. Avtex personnel who were contacted in the course of the assessment included Mr Donoghue,

Mr Couch, Mr Newberry and Mr Steve Morgan, who was the spare parts manager. Unlike a number of statements to the contrary, according to ACS, by examining the documentation, they found Mr Siewert played an active role in the company including chairing the company safety committee. Once again, the report is very sparse on detail. There are six observations noted in the report and they are:

- (a) Avtex has a management system which was adequate for its operation;
- (b) Avtex satisfied the CASA AOC requirements;
- (c) Avtex had the necessary resources to conduct safe operations;
- (d) Avtex had appropriately licensed air crew;
- (e) Avtex had appropriately licensed maintenance engineers;
- (f) Avtex had some documentation which did not comply with industry best practice; and
- (g) Avtex needed to review its quality control process.

58. The report then detailed six recommendations arising out of the audit. Those recommendations involved:
    - (a) the storage of gas cylinder storage trolleys;
    - (b) relocating oxygen cylinders;
    - (c) a more robust revision process should be enforced for the distribution and confirmation of the procedures manual revisions (it is unclear what is meant by this);
    - (d) the stores area should be cleaned out;
    - (e) Avtex should develop its own comprehensive internal audit checklist for operations and maintenance; and
    - (f) Avtex should create a stencil to enable expired life jackets to be marked with the caution *DEMONSTRATION USE ONLY.*
59. On 15 and 16 September 2009 ACS conducted a third audit. The auditors' report recorded that they interviewed Mr Siewert, Mr Donoghue, Mr Couch and Mr Newberry.
60. The audit purported to address the concerns referred to in the conditions attached to Avtex's AOC regarding quality and aviation safety systems audits. However, many of the matters are not addressed in detail in the report and it makes reference to issues in a superficial manner. Also, it focused on documents rather than assessing whether or not there was any positive implementation of procedures which might ensure quality and aviation systems were in fact activated. Nevertheless, the ACS report concluded that Avtex was complying with Australian legislation and the conditions of its AOC. This is despite the fact that there were no personnel within Avtex at that time who had received any training in SMS. Also, despite its previous recommendation that a safety officer be appointed, that also had not been implemented. Regardless, the auditors concluded that in their view, progress had been made in developing the SMS. Again, no details were given.
61. CASA officers conducted another risk based audit of Avtex between 10 and 16 February 2010. The leader of the audit team was Mr Gregory Worthington, a FOI with CASA. He was accompanied by two flying operations inspectors, three senior airworthiness inspectors and two air transport inspectors. The audit scope was stated to be:
    - Operational standards;
    - Aircraft load control;
    - Crew schedule;
    - Airworthiness control;
    - AOC operations;
    - Operational support systems; and
    - AOC conditions compliance.
62. The audit report indicated that its purpose was to determine whether the systems Avtex had put in place would enable CASA to remove the conditions on its AOC. Although Avtex had told CASA previously that its operations would involve only the utilisation of the turbine powered aircraft (SA226 and SA227 aircraft) and the audit focussed primarily on those aircraft and their use, it became apparent during the audit that the company continued to use the Piper PA-31 piston engine aircraft in its operations. The auditors also noted that the majority of scheduled and unscheduled maintenance on the turbine powered aircraft was carried out by ANA and that Avtex, under its COA, only occasionally certified for completion of minor maintenance work.
63. Of considerable concern was a finding by the auditors that many of the issues raised in the June 2008 risk based audit remained. They included:

- (a) Metro endorsements not conducted in accordance with CAO 40.1.0;
- (b) type endorsement ground school training completed in one day, in contradiction to the operations manual;
- (c) CAO 20.11 checks conducted without removing emergency exits;
- (d) proficiency checks not conducted in accordance with CAR 217;
- (e) aircraft exceeding structural and performance limitation; and
- (f) the carrying of passengers during training flights.

64. A number of the CASA findings in the course of this audit were disputed by Avtex. I deal in detail with those issues below. In addition to a number of RCAs being issued, a SA was also issued in respect of Mr Couch, who was then HOTC. CASA found that Mr Couch had not completed a proficiency check as required by CAR 217(2) and that his last proficiency check was on 24 July 2008 by Mr Myles. According to CASA, that invalidated any check and training duty undertaken by Mr Couch after 24 March 2009. This audit resulted in Avtex ceasing its flying operations and that position has remained as at the date of the hearing of this matter.
65. RCA number 322118 indicated that Avtex acknowledged the invalidity of proficiency checks undertaken by Mr Couch from 24 March 2009 and it provided CASA with a list of all flight crew affected. It arranged for Mr Couch to undergo a proficiency check under the supervision of Mr Worthington on 15 February 2010. However, this proficiency check was terminated by Mr Telling, who was to be the second pilot, because Mr Couch could not provide answers to questions or scenarios put to him to ensure his knowledge was adequate to establish competency. Mr Telling assessed the proficiency check as a fail. He reported that the effort by Mr Couch was well below the standard for a HOTC position. The audit report also noted that Mr Couch arrived about one and a half hours late for this check flight and that he appeared to be suffering from the effects of alcohol. He was described as having *an aroma of alcohol about him*. This, it was said, was noted by FOIs Worthington and Kane Du Bois. CASA's concerns about Mr Couch's condition on that day were relayed to Mr Donoghue, who was then the DAMP supervisor. It was Avtex's responsibility to then conduct alcohol and drug testing in accordance with CASR 99.050. There is no evidence this was undertaken.
66. Also of serious concern to CASA was the implementation of a comprehensive, company-wide SMS. Although the requirement to implement a SMS arose out of the June 2008 audit, CASA noted that a SMS manager was only appointed in November 2009. Furthermore, the SMS manager, Mr Morgan, had not had any formal training nor had any of the senior management of Avtex, including the chief pilot and the HAAMC.
67. In addition to the SA, some 24 RCAs were issued. The airworthiness branch also issued four ASRs. Five RCAs were issued regarding the airworthiness of aircraft used in the AOC operation. According to the auditors, the airworthiness component of the AOC audit identified a disturbing culture and revealed that pilots were not adequately discharging their regulatory responsibilities. In particular, the auditors identified a culture of pilots not always recording defects and there appeared to be a willingness to operate the aircraft past the due date for required inspections. The audit report stated that Avtex had a poor and disorganised approach to the management and control of airworthiness matters which was demonstrated by a system of poor record control. The audit report stated that a particular concern was that Avtex failed to satisfactorily monitor, and ensure compliance with, conditions and requirements associated with the piston engine TBO extension program which was approved by CASA on 7 January 2002. The auditors particularly referred to s 28BD and s 28BE of the CA Act which deal with compliance with civil aviation law and a duty to exercise care and diligence.
68. The findings of the audit team in respect of airworthiness were that Avtex's management failed to ensure that it had adequate personnel and systems in place to effectively discharge its responsibilities for airworthiness control.
69. On 28 May 2010, prior to the Canley Vale Road accident, CASA served on Avtex the first *show cause notice* referred to above. That *show cause notice* listed 28 RCAs and 1 SA. It also referred to the audit conducted by ACS on 15 and 16 September 2009. The *show cause notice* concluded that:
    - (a) Avtex had not complied with the Regulations and the CAOs applicable to it on numerous occasions and had breached the conditions specified in s 28BD of the CA Act which deals with compliance with civil aviation law;
    - (b) Avtex's directors had not taken all reasonable steps to ensure that every activity covered by its AOC had been done with a reasonable degree of care and diligence and therefore breached

s 28BE of the CA Act;
- (c) because of the numerous regulatory breaches referred to in the notice, it appeared Avtex failed to maintain an appropriate organisation with a sound and effective management structure to ensure the safe and lawful conduct of its AOC activities and thereby breached s 28BF(1) of the CA Act; and
- (d) Avtex had not properly maintained a reference library and it therefore breached s 28DH of the CA Act.

70. On 15 June 2010 a PA-31P aircraft operated by Skymaster crashed while attempting to make an emergency landing on Canley Vale Road near Bankstown Airport. The pilot had reported an in-flight engine shut down and was attempting to return to Bankstown Airport. The cause of this crash remains unknown as the ATSB has not yet concluded its investigation. It has released a preliminary report into the accident. Following this accident, CASA conducted a special audit of the Skymaster operations between 22 and 29 June 2010.
71. Mr Langmead submitted that any operating problems experienced by Skymaster while operating aircraft under its AOC could not and should not be taken into account in the decision to cancel Avtex's AOC. He referred to the evidence given by Mr Roger Chambers, a CASA officer who is the acting manager of the Sydney Region General Aviation Office. Mr Chambers said that if Skymaster's AOC was cancelled, Avtex's AOC would also have to be cancelled because it would simply take over the operations previously carried out by Skymaster. In fact, Mr Langmead submitted that although the cause of the Metro III accident in 2008 and the Canley Vale Road accident in 2010 were not known, they were the key reasons why CASA took administrative action against Avtex's AOC which resulted in its cancellation. Mr Langmead submitted that while that may be convenient for CASA's purposes, the merging of the distinct operations is illogical and without foundation.
72. However, given the significant overlap of key personnel in both Skymaster and Avtex's operations, it is my opinion that Mr Langmead's submission overstates the position. While it may be possible to distinguish some aspects of the operations of each entity by reason of decisions taken by the chief pilot of either company, it is nevertheless significant and relevant to examine the influence exerted by those persons whose activities are common to both companies. Those personnel were identified by Mr Harvey and I have referred to them above.
73. A team of CASA specialists, including flying operation inspectors, airworthiness inspectors and specialists from the disciplines of safety management systems, alcohol and other drugs, and fatigue risk management systems, conducted a special audit of Skymaster activities between 22 and 29 June 2010. According to Mr Chambers, who initiated the audit, it revealed a large number of safety deficiencies in the systems and work practices in place within the Skymaster AOC organisation. The audit resulted in three SAs being issued by CASA. A number of RCAs were also issued. CASA issued an audit report on 12 July 2010 together with separate audit reports of the DAMP and the SMS. Mr Chambers identified two systemic deficiencies which he regarded as most serious. They were:
    - (a) insufficient resources to support the chief pilot leading to poor safety outcomes particularly in the area of pilot training and monitoring flying standards; and
    - (b) insufficient resources to support the position of HAAMC as Mr Newberry had multiple responsibilities across both Skymaster and Avtex AOCs and the Avtex maintenance organisation.
74. Mr Chambers then summarised those matters which fell within the description of poor safety culture and recent service difficulties. These issues are dealt with in more detail below, including Avtex's response to the allegations levelled against it by CASA.

SIGNIFICANT ISSUES UPON WHICH THE AOC CANCELLATION DECISION WAS MADE

75. In the course of hearing this matter, numerous issues were raised which caused CASA concerns about the safety of the Avtex and Skymaster operations. I do not propose to examine in detail every matter identified by CASA during its audits of both organisations between 2008 and 2010. However, there are a number of crucial issues which go to the heart of the safety of operations under Avtex's AOC and which were vigorously contested by Avtex. My findings in relation to these matters are central to the outcome in this case.

DEFECTIVE ENDORSEMENT TRAINING

76. Mr Myles was appointed chief pilot of Avtex on 21 November 2005. On 26 July 2007 he was approved by CASA as a check pilot. Mr Myles also held a Grade 3 (aeroplane) Flight Instructor rating. On 26 July 2007 CASA made an Instrument (No 252/07) under CAR 7(1), delegating a number of CASA's powers to Mr Myles and also providing to him certain approvals. This Instrument of Delegation and Approval is highly significant and its operation controversial. I have set out in full the relevant parts of that Instrument.

> ***Delegation and approval – Steven Norman Myles***
> ***1 Delegation***
> *I delegate to*
> ***Steven Norman Myles,*** *Aviation Reference Number (**ARN**) 165144*
> *CASA's powers and functions:*
> *(a) under subregulation 5.14 (2) of CAR 1988; and*
> *(b) under subregulation 5.19 (3) of CAR 1988 to conduct flight tests applicable to the renewal of command (multi-engine aeroplane) instrument ratings on condition that the delegate holds:*
> *(i) a current command (multi-engine aeroplane) instrument rating; and*
> *(ii) an aircraft endorsement for the aircraft in which the flight test is to be conducted; and*
> *(c) under subregulation 5.23 (2) of CAR 1988;*
> *In relation to applicants who:*
> *(d) are employed by or working under an arrangement with **Avtex Air Services Pty Ltd, trading as Airtex Aviation,** ARN 408867; and*
> *(e) require the rating or endorsement for their employment or working arrangement.*
>
> ***2. Approval***
> *(1) For subregulation 5.20 (1) of CAR 1988, I approve the delegate to give flying training for the issue of command (multi-engine aeroplane) instrument ratings on condition that the delegate holds:*
> *(a) a current command (multi-engine aeroplane) instrument rating; and*
> *(b) an aircraft endorsement for the aircraft in which the flying training is to be conducted.*
> *(2) For subregulation 5.21 (1) of CAR 1988, I approve the delegate to give aeroplane conversion training on Metro 3/23 type aircraft to commercial (aeroplane) pilots and air transport (aeroplane) pilots:*
> *(a) who are employed by, or are working under an arrangement with, Avtex Air Services Pty Ltd, trading as Airtex Aviation; and*
> *(b) on condition that the delegate holds an aircraft endorsement for the aircraft in which the training is to be conducted.*
> ***3 Current rating***
> *For this instrument, a rating is a current rating if:*
> *(a) under the Civil Aviation Orders, the rating is current; and*
> *(b) the rating was issued, or was last renewed, on the basis of a flight test conducted:*
> *(i) by a CASA flying operations inspector; or*
> *(ii) by a person approved by a CASA Team Leader Flying Operations to conduct the flight test.*
> ***4 Conditions***
> *The delegate may conduct a flight test relating to use of a navigation aid or procedure with a grade of instrument rating only if:*
> *(a) the delegate currently meets the requirements for use of that navigation aid or procedure; and*

(b) the requirements were satisfied on the basis of a flight test conducted:
(i) by a CASA flying operations inspector; or
(ii) by a person approved by a CASA Team Leader Flying Operations to conduct the flight test.
5 Expiry
This instrument stops having effect at the earlier of:
(a) the delegate ceasing to be employed as chief pilot by Avtex Air Services Pty Ltd, trading as Airtex Aviation; or
(b) the end of June 2010.

77. In order to understand the extent of the delegation and approval, it is necessary to set out the relevant CARs referred to in the Instrument. CAR 5.14(2) provides:

> *(2) Subject to subregulation (3), CASA must issue a flight crew rating, or grade of flight crew rating, to a qualified person, or renew the person's rating, or grade of rating, by entering the rating, or grade of rating, in the person's personal log book only if:*
> *(a) the person has passed the necessary flight tests; and*
> *(b) the person satisfies the other requirements; and*
> *(c) any other condition to be met by, or in relation to, the person has been met;*

78. The flight crew ratings and grades of flight crew rating are referred to in CAR 5.13.
79. CAR 5.19(3) deals with the flight tests relating to flight crew ratings and grades of flight crew ratings. It provides:

> *(3) CASA may conduct the flight tests in relation to a flight crew rating, or grade of flight crew rating, that are required by the Civil Aviation Orders.*

CAO 40 covers pilot licences and ratings.

80. CAR 5.23(2) deals with aircraft endorsements. It provides:

> *(2) Subject to subregulation (3), CASA must issue an aircraft endorsement to the holder of a flight crew licence, a special pilot licence or a certificate of validation by entering the endorsement in the holder's personal log book if, and only if, the holder satisfies the requirements for the issue of the endorsement.*

81. CAR 5.20(1) provides:

> *(1) CASA may approve a person who holds a pilot licence to give flying training for the issue of a flight crew rating, or a grade of flight crew rating.*

CAR 5.20(2) provides that CASA may give an approval to give training subject to any condition that is necessary in the interests of the safety of air navigation. The Instrument issued to Mr Myles at cl 2(1) sets out those conditions.

82. CAR 5.21(1) provides:

> *(1) CASA may approve:*
> *(a) a person who holds an aeroplane pilot licence to give aeroplane conversion training; or*
> *(b) a person who holds a helicopter pilot licence to give helicopter conversion*

training.

83. Mr Myles first came to the attention of CASA following the Metro III fatal accident on 9 April 2008. The ICC received an anonymous letter regarding poor standards of check and training practices at Avtex. The author of the letter stated that Mr Myles completed Metro III endorsements for Mr Hamilton, Mr John Saad, Mr Sandor Antal, Mr Scott Coakley and possibly others. According to the author, none of those pilots received formal ground school training. Mr Myles' Instrument of Delegation and Approval authorised him to give conversion training on Metro III type aircraft to pilots who were employed by, or were working under an arrangement with Avtex.
84. Following CASA's audit conducted in June 2008, it found that Mr Saad and Mr Antal stated they did not receive the ground school training. CASA noted that Avtex's Operations Manual Part C, which deals with flying training conducted under CAR 217, did not indicate the way in which the ground school training was to be delivered. CASA raised a RCA in respect of this. CASA also noted that written exams completed by pilots undergoing conversion training were not completely corrected. This aspect was also the subject of a RCA by CASA.
85. A more significant aspect of the training conducted by Mr Myles was in respect of the PA-31 aircraft. At that time, Avtex was operating the piston engine fleet of aircraft as well as the turbine engine aircraft. The first problem recognised by CASA was the fact that Mr Myles was not providing adequate endorsement training for flight in pressurised aircraft. The duration of the flights examined were clearly not sufficient for the aircraft to have climbed to above 10,000 feet and to have conducted a depressurisation followed by an emergency descent. CASA noted that after discussions with Mr Myles, Mr Donoghue and Mr Siewert, Mr Myles and Mr Siewert stated that all pilots not properly endorsed for pressurised aircraft would be re-endorsed as soon as possible.
86. Of more concern to CASA was that it discovered most pilots who had completed a Piper Chieftain endorsement did not conduct any asymmetric training. When questioned about this, Mr Myles emphatically denied conducting endorsements without asymmetric training. CASA contacted 26 pilots endorsed by Mr Myles and asked them a number of questions regarding asymmetric training in the course of endorsement. Eleven of those pilots said they had not received that training. One pilot said he was unsure and four pilots said they had only carried out one engine failure drill. Ten of those pilots said they had conducted one or two drills. CASA also recorded that most of the pilots who said they conducted one or two drills were not definite in their answers. This was discussed with Mr Myles, Mr Donoghue and Mr Siewert.
87. Subsequently, Mr Myles did not deny that many pilots had not received asymmetric training in the course of their endorsement. This resulted in CASA issuing a SA requiring Avtex to rectify the defective endorsements before continuing any further activities under its AOC. Mr Campbell, a team leader in the flying operations Sydney Region General Aviation Office, was present at meetings held following the June 2008 audit. Mr Campbell said in a written statement dated 22 September 2010 that although Mr Siewert did not accept that the PA-31 endorsements were conducted by Avtex, he nevertheless gave an undertaking to revalidate the training and that none of the affected pilots would be rostered until this had been completed. In fact, Mr Siewert provided Mr Campbell with a letter dated 8 July 2008 to that effect. In that letter, Mr Siewert said:

> *The training and type endorsement provided by Steve Myles was not provided under the Airtex AOC. As you will be aware, the Airtex CAR 217 Organisation Approval only extends to its Metro III aircraft. Airtex hired aircraft to Steve who was providing the endorsement training using his personal CASA authorisations. Because of this, the ASR in respect to the training and endorsement, provided to pilots not in Airtex employ, may not be applicable to Airtex.*

88. In his statement, Mr Campbell said he was not satisfied that those pilots who, when contacted, said that they had completed one or two simulated engine failures in the course of the endorsement, had in fact received an adequate endorsement. In his view, an adequate endorsement would involve the completion of a minimum of five correctly handled engine failures to demonstrate competency. Mr Campbell provided Mr Donoghue with a list of pilots and their contact telephone numbers. These were the pilots CASA was concerned had not received sufficient asymmetric training in the course of their

endorsement on multi engine piston aircraft by Mr Myles. This list was sent by email on 1 July 2008. On the following day, Mr Donoghue wrote to Mr Campbell confirming that the remedial action which was discussed on the previous day with Mr Weeks was to:

- (a) identify all pilots on the list currently flying for Avtex and who had not received asymmetric training and to cease flying immediately until independent asymmetric or remedial training could be undertaken; and
- (b) identify pilots who had been trained by Mr Myles and had yet to complete asymmetric training, as a matter of urgency, arrange further training by an independent instructor.

89. Mr Donoghue also pointed out in his letter that prior to Mr Myles' appointment as chief pilot, he (Mr Myles) conducted endorsement training independently using his instructor rating and twin training approval with the hire of Avtex's aircraft. Mr Donoghue said that the pilots were sourced independently by Mr Myles. He said that Mr Myles continued his practice of endorsing pilots after he became chief pilot because the company took the view that the better candidates would prove a good source of contract pilots for use by Avtex. Mr Donoghue also said:

> *During the previous afternoon Dieter Siewert previously contacted all pilots to establish the level of training and to make arrangements for retraining and/or stop flying. With the help of your list the following pilots have been stood down pending retraining. . . .*

90. In his letter of 8 July 2008, Mr Siewert said that Avtex's compliance with the SA was delayed because the alert addressed only generic issues without initially supplying specific details such as the names of pilots CASA believed were inadequately endorsed. With respect to Mr Siewert, this statement is difficult to reconcile with the fact that the RCA dealing with Mr Myles' endorsements was issued on 1 July 2008 and was responded to by Mr Donoghue on the following day. Mr Siewert also said that without access to Mr Myles' log book, Avtex had to delay action until CASA supplied Avtex with a list of pilots whose endorsements were in question. However, and there seems to be no dispute about this, the email with the attached list of pilots who were the concern of CASA's RCA was sent to Mr Donoghue on 1 July 2008.
91. In his letter of 8 July 2008 Mr Siewert also repeated the statement that Mr Myles provided the endorsement training using his personal CASA authorisations and that as far as the endorsements related to pilots who are not employed by Avtex, this was outside Avtex's control. Mr Siewert said Avtex did not accept legal responsibility for pilots not employed by Avtex but nevertheless, it was prepared to make available a retraining and rectification program to those pilots at no expense to them.
92. In his evidence-in-chief, Mr Siewert said it was his opinion that the RCA should not have been served on Avtex, but rather on Mr Myles, as he was exercising the privileges granted to him personally by CASA. Mr Siewert said that Mr Myles did endorsements on twin engine aircraft on weekends with the permission of Avtex. He said that Mr Myles would pay Avtex for the use of the aircraft. Mr Siewert denied that Mr Myles had ever endorsed a pilot on a PA-31 aircraft in the course of his employment with Avtex. Although Mr Siewert acknowledged that some of the pilots on the list provided by CASA were working for Skymaster at the time, he did not believe any worked for Avtex. However, subsequently Mr Siewert acknowledged that it may not have been as clear as he suggested because of the changeover to Skymaster taking over the piston engine operations of Avtex. Mr Siewert then suggested he could not distinguish between the two.
93. Mr Langmead submitted that Mr Myles conducted PA-31 endorsement training in his own time, using aircraft which he hired from Avtex or Wingaway, apparently relying on the authority of his instructor rating. Mr Langmead submitted that Mr Myles was entitled to do this.
94. With respect to Mr Langmead, I cannot accept this submission as being correct. However, Mr Langmead correctly submitted that the delegation and approval instrument, which was described by him as the CAR 217 delegation, did not authorise Mr Myles to conduct endorsement training for pilots outside Avtex. Clause 1 of the Instrument deals with delegation. The only possible relevant delegation is that contained in cl 1(c) which refers to CAR 5.23(2). While that delegation most certainly authorised Mr Myles to issue an aircraft endorsement to the holder of a flight crew licence, which was normally done by the attachment of what is described as a *sticky label* to the pilot's log book and providing the counterpart to CASA, the delegation only authorised the issue of endorsements where the

applicants were employed by or were working under an arrangement with Avtex and they required the endorsement for their employment or working arrangement.

95. Furthermore, the Instrument of Delegation and Approval is clearly intended to be read as a complete document. The delegations in clause 1 plainly relate to the approvals in clause 2. For example, the approval to conduct flying training for the issue or renewal of a CIR is linked to the delegation to issue or renew that rating if the pilot has passed the necessary flight tests and satisfies any other requirements for the issue of that rating. Likewise, the approval to give conversion training on the Metro 3/23 type aircraft is linked to the delegation to issue an aircraft endorsement to the holder of a flight crew licence if the holder satisfies the requirements for the issue of the endorsement for that aircraft. It should also be abundantly clear that all of the delegations and approvals in the Instrument are related to Mr Myles' approval to act as chief pilot of Avtex. The Instrument plainly did not give approval to Mr Myles to give conversion or endorsement training on the PA-31 aircraft and it must follow that it did not delegate CASA's power to issue an aircraft endorsement for that aircraft type.
96. It was common ground that when Mr Myles conducted the endorsement training on the 26 pilots in question, they were not employed by or working under an arrangement with Avtex. The endorsement or conversion training preceded their employment arrangements with Avtex. Therefore, as Mr Langmead submitted, the only possible legal means by which Mr Myles conducted endorsement training was as a result of him holding a Grade 3 Instructor rating. However, there are significant difficulties with this submission.
97. A Grade 3 Flying Instructor rating is the most restrictive instructor rating which can issue. As is clear from a reading of CAO 40.1.7, paragraph 9.1, a Grade 3 Flying Instructor may give flying training for the issue of an aircraft endorsement for a multi engine aeroplane provided he can satisfy the requirements in paragraph 9.7. However, as is stated in paragraph 9.1(a), this must be done under the direct supervision of the chief flying instructor or a Grade 1 Flight Instructor. The expression *direct supervision* is defined in paragraph 9.1.1 which provides:

> ***direct supervision*** *means guidance and supervision provided by an instructor who is on duty for that purpose and:*
> *(a) is on the premises of the flying school; or*
> *(b) is flying in a local flying training area or an associated circuit area used by the flying school and can be contacted by radio.*

98. It should be apparent that CAO 40.1.7 only permits a Grade 3 Flying Instructor to give endorsement training at a flying school under the direct supervision of the chief flying instructor or a Grade 1 Flight Instructor. Therefore, if Mr Myles in fact hired aircraft to conduct endorsement training, one might reasonably expect Mr Myles to have hired the aircraft belonging to a flying training school. Undoubtedly, there are many of these situated at Bankstown Aerodrome. Avtex does not conduct a flying training school. I have no doubt that Mr Siewert was aware, or should have been aware given his past experience as a commercial pilot, of the limitations attached to a Grade 3 Flying Instructor rating. If it was the case that none of the flying schools at Bankstown operated PA-31 aircraft, then it seems logical that Mr Myles would have arranged the hire of an Avtex aircraft by a flying training school for the purpose of allowing Mr Myles to conduct endorsement training. However, there was no evidence that occurred. If, as Mr Siewert said in his evidence-in-chief, Mr Myles was conducting endorsement training on multi engine aircraft prior to becoming the chief pilot of Avtex, then no doubt Mr Myles had access to suitable aircraft which were either owned or hired by the flying training school where such endorsement training took place.
99. Perhaps the more difficult question is whether, by failing to make adequate enquiries about the endorsements of pilots on PA-31 aircraft which were operated by Avtex, Avtex breached a condition of its AOC. Every AOC issued by CASA has effect subject to the conditions set out in s 28BE of the CA Act (s 28BA(1)(a)). Section 28BE(1) provides that the holder of an AOC must at all times take reasonable steps to ensure that every activity covered by the AOC, and everything done in connection with such an activity, is done with a reasonable degree of care and diligence. The duty to take reasonable care and to exercise a reasonable degree of diligence, where a corporation is the holder of the AOC, applies equally to each of its directors (s 28BE(2)).
100. Mr Langmead submitted that it was not clear whether Mr Myles purported to rely on his instrument of

delegation to issue endorsements or whether he did so in his private time outside of his employment with Avtex by exercising the privileges of his Grade 3 Flight Instructor rating. This was in fact put to Mr Chambers in cross-examination and Mr Chambers responded that the Instrument of Delegation No 252/07 was the only Instrument of Delegation under which Mr Myles could issue an endorsement. He said there was no evidence to the contrary. Therefore, even if Mr Myles could have lawfully given pilots endorsement training using his instructor rating, that did not authorise him to issue endorsements. In my opinion, that is plainly correct.

101. The best evidence of the basis upon which Mr Myles acted would have come from Mr Myles. If, as Mr Siewert maintained, Mr Myles conducted endorsement training and issued endorsements as a consequence of holding a Grade 3 Flight Instructor rating (assuming that was possible), it would have been a simple matter for Avtex to have called Mr Myles to give evidence about that. The fact that Mr Myles was not called does raise the inference that the evidence which he could have given would not have supported what Mr Siewert claimed to be the position (see *Jones v Dunkel [1959] HCA 8; (1959) 101 CLR 298).* In fact there is other evidence which points to the fact that in issuing endorsements to pilots for the PA-31 aircraft, Mr Myles purported to exercise the powers expressed in the delegation instrument which refer to CAR 5.23(2). The endorsements were those which Mr Myles issued between 23 January 2007 and 7 May 2008. This involved 26 pilots, not all of whom were subsequently employed by Avtex or entered into an employment arrangement with Avtex. There was no evidence that any of those pilots, at the time of the endorsement being issued, were either employed with or had an employment arrangement with Avtex.

102. Mr Myles was appointed Avtex's chief pilot on 21 November 2005. He was approved as a check pilot of Avtex on 26 July 2007 which was the date on which the Instrument of Delegation and Approval was issued. CASA checked Mr Myles' log book entries from 23 January 2007. Therefore, there was a six month period following that date during which Mr Myles could not have issued endorsements because he did not have a book of the so called *sticky labels* to enable endorsements to be recorded. However, there is no reason why Mr Myles could not have issued the endorsements after 26 July 2007 on the basis that he had conducted the training at an earlier date. In any event, in the notice to Mr Myles dated 19 January 2009 from CASA wherein it revoked Mr Myles' approval as a check pilot and recommended to the Director of Aviation Safety that his Instrument of Delegation No 252/07 be revoked, the grounds upon which that action was taken were the pressurisation endorsements on PA-31P aircraft and endorsement training on PA-31 and C-340 aircraft. CASA referred to Mr Myles' response about the asymmetric training issue and nowhere in that response did Mr Myles suggest that he conducted endorsement training or in fact issued endorsements under some other delegation. CASA did impose conditions on his instructor rating but there is no suggestion that was at all related to the issue of endorsements, as opposed to conducting endorsement training.

103. In cross-examination Mr Chambers was unable to confirm that Mr Myles in fact issued PA-31 endorsements by using the book of *sticky labels* provided to him because of the Instrument of Delegation and Approval. Mr Langmead was critical of Mr Chambers for not having investigated that further, even though a break in his cross-examination afforded him the opportunity to do so. Be that as it may, on the evidence before me, I find that Mr Myles improperly used his book of *sticky labels* to issue PA-31 endorsements to pilots. While that clearly suggests that CASA may not have been as vigilant as it should have been, it does not alter my opinion that Mr Siewert should also have been aware of Mr Myles' unlawful conduct. Although he testified that he was aware of the Instrument of Delegation and Approval, he apparently did nothing to ensure Mr Myles' conduct was lawful despite him using Avtex resources to conduct endorsement training. Furthermore, he must have been aware that the endorsements were given to pilots before they commenced working for Avtex.

104. A number of former pilots of Avtex gave evidence about endorsement training. Not one of them suggested that their endorsement training was conducted by Mr Myles under the supervision of a flying training school or that Mr Myles issued the PA-31 endorsements under any delegation other than the one he held in respect of Avtex. For example, Mr Michael Sill said he commenced working for Avtex in January 2008. He did his PA-31 endorsement in December 2007 with Mr Myles. He said that the endorsement training was provided in anticipation of him becoming a casual pilot with Avtex. After he obtained the endorsement, he began work with Avtex.

105. Mr Benedict O'Keefe worked as a casual pilot with Avtex between March 2008 and December 2009. He did his endorsement on the PA-31 with Mr Myles in February 2008. He said that he had an

interview for employment as a casual pilot prior to Mr Myles conducting his endorsement. About one week after the issue of his endorsement on the PA-31, he began working casually for Avtex. He confirmed that at the interview, he was told he would be engaged as a casual pilot after the endorsement was issued.

106. Mr Scott Bradley worked as a casual pilot for Avtex and Skymaster between August 2007 and February 2009. Mr Bradley already had a PA-31 endorsement, that having been issued to him in June 2005 by another organisation. He had extensive training in asymmetric flight recalling that the flight itself was some 2.1 hours. He believed he probably did up to six practice engine failures.

107. Mr Terrence Latchman joined Avtex in July 2007. He did his PA-31 endorsement training with Mr Myles who issued him with an endorsement. Mr Latchman was employed on a full time basis and he was based in Dubbo. He did his endorsement training prior to becoming a full time employee of Avtex. He recalled it was about two weeks prior to him taking up his full time position at Dubbo. Mr Latchman recalled paying Mr Myles personally for the endorsement training. Mr Latchman also said that his endorsement training was conducted at Avtex, and not at a flying school.

108. Mr Nicholas Bongiorno commenced employment with Avtex in about April 2008. He did his PA-31 endorsement training with Mr Myles in about March 2008, prior to commencing employment with Avtex. At the time of doing his endorsement training, Mr Myles did not offer him work but indicated that there may be work available with Avtex.

109. I find it difficult to understand how Mr Siewert, being fully aware of Mr Myles' delegation and approval instrument, could come to the conclusion that Avtex was not in any way responsible for the endorsement training and issue of the endorsements by Mr Myles while he held the position of chief pilot and check pilot. While it may have been possible for Mr Myles to conduct endorsement training on multi engine aircraft outside of Avtex, that could only be conducted at a flying training school. The training Mr Myles conducted was using aircraft owned by Mr Siewert or one of his companies and it was conducted by operating out of Avtex's premises. There was clearly no supervision. Furthermore, those pilots were then given an endorsement by Mr Myles. This could only be done by Mr Myles unlawfully using the book of *sticky labels* issued to him under his instrument of delegation and only in relation to applicants who were employed or working under an arrangement with Avtex. The fact that Mr Siewert did not, it appears from the evidence, enquire about the basis upon which the endorsement training was being conducted, speaks of a lack of due care and diligence. The failure of Mr Myles to give evidence about endorsement training and the issue of endorsements simply highlights my concerns.

110. Despite Mr Siewert's denial that endorsement training conducted by Mr Myles had anything to do with Avtex, Mr Donoghue had a different view. When asked in his evidence-in-chief whether Avtex did PA-31 endorsements, his answer was: *It did under Steve Miles* [sic], *but it subsequently hasn't.* Mr Donoghue at that time was the general manager of Avtex and therefore I accept that this statement is likely to be reliable.

111. The grave concerns that CASA raised about the PA-31 endorsements issued by Mr Myles arose again following the special audit of Skymaster in June 2010. What concerned CASA was it appeared that not all of the pilots who were on the list of 26 pilots provided to Avtex in 2008 were notified about defective endorsements; nor were some current pilots who were previously flying under the Avtex AOC and were now flying under the Skymaster AOC grounded until such time as they had remedial training. This was despite the fact that Mr Siewert had given an undertaking to contact all pilots concerned. Furthermore, in his letter of 8 July 2008 to Mr Campbell, Mr Siewert said that Avtex was able to identify pilots who were currently employed by the company. He said that those pilots had already been re-endorsed using an independent ATO. This person was Mr Graeme Atchinson. In fact in his letter of 2 July 2008 to Mr Campbell and Mr Weeks, Mr Donoghue said that on the previous day, Mr Siewert contacted all pilots to establish their level of training and to make arrangements for retraining and/or to stop flying. Mr Donoghue then listed six pilots who had been stood down pending retraining. On that list was a Mr Dirk Meinecke.

112. Mr William Cox, a FOI with CASA who was the audit team leader of the special audit in June 2010, said in his statement made on 16 August 2010 that CASA determined from the pilot logbooks of Mr Andrew Wilson (the pilot who died in the Canley Vale Road accident), Mr Meinecke, Mr Toby Messner and Mr Marcus Callegaro, that they continued to fly in Skymaster and Avtex operations following the 2008 SA and RCA regarding PA-31 endorsements without any remedial training. Putting

aside for the moment the other pilots, Mr Meinecke was identified by Mr Donoghue in his letter of 2 July 2008 as a pilot who had been stood down pending retraining. He did not receive this until July 2010. Ms Sue Davis, the ATO who conducted the retraining, found that all the pilots who she retrained were *rusty and knowledge deficient* as far as asymmetric situations were concerned. She found the pilots were deficient when tested in an aircraft synthetic flight trainer and confronted with engine failures at low altitude and/or maximum weight at takeoff. All pilots responded well to training and were returned to line flying after that training.

113. In cross-examination Mr Donoghue said that he had undertaken part of the exercise of contacting pilots. Mr Coakley had undertaken another part and Mr Siewert had also done part of it. However, this seems to contradict what Mr Donoghue said in his affidavit sworn on 14 September 2010, where he said Mr Coakley was placed in charge of contacting all of the pilots' on the list provided by CASA who were employed by Avtex. In fact, it was Mr Donoghue who identified Mr Meinecke as having had no previous asymmetric training and yet he did not follow this up to ensure that Mr Meinecke did not return to line flying prior to remedial training. Mr Coakley was not called to give evidence. Mr Donoghue identified Mr Callegaro as saying he could not remember if he had done any asymmetric training in the course of his endorsement on a PA-31.

114. In his letter of 2 July 2008, Mr Donoghue also identified Mr Latchman, Mr Kevin Brown, Mr Sill, Mr O'Keefe, Mr Meinecke and Mr Bongiorno as pilots who had been stood down pending retraining. In cross-examination, Mr Donoghue admitted that Mr Latchman had flown a line sortie prior to him conducting retraining. Mr Latchman testified that on 1 July 2008, he flew as line pilot between Dubbo, Orange, Bankstown and Dubbo, a time of 2.6 hours. Then, before doing remedial training with Mr Atchinson on 3 July 2008, he flew from Dubbo to Bathurst and on to Bankstown, a flight time of 1.4 hours. Mr Latchman said he didn't actually know or he wasn't told that he had been stood down. He was simply told he'd better go and do the training with Mr Atchinson. If he didn't do it, he was stood down. Mr Donoghue described that as something *which slipped through the net.* Mr Brown continued to fly the PA-31 for Avtex or Skymaster and he did so on a number of occasions without receiving retraining. Mr Latchman was recorded as having told CASA he had only one simulated engine failure in cruise as part of his endorsement training. There was no evidence that Mr Brown did any asymmetric training when endorsed on the PA-31 and neither Mr Sill nor Mr O'Keefe appeared to have done any asymmetric training. Mr Wilson on the other hand, reported that he had quite a good endorsement.

115. Mr Hanley, who became chief pilot of Skymaster on 6 August 2008, did not review the endorsement records of each of the Skymaster pilots who had received remedial asymmetric training. He said he first became aware of the issue in June 2010. In my opinion, this is remarkable. Having taken up the chief pilot position with Skymaster following problems identified by CASA about four weeks previously, it is almost inconceivable that Mr Hanley was not informed of the faulty endorsement issues. After all, he became responsible for the safe operation of aircraft operated under the Skymaster AOC, using pilots who had only some four weeks previously been identified as having defective endorsements on PA-31 aircraft, which were operated by Skymaster. While I do not for one moment suggest that Mr Hanley was being untruthful, it does speak of serious communication problems within the group of companies.

116. Perhaps the most telling part of the defective endorsement training issue is the opinion expressed by Mr Siewert regarding the RCA issued about that subject. He said that in his opinion, the RCA should have been issued to Mr Myles rather than to Avtex. This notion of deflecting responsibility was a common theme in Mr Siewert's evidence. It does not sit comfortably with his responsibilities as CEO of a corporate entity which is an AOC holder.

117. Another example is Mr Siewert's knowledge that Mr Myles did conduct endorsement training on weekends with his permission. These operations were in fact conducted from Avtex's premises as Mr Donoghue said in his evidence. It is difficult to understand why Mr Siewert, as CEO of that entity, did not carefully examine the limits of Mr Myles' delegation and approval and the suggestion that the endorsements were being conducted under Mr Myles' Grade 3 Flight Instructor rating. Either Mr Siewert closed his eyes to the fact that this endorsement training was being performed at Avtex or he was indifferent to the fact that it was taking place unlawfully. In my opinion, it is not appropriate for Mr Siewert to deflect responsibility for this training onto any other person, including Mr Myles. He facilitated Mr Myles' conduct.

118. A further example of this behaviour occurred when Mr Siewert was asked whether he identified any of the pilots' names on the list provided by CASA who had received defective PA-31 aircraft endorsements. Although Mr Siewert said he recognised some names, he agreed with the suggestion from Mr Langmead that there were no Avtex pilots on that list. However, Mr Siewert subsequently retracted that statement, explaining that there was some confusion because of the changeover between Skymaster and Avtex. Why there should be a distinction drawn between pilots who were endorsed by Mr Myles and then transferred, no doubt on Mr Siewert's instructions, to fly under the Skymaster AOC following the audit of Avtex in 2008, and Avtex pilots is difficult to fathom. After all, if pilots had deficient endorsements on PA-31 aircraft, as the CEO of Skymaster, it clearly remained Mr Siewert's responsibility. This event also demonstrates the artificiality of distinguishing between Skymaster and Avtex operations for the purposes of this application.
119. Mr Siewert performed a somewhat complex analysis and produced a colour coded chart regarding whether pilots needed retraining following Mr Myles' endorsement of those pilots. Although in his letter of 8 July 2008 Mr Siewert said Avtex did not accept legal responsibility for the endorsement of pilots employed by that company, he said to protect the company's reputation, Avtex would make available *ex gratia* retraining to be conducted by a third party provider. He said that the purpose of this retraining was to ensure that Avtex could in no way be associated with the compromise to aviation safety. With respect, it makes little sense to me to identify the deficiencies in PA-31 endorsement training for all pilots and to go to some effort to identify those pilots who *might* need further retraining as well as those who *did* need retaining, and then not follow up whether that retraining had in fact been performed. Furthermore, Mr Siewert's suggestion to CASA that Avtex retain the services of Mr Myles as chief pilot after having had him counselled by Mr Donoghue is not indicative to me of a person seriously concerned with the safety aspects of having properly qualified pilots operating his aircraft.
120. Some criticism was levelled at the fact that CASA provided Avtex with a list of pilots who had been endorsed on the PA-31 by Mr Myles, where the comments which CASA had put against the names on that list had been removed. In my opinion, that makes no difference at all to the response one would reasonably expect from the CEO of an AOC holder following the revelation of defective endorsements. Although Mr Siewert said he handed over the task to Mr Coakley, or alternatively to operations, quite plainly that was the extent of Mr Siewert's involvement. There appeared to have been no checking to ensure that all pilots continuing to operate the PA-31 aircraft for Avtex or Skymaster had complete and proper endorsements on that aircraft. In my opinion, a logical and safe response by Mr Siewert would have been to immediately ground all pilots operating that particular aircraft type until they had undergone a check ride with an ATO and, if necessary, remedial training followed by a further check ride. As for those pilots no longer flying for Avtex or Skymaster but who received their PA-31 endorsements from Mr Myles, I would have expected that Mr Siewert or somebody delegated specifically to the task would have liaised with CASA and arrived at a consensus about whether any other pilot should be offered remedial training. Those pilots having been identified, the remedial training could have been put into place immediately. Avtex's failure to deal in a systematic and safe way with the deficiencies identified by CASA is seriously disturbing. While many of the responses to CASA's requests about endorsement training certainly seem appropriate *on paper,* when one examines the underlying actions taken, the response was anything but adequate. This appears to be a case of *say one thing* and *do another.*

AVTEX TRAINING AND CHECKING ORGANISATION – CAR 217

121. Problems with Avtex's CAR 217 organisation first surfaced following the special audit in June 2008. In addition to the PA-31 endorsement problems, a number of issues were identified with the conversion training Mr Myles conducted on Metro III pilots. They involved the failure by Mr Myles to conduct formal ground school training for those pilots undergoing a Metro III conversion and Mr Myles' failure to correct ground school exams.
122. The audit also identified the following deficiencies:
    - (a) on numerous occasions in 2007, Avtex carried in excess of 15 passengers in its Metro and Merlin aircraft without a qualified second pilot or flight attendant on board because *wet drills* had not been completed for a number of flight crew;
    - (b) the training records of one pilot revealed that the supervising pilot on an ICUS flight in a

Metro III was not the company designated check pilot;

- (c) the recording of training flight time while the aircraft was on a revenue flight;
- (d) a pilot conducting revenue flights without having completed the required line check;
- (e) pilots conducting supervisory Captain and Training Captain duties while not approved under Part C of the Operations Manual or by CAO 82.13.3;
- (f) the head of training and checking being displaced by Mr Myles although ostensibly retaining his position;
- (g) the need to review a number of provisions in Avtex's operations manuals;
- (h) a pilot flying as PIC of a Metro III aircraft in single pilot operations without having the required 50 hours of time ICUS; and
- (i) a number of incidents where maximum takeoff weight was exceeded.

123. The outcome of the audit was that Avtex, rather than have its AOC cancelled, agreed to add eight conditions to its AOC to enable it to continue to operate. While CASA's principal concerns were directed at the way in which Mr Myles conducted himself both as chief pilot and as a check pilot for Avtex, and it demanded his immediate removal, the remainder of the conditions reflect more broadly CASA's concerns with Avtex's operations. According to Mr Campbell in the witness statement he made on 22 September 2010, following discussions between himself, Mr Weeks, CASA's Legal Services Group and the then General Manager of General Aviation Operations, Mr Greg Vaughan, it was agreed that Avtex posed serious and imminent threat to safety should it continue to operate. CASA therefore decided that in an attempt to lift the operation to a safe standard, if Mr Siewert was willing to maintain appropriate control over the safety and compliance of the operations, and he agreed to conditions to be added to the AOC, Avtex would be permitted to continue its operations. The eight conditions were then placed on Avtex's AOC with the agreement of Mr Siewert.

124. In August 2008 CASA indicated to Avtex that it could not continue its operations under its AOC unless it appointed a new chief pilot in place of Mr Myles. CASA had also relieved him of the HOTC position. Mr Donoghue was appointed chief pilot of Avtex and Mr Couch HOTC, also described as Manager of Training Operations. On its February 2010 audit CASA discovered that Mr Couch's last proficiency check was conducted on 24 July 2008 by Mr Myles. CAR 217(2) provides:

> . . .
>
> *(2) The operator must ensure that the training and checking organisation includes provision for the making in each calendar year, but not at intervals of less than four months, of two checks of a nature sufficient to test the competency of each member of the operator's operating crews.*
>
> . . .

125. In addition to issuing an RCA in respect of Mr Couch's failure to comply with CAR 217(2), it issued a SA indicating that this raised a serious safety concern and required immediate action by Avtex. According to CASA, Mr Couch had not completed a proficiency check between 24 July 2008 and the date of the audit, 10-16 February 2010. Therefore, any duties in relation to training and checking undertaken by Mr Couch after 24 March 2009 were invalid. Avtex ceased flying operations on 11 February 2010 and, according to the RCA, it acknowledged the invalidity of proficiency checks undertaken subsequent to 24 March 2009. It provided a list of all flight crew affected to CASA. Avtex undertook to revalidate Mr Couch's HOTC approval immediately and that was scheduled to take place under the supervision of FOI Mr Worthington on 15 February 2010. However, in the course of this hearing, Avtex disputed CASA's contention that Mr Couch had failed to maintain his proficiency after July 2008. In fact, Mr Langmead submitted that the problem was not one of lack of proficiency, but of a legalistic approach to the meaning of the legislation and the Operations Manual provisions upon which reasonable people could differ.

126. In fact Mr Langmead submitted that because Mr Couch had undergone a CIR renewal with CASA FOI Mr Eric DeMarco on 24 March 2009, that constituted an adequate proficiency check in accordance with the provisions of the Avtex TCM. In fact the TCM which was approved by CASA at that time was described as the 2004 TCM. An extract of the relevant section in that manual discloses (at para 9.1) that a pilot's proficiency must be checked at least twice in each calendar year in accordance with CAR

217. The paragraph goes on to state:

> *These checks may not be closer than four months together, or greater than eight months apart. Both checks will be BASE CHECKS, with one check including an INSTRUMENT RATING test if appropriate. Additional checks may be rostered at the chief pilots* (sic) *discretion.*

CAR 217(3) provides that the training and checking organisation and the tests and checks provided for therein shall be subject to the approval of CASA. In other words, no amendments can be made to the TCM without CASA's approval.

127. In his affidavit of 14 September 2010, Mr Donoghue testified that as he understood CASA's complaint, it was that Avtex had adopted the new Part C of the TCM for which it did not have approval. In his opinion, Mr Couch was proficient if the new manual had been approved and was in force.
128. In his affidavit of 26 August 2010 Mr Donoghue pointed out that Part C of the Company Operations Manual, which is also referred to as the TCM, had to be completely rewritten following CASA's audit in 2008. In a letter dated 20 October 2008, Mr Siewert wrote to CASA indicating that the Company Operations Manual had been completely revised and had been delivered to CASA on 17 September 2008. Mr Donoghue said CASA responded to that by issuing a new AOC to Avtex dated 16 December 2008. According to Mr Donoghue, it follows that CASA, by issuing a new AOC, must have been satisfied that Avtex met the regulatory requirements including those relating to training and checking.
129. With respect to Mr Donoghue, the fallacy in his reasoning is immediately apparent upon examination of the original eight conditions imposed by CASA on Avtex's AOC. Condition number 8 provides:

> *Reviews and where required, amend the Company Operations Manual with such amendments* ***submitted*** *to CASA* ***for acceptance*** *by 30 September 2008.*

130. Quite plainly, Avtex had complied with condition number 8 as it had submitted to CASA for acceptance the amendments to its Company Operations Manual. It does not mean that submission for approval, followed by the issue of an AOC deleting a condition which simply required the amendments to be submitted for approval or acceptance, can be treated as acceptance of the amendment to the manual. Submitting the amendments to CASA by 30 September 2008 merely evidenced compliance with condition number 8 and, if the other conditions had been met, allowed CASA to issue a new AOC. It said nothing about acceptance of the proposed amendments.
131. Mr Donoghue then said he had a conversation with Mr DeMarco where Mr DeMarco is said to have told him that CASA had *stuffed up* because it had not immediately approved the revisions to the manual. That would be fixed up immediately. Mr Donoghue said that throughout 2009, there were a number of communications received by Avtex from CASA consistent with the new manual being approved. He then referred to CASA's recommendations in relation to *fine tuning and improving the new manual.*
132. How it can be said that the amended manual was approved when discussions continued about further amendments is not clear. In fact, as Mr Donoghue said in his statement, CASA issued an audit observation dated 13 July 2009 requiring further amendments to the new manual. Following the audit, a revised copy of the checking and training part of the manual was sent to CASA. It is difficult to understand how Mr Donoghue arrived at his conclusions about approval after that audit. Mr Donoghue then testified that CASA issued Avtex with a new AOC in October 2009 and by that issue, he understood that Avtex met the regulatory requirements including those relating to training and checking. Again, such a presumption is not warranted because the amended manual was the subject of continuous further amendments in the course of 2009. The evidence does not disclose express approval granted by CASA prior to October 2009.
133. When Mr Donoghue was asked in cross-examination why it was that he considered Mr Couch was compliant with CAR 217 as a consequence of the amendment to the TCM, he said that a CIR renewal formed part of the proficiency check. In fact, cl C3.2.1 of the manual said to be valid on 1 January

2009 states that a typical training and checking organisation program for a pilot would approximate the following:

- January: Base check and night proficiency. (CAO 40.1.5).

- June: CIR renewal and CAO 20.11 testing. (CAO 40.2.2).

There is a note to this item indicating that the *month is for example only*. Sub-clause B refers to CAR 217 requiring two checks per annum to be conducted to test the competency of each crew member. That of course is, strictly speaking, incorrect. CAR 217 refers specifically to *each calendar year*. However, as Mr Langmead submitted, CASA has issued a Ruling (4/2004) in which it sated:

6. *It is CASA's view that CAR 217(2) indicates a contrary intention for the purposes of the definition of "calendar year" in the Acts Interpretation Act and that "year" in CAR 217(2) is to be interpreted as a rolling year. For example, if a pilot joins on 1 September and has a check on 1 October in the first year he would be allowed to have a second check on 1 February in the 2nd year followed by a 3rd check on 1 June and so on.*

Although, as CASA states in its Aviation Rulings, this is an advisory document only, CASA has agreed to proceed on the basis that a person who relies on a ruling is complying with the law.

134. Appendix II of CAO 40.1.5 sets out the requirements for a flight proficiency check. It involves general flying, instrument flight (the manoeuvres and procedures specified in CAO 40.2.1), emergency manoeuvres (multi engine aircraft), bad weather circuit, night flight (an annual requirement) and emergency procedures. As CASA submitted, a CIR renewal may form part of a proficiency check but it is by no means adequate, by itself, to satisfy the proficiency requirements set out in section 40.1.5.
135. When it was put to Mr Donoghue in cross-examination that the requirement was to have two checks in the same calendar year, Mr Donoghue disagreed and said that it had to be in a rolling 12 month period as per the ruling. For that reason, he was of the view that Mr Couch had met the proficiency checks requirement by virtue of having had a check conducted by Mr Myles on 24 July 2008 followed by a CIR check conducted by FOI DeMarco on 23 March 2009. In other words, within the 12 month period commencing 24 July 2008, Mr Couch had completed a proficiency check and a CIR check. Mr Donoghue then explained that Mr Couch had undertaken a base check and night proficiency check in July 2009, therefore he fulfilled the requirements for proficiency checking in accordance with the 1 January 2009 TCM.
136. With respect, I cannot accept Mr Donoghue's interpretation of the legislation or the way in which this aspect of the case was put by Avtex. The first problem is that proficiency checks are required to be conducted by TCO pilots, not CASA FOIs. Clause C1.10.0, which deals with pilot proficiency, states:

> *Proficiency and currency checks will be conducted by a suitably qualified TCO pilot in conjunction with a scheduled en route flight.*

There was no evidence that this requirement was met. Mr DeMarco was not a TCO. A CIR check by itself does not satisfy the requirements of a proficiency check. However, Avtex pointed to the fact that Mr Couch completed a full proficiency check on 21 July 2009 conducted by Mr Telling, who was a TCO. The training records for this proficiency check were in evidence. Although perhaps a minor point, the flight proficiency form used to assess Mr Couch was from the 2009 manual which had not been approved at that time. More significantly, as CASA submitted, there was no evidence that Mr Telling, who conducted Mr Couch's 21 July 2009 check, was himself proficient at that time. He had a check on 27 February 2008 and the earliest recorded subsequent check was 21 July 2009 in conjunction with Mr Couch's check on that date. Even if I am wrong about that, the CASA approved TCM at that time stated that the two annual checks must not be greater than eight months apart. To comply, Mr Couch had to have completed his second base check no later than 24 March 2009. This did not happen. Accordingly, I find that any training and checking undertaken by Mr Couch after 24 March 2009 was invalid.

137. Perhaps of even greater concern from a safety perspective was the fact that Mr Couch was required by CASA on 15 February 2010 to have his proficiency check conducted by Mr Telling, a person authorised by CASA to conduct training and checking for Avtex's TCO.
138. On 15 February 2010 Mr Couch arrived for his proficiency check with Mr Telling. He was one and a half hours late and, according to Mr Worthington and Mr Du Bois, his breath smelled of alcohol. Mr Telling, who was to conduct the proficiency check, aborted the flying part of the check because Mr Couch failed the briefing phase. He described Mr Couch as well below the standard expected for HOTC. Following that failure, CASA was not asked to observe any subsequent proficiency checks of Mr Couch.
139. On 4 March 2010 Mr Couch submitted to a proposal by CASA that he undergo proficiency checking in the Ansett Simulator in Melbourne. On 23 April 2010 Mr Couch undertook a proficiency check in the Ansett Simulator conducted by Mr Greg Steele. He failed that check. As a result of that failure, CASA suspended his CIR (multi engine) and his Metro III endorsement. On 2 July 2010 Avtex proposed Mr Couch repeat the examination to regain his CIR and his Metro III endorsement. This was to be observed by a CASA FOI. However, on 14 July 2010, Avtex cancelled that check flight. On 20 July 2010 Avtex submitted a request to CASA to conduct an assessment of Mr Bruce Moncrieff in the simulator, so that he could assume Mr Couch's position as HOTC. That assessment has not been completed by CASA.
140. There were two further incidents involving Mr Couch which caused CASA concern. Both of these incidents involved the recording of night flying time to satisfy proficiency requirements and also endorsement training.
141. On 10 August 2009 Mr Couch purported to conduct a proficiency check on Mr Clinton Barker in a Merlin aircraft. This training was conducted at Darwin Airport. Although the check report completed by Mr Couch indicated that night flying had been undertaken, enquiries lodged with Air Traffic Control at Darwin revealed that the flight had taken place in daylight hours. In addition, the forms submitted by Mr Couch indicated that an NDB and an ILS approach had been conducted. Air Traffic Control confirmed those approaches were not flown on that occasion. There was no evidence to contradict the evidence provided by the Air Traffic Controller at Darwin.
142. On 23 December 2009 Mr Couch apparently conducted conversion training on two pilots in the Metro III Aircraft. Both pilots were recorded as having flown night circuits as is required under CAO 40.1.0. Investigations revealed that the first training flight was concluded approximately two and a half hours before last light and the second flight concluded approximately 15 minutes before last light. Therefore, neither pilot completed night circuits which are a mandatory part of the syllabus of training for the issue of the endorsement. The Air Traffic Controller on duty at the time was Mr Michel Tessier. He made a Statutory Declaration to the effect I have referred to above.
143. In another matter involving Mr Couch, he conducted a check and training flight on 10 August 2009 with Mr Barker. That flight was in a Merlin III aircraft and a report prepared by the investigating officer of CASA, Mr Steve Cremerius, indicated the flight was from Darwin to Garden Point and return, an airborne time of 1.1 hours. Mr Couch recorded a flying time of 1.8 hours and Mr Barker 2 hours ICUS. Mr Barker had no previous flying experience in a Merlin III aircraft but he held a current Metro III aircraft endorsement. CAO 40.1.0 paragraph 3.3 provides that a command endorsement for a type of aeroplane specified in Column 2 of an Item in Appendix VI authorises a person to fly an aeroplane of a type or class specified in Column 3 of that Item as pilot in command. Item 4 in Appendix VI, Column 2, includes a Metro III aircraft and Column 3 refers to a Merlin III aircraft. Therefore, as is stated in paragraph 3.3 of CAO 40.1.0, a person with a command rating on a Metro III aircraft may fly a Merlin III aircraft as pilot in command.
144. On the day following Mr Barker's endorsement flight, he conducted an international passenger carrying flight under IFR in a Merlin III aircraft although he had not accrued 10 hours experience as a pilot in command in that aircraft type prior to undertaking the flight. Nor had he received an emergency procedures proficiency check on that type of aircraft. Therefore, according to CASA, Mr Barker could not have lawfully undertaken that international flight.
145. Mr Donoghue responded to CASA and he explained that if a pilot was endorsed on a Metro III aircraft, he was entitled to fly the Merlin III aircraft. Mr Donoghue also referred to CAO 82.1 which is made under s 28BA(1)(b) and s 98(4A) of the CA Act. Under that section of the CA Act, any conditions specified in the CAO become a condition of the AOC. Mr Donoghue referred specifically to paragraph

6 dealing with obligations in relation to operating different aircraft models. Paragraph 6.2 of CAO 82.1 provides:

> *The operator must ensure that:*
> *(a) the operations manual contains current and appropriate operating information, procedures and instructions (the **specific instructions**) for each aircraft type and model operated; and*
> *(b) before a pilot operates an aircraft, the chief pilot is satisfied that the pilot:*
> *(i) is competent to operate the aircraft in accordance with the specific instructions for the aircraft type and model; and*
> *(ii) understands the differences in each model of the aircraft type operated by the operator;*
> . . .

146. While what Mr Donoghue said is undoubtedly correct, he appears to have overlooked the requirements of paragraph 4 in CAO 82.1 dealing with obligations in relation to flight crew requirements in charter operations. Insofar as it is relevant, paragraph 4 provides:

> *4.1 Each operator who holds a certificate authorising charter operations must ensure that a person does not act as pilot in command of multi-engine aeroplanes not exceeding 5 700 kg MTOW* [maximum take off weight] *that are engaged in charter operations unless the pilot satisfies the following requirements:*
> *(a) in the case of V.R.F. operations . . . ;*
> *(b) in the case of I.F.R. operations, the pilot must have at least 10 hours experience as pilot in command of the aircraft type which may include flight time accrued as pilot acting in command under supervision.*

147. CASA also pointed to the requirements of CAO 20.11 which is made under the CARs. That CAO deals with emergency and lifesaving equipment and passenger control in emergencies. Paragraph 12 deals with crew member proficiency in the execution of emergency procedures. Insofar as it is relevant to this matter, it provides:

> *12.1 A crew member shall not be assigned or accept assignment to emergency duties in an aircraft engaged in a charter or regular public transport operation unless he has undertaken and passed the proficiency test specified in Appendix IV of this section on that type of aircraft.*

148. I find that CASA's contentions regarding this issue are correct. The requirements set out in CAOs 82.1 and 20.11 quite clearly refer to types of aircraft. The Merlin III is plainly a different type of aircraft to a Metro III. Therefore, Mr Barker could not fly under the IFR in command of a Merlin III in charter operations unless he had 10 hours experience as pilot in command or ICUS on that type of aircraft. Furthermore, he could not be assigned to or accept an assignment to operate a Merlin III aircraft without having undertaken and passed the proficiency tests set out in CAO 20.11. There was no evidence that he met those requirements and therefore, as CASA submitted, Mr Donoghue failed to understand the requirements for these operations under the AOC which, I agree, are fundamental regulatory requirements. It resulted in the pilot conducting an international passenger carrying flight after only two hours experience on the aircraft type.

149. CASA also alleged that proficiency checking and endorsement training took place under the supervision of Mr Couch while passengers were on board the aircraft. According to CASA, this breached CAR 249 which, relevantly, provides:

249. ***Prohibition of carriage of passengers on certain flights***

> *(1) The pilot in command of an aircraft that carries a passenger must not engage in any of the following types of flying:*

(a) ...;
(b) practice of emergency procedures in the aircraft;
. . .

150. According to Avtex, passengers were not carried on board training flights but because the flight log did not provide space for the entry of more than two crew on any one flight, operating crew were recorded as passengers. In his evidence-in-chief Mr Donoghue said that regarding the flight in question, only operating crew were on board and they were pilots who were going to undertake retraining. They were ferried across to Wagga where one of the pilots got out and then the training continued. Following completion of that training, the aircraft landed and the pilots exchanged places. He said there were no passengers on board at any stage. Mr Donoghue suggested that the form or flight log used to record persons on board was inadequate and that it created the impression that passengers were on board during the training flight. In the course of questioning about whether in fact there were other persons on board, Mr Langmead submitted that this was not a debate about definitions but rather whether other persons were in fact being carried on that flight. Of course without other evidence, the explanation given by Mr Donoghue would certainly appear reasonable and acceptable. However, while giving evidence about Mr Myles' proficiency check on 31 august 2009, in response to a question about how he had knowledge of that matter, he said:

> *We conducted the check, and the check – my part of the check went from Bankstown straight to Richmond ILS. Failure on approach, single engine overshoot, NDB engine failure and a circuit and a rejected takeoff and then we changed places. We conducted emergency procedures at Cowra.*

151. Following that response by Mr Donoghue, he was asked whether he was in the aircraft when Mr Myles' training was done. He answered *coming back, yes.* The word *passenger* is defined in CAR 2 in the following way:

> ***operating crew*** *means any person who:*
> *(a) is on board an aircraft with the consent of the operator of the aircraft; and*
> *(b) has duties in relation to the flying or safety of the aircraft.*
> *Note This definition includes persons:*
> *(a) who are conducting flight tests; or*
> *(b) who are conducting surveillance to ensure that the flight is conducted in accordance with these regulations; or*
> *(c) who are in the aircraft for the purpose of:*
> *(i) receiving flying training; or*
> *(ii) practising for the issue of a flight crew licence.*

152. In other words, even if another pilot was onboard but not involved in operating the aircraft, for the purposes of CAR 249(1), that person could not be carried where practice emergency procedures were conducted in the aircraft.
153. Mr Langmead submitted that the expression *operating crew* includes pilots not occupying an operating seat in the aircraft, but who are nevertheless on board for the purpose of taking a turn at the flight controls at some stage during the flight. He arrived at this interpretation of the expression *operating crew* by referring to the endnotes which follow the statutory definition. With respect, I cannot agree.
154. Section 13 of the *Acts Interpretation Act 1901* provides that endnotes to an Act do not form part of the Act. They are not subject to amendment by the parliament and they may be altered by the drafter or a person who is consolidating the Act (see DC Pearce and RS Geddes, *Statutory Interpretation in Australia, 6th Ed., 2006*, at p161). While an endnote may provide some guidance to the scope of the substantive provisions, it has been described as *a minor guide* and *a most unsure guide*. In my opinion, if the note is to be useful at all, it must be read in context with the substantive provisions. CAR 2(b) refers to duties in relation to flying or the safety of the aircraft. Persons receiving flying training or

practising for the issue of a flight crew licence, although occupying an operating seat in the aircraft, might nevertheless be understood not to fall within (b) of the definition. Strictly speaking, such persons may not have duties in relation to flying or the safety of the aircraft as they may not be qualified to operate the aircraft. In those circumstances, the duties are those of the instructor pilot or testing pilot. The purpose of the note seems to be to make it clear that the definition contemplates trainee pilots to fall within it. It cannot apply to qualified pilots who are merely occupying passenger seats, waiting for a turn at the controls.

155. Quite plainly, as CASA submitted, Avtex continued with the practice of allowing a passenger to be carried onboard aircraft during operations involving practice emergency procedures. I find that this was contrary to CAR 249(1). The practice continued despite the fact that CASA issued a RCA in respect of this practice in the 2008 audit.

OVERWEIGHT TAKEOFFS AND LANDINGS

156. Following the June 2008 audit, CASA issued a number of RCAs dealing with overweight takeoffs and overweight landings. According to Avtex, CASA issued seven RCAs in the course of conducting the audit in June 2008 and these were repeated in the February 2010 audit, although six of the seven allegations were dropped, without mention of that fact. A new allegation had been added. According to Avtex, only one of the flights mentioned was in fact overweight, by 24 kilograms, and Avtex admitted that error. In cross-examination Mr Chambers agreed that the show cause notice of 28 May 2010 contained an allegation about an overweight flight which took place on 9 September 2007 but which was not the subject of a RCA as stated in the notice. He also said that there were more examples of overweight takeoffs identified on audit but on closer examination or examination of the responses from the operator, which were accepted by CASA, the takeoffs were not regarded as being overweight. That is why they did not appear in the show cause notice.

157. As a result of the February 2010 audit, RCA 322179 issued regarding maximum weight takeoffs. In fact, this RCA dealt with maximum RTOW. CAR 235(2) provides that for the purpose of ensuring the safety of air navigation, CASA may give directions about the maximum weight at which an aircraft can operate, being a weight less than the maximum takeoff weight of the aircraft. It may also give directions about determining the maximum landing weight of the aircraft. For the purposes of determining maximum takeoff weight, CASA has set out a number of requirements in CAO 20.7.1B. The calculation of these weights is relatively complex and it requires aircraft to achieve particular climb gradients at particular points after takeoff, including single engine climbs for multi engine aircraft. This is to ensure obstacle clearance on departures from particular aerodromes under IMC. CASA has recognised that on many occasions it is impractical for operating crews to make the calculations required by CAO 20.7.1B using flight manual performance data against runway distance and obstacle or climb gradient data. This has resulted in the development of what are described as RTOW charts. These charts are prepared from surveys of specific runways. Quite obviously, those charts need to be regularly updated because of changes to obstacles on approach and departure tracks.

158. When asked about Avtex pilot's access to RTOW charts, Mr Donoghue said they were available on the internet. He said there was a library of Aleda data which was kept on the internet. He also referred to APG data and NOTAMs available through APG. However, as was pointed out to Mr Donoghue, the Aleda charts were maintained by Mr Jim Barker, who ran the Aleda organisation. The problem is that Mr Barker died in 2008 and the data had not been updated since his death. Despite that, Avtex continued to use the data, at least for departures from Bankstown. Apparently the Aleda data allows for a curved departure while the APG data provides for a straight departure.

159. Mr Donoghue confirmed that in December 2009 and January 2010, which is the period referred to in RCA 322179, Avtex was using the Aleda systems charts. When it was put to Mr Donoghue that the data was out of date, he disagreed and said there was no substantial change to the data. He said that can be checked with the ERSA issued by CASA. As for NOTAMs, which generally provide information regarding temporary obstructions, Mr Donoghue said they can be checked through APG. However, Mr Worthington said in his witness statement made on 22 September 2010 that the Aleda charts did not contain up to date information from the Bankstown Aerodrome Survey of 18 May 2009. Mr Campbell claimed that continuing to use Aleda charts which had not been updated constituted a safety hazard. He also said that the use of NOTAMs and ERSA cannot be used as a substitute for updating changes to a

survey chart because without knowing the criteria under which the chart was created, that was not possible.

160. Mr Chambers was cross-examined about the fact that, in the show cause notice issued to Avtex on 28 May 2010, reference to the flight which took place on 11 December 2009 and which was the subject of the RCA indicated that the temperature at 1600 hours on that day was 28.6 degrees Celsius. It was pointed out to Mr Chambers that the original RCA indicated the temperature on that day was 25 degrees. Mr Chambers explained that the takeoff time was in fact 1558 hours, almost 4pm. The Bureau of Meteorology weather for the purposes of the issue of the RCA was taken at 1500 hours and that indicated a temperature of 25 degrees Celsius. However, an hour later, it had risen to 28.6 degrees Celsius. Mr Chambers noted that the pilot would have had access to the precise temperature at the time of takeoff. He had available to him the ATIS indicating the precise temperature. Irrespective of whether the correct temperature was described on that day for the purposes of the show cause notice, quite plainly, Mr Couch, who was the pilot in command, conducted an overweight takeoff. He was either overweight by either 203 kilograms or 261 kilograms.

161. While some of the overweight figures set out in the RCA may be seen as relatively small, and there was some dispute about the headwind component used for the calculations, the problem that the RCAs highlight is the fact that outdated and inappropriate charts were being used for the calculation of RTOW. While I accept that this was a contentious issue, and it might have been appropriate for CASA to indicate in its show cause notice that the data upon which an RCA was issued had in fact been amended to reflect actual meteorological conditions at the time of an aircraft's departure, it does not alter the fact that Avtex continued to operate aircraft in excess of their RTOWs after that matter had been brought to its attention in 2008. It seems to me that if the company had been intent on making its operations as safe as possible, such errors would not have been repeated.

SAFETY MANAGEMENT SYSTEM (SMS)

162. Following CASA's audit in June 2008, one of the conditions imposed on Avtex's AOC to ensure it was able to continue its operations safely was that it was required to put in place a comprehensive, company wide, SMS which was fully supported by the CEO. This condition remained on Avtex's AOC until CASA's notice of 23 July 2010 suspending its AOC. CASA's audit in February 2010 disclosed that Avtex did not have in place a comprehensive company wide SMS.

163. ACS conducted an audit of Avtex's operations between 29 August and 1 September 2008. In its report following that audit, ACS stated that the SMS was not yet fully established although Avtex had laid the ground work at a level comparable with other similar sized organisations. It made the following findings and recommendations:
    - (a) currently the SMS is targeted at company pilots and the remainder of the organisation was yet to be fully involved;
    - (b) a formal safety officer needed to be appointed and although such a position was documented in the company SMS manual, it had not yet been filled;
    - (c) the company's risk and hazard assessment procedures were reactive in that they responded to incident reports as submitted, whereas there should be a documented system identifying items such as operations, processes, facilities, equipment and the like requiring risk analysis before an incident occurred;
    - (d) there needed to be a procedure for the review of new and aviation safety related facilities and equipment for hazard/risks before those are commissioned and a review of current facilities and equipment;
    - (e) no personnel within the organisation had received formal SMS training even though such training was identified in the SMS manual and this should be addressed with some urgency;
    - (f) the safety operations and SMS manuals needed to be merged to provide a complete manual; and
    - (g) the emergency response procedures should be capable of responding to accidents throughout the organisation not merely aircraft accidents.

164. Despite the above comments, ACS found Avtex to be compliant with Australian legislation and the conditions contained within its AOC. Quite plainly, that is incorrect. Avtex did not have a comprehensive; company wide SMS in place which was fully supported by the CEO. It was in breach

of that condition of its AOC.

165. In response to that ACS audit, Mr Donoghue wrote a letter to Mr White dated 6 November 2009 stating that following a meeting with the CEO, it was agreed that Avtex would put in place a GSMS which would be the master document for all departments within the group of companies.

166. Avtex sent to CASA its amended SMS manual in December 2009 and it was reviewed by Mr Michael Burgess. Mr Adrianne Rowland provided a report on the new SMS manual to Mr Chambers in an email dated 23 December 2009. The first point Mr Rowland made was that both he and Mr Burgess had reservations about the audit methodology used by ACS and they were not of the view that the audit findings could be acquitted merely by changing the manual. In any event, they identified remaining serious deficiencies. Mr Rowland said:

> *Clearly from the manual assessment there are important elements which are covered as headings, but have no explicit detail as to how they are implemented. My experience would suggest that if the detail is not there, then it is rare to find that the real life practise exists, but you can only tell this from an on site assessment.*

167. Mr Rowland also referred to the absence of SMS training and the reactive nature of the SMS. He expressed concern that after two years of operation, the safety assurance processes should be tailoring how the SMS functions, but this was not evident from the manual. In his view, an on site review was necessary to get a clear picture of whether the SMS was actually functioning or whether it was simply a book/plan *on the shelf.*

168. On 14 July 2010 Mr Clinton Piadasa, a safety system specialist with CASA, provided a report following the fatal accident of the PA-31P aircraft operated by Skymaster. Mr Piadasa also provided to the Tribunal a statement made on 30 September 2010 which was admitted into evidence. His position is now described as Team Leader Safety Systems. He holds a number of tertiary qualifications dealing with aviation human factors, a full aviation safety investigator certification and aviation system/flight crew development qualifications. Mr Piadasa also testified that he was a member of the CASA audit team which conducted a systems audit of Avtex in February 2010. His report was included in the T-documents.

169. Perhaps the most significant observation made by Mr Piadasa was that the SMS manual did not reflect the practices of the organisation at the time of the audit. The auditors identified significant instances where the company had not complied with its regulatory obligations, for example, flight crew proficiency check records. Deficiencies were also identified with the company's oversight of document control and amendment procedures. The manual was amended without the authorisation of the safety manager. The auditors recommended that the condition regarding the SMS on Avtex's AOC remain until such time that the company could demonstrate effective SMS processes that reflected the company's day to day operations. It should be borne in mind that this audit took place some 18 months following the condition being placed on the AOC.

170. Mr Langmead submitted that the concept of safety management in charter and aerial work operations in Australia is in its infancy. Courses and documentation were difficult to obtain and that while CAO 82.5 imposes a condition on AOC holders conducting RPT operations in high capacity aircraft to establish and maintain a CASA approved SMS, there is no such requirement imposed on AOC holders authorised to conduct charter and aerial work operations.

171. Mr Siewert was critical of CASA stating that CASA was invited to comment on the initial SMS manual produced in late 2008 and although audited twice, it made no comment. He explained that the SMS was being expanded in September 2009 and was in the process of being bedded down when CASA conducted its audit in February 2010.

172. In his evidence-in-chief Mr Siewert said that Avtex conducted monthly safety meetings which included himself, Mr Myles and Mr Hanley. A copy of an extract from Avtex's operations manual comprising its SMS was admitted into evidence. While it sets out many items which are desirable in an SMS, as CASA reported, it is short on detail. It certainly contains very little, if any, measures taken to implement the system. In other words, it devotes much time to the discussion of what constitutes a SMS but it contains very little detail about how it is to be put into practice. The chapter dealing with the SMS in the company operations manual was amended in January 2009. That document was certainly an improvement on the first version of that document, indicating more broadly what needed to

be achieved, but how that was to be done was not stated.

173. Mr Siewert explained that Avtex had moved to the next phase in the development of the SMS by looking at applying it across all of the organisations in the Siewert group of companies. He explained that a SMG consisting of himself, engineers, the maintenance manager, safety manager and the chief pilots from Skymaster and Avtex held meetings every three months. Mr Siewert also stated that after the February 2010 audit where some matters were highlighted, he made the decision that the November 2009 document was too cumbersome and that it should be rewritten. Mr Siewert pointed out that the process of rewriting had started but there was a problem getting the safety manager to complete an approved course. He said that it was not possible to get the safety manager onto a course before June 2010. Mr Siewert said that Mr Morgan was booked on courses which were advertised, but they were always cancelled. This was essentially because there were insufficient participants.
174. Mr Siewert also said that since July 2010, Avtex had engaged the services of Mr Michael Quinn, a former Deputy CEO of Operations in CASA. Apparently Mr Quinn advised that rather than rewrite the SMS manual, which he thought was aimed to satisfy the needs of airlines, it would be more effective to obtain a system which was available commercially.
175. In cross-examination Mr Siewert was asked to whom he applied or made enquiries to obtain relevant training for the safety manager. Mr Siewert could not answer that question and suggested the safety manager would know. He said that in his written statement, where he referred to the unavailability of training, that information came from Mr Donoghue who obtained the information from Mr Morgan. He did not personally seek to obtain training for the SMS. Mr Donoghue's evidence was that Mr Morgan undertook a training course in June 2010. No other key personnel in either Skymaster or Avtex have attended an SMS training course.
176. In his evidence-in-chief Mr Quinn said that in his opinion, the only area in which an SMS can add significant value to an operation such as Avtex is that of risk management, which is the process of identifying hazards and being able to formally assess the risks associated with those hazards. It was this aspect of the SMS which Mr Quinn said required some external assistance and that significant improvements could be made. He said there was nothing to be overly concerned about regarding the willingness of Mr Siewert to work and develop a SMS. In his opinion, it was more about education, guidance and understanding, rather than will. He did not believe there was a lack of resources.
177. Although Mr Quinn also described the fact that Avtex was prepared to engage external consultants to audit the organisation as positive, with respect to Mr Quinn, he did not appear to appreciate that the requirement to have external auditors arose because CASA required that as a condition of Avtex continuing to hold its AOC following the 2008 audit. Mr Quinn was asked whether the appointment of Mr Morgan, who was in effect the spare parts person in the Avtex organisation, as the *lynch pin* for connections between Skymaster, Avtex and the maintenance organisation, created a problem. He said he believed that simplification of the business model would aid in the way in which success could be achieved with the SMS. He did not consider the combined model to be ideal.
178. In his oral evidence, Mr Hanley referred to having discussions with Mr Piadasa regarding SMS meetings which he said took place every two months. That is not what Mr Siewert said. He maintained meetings were three monthly. Mr Siewert also maintained that Minutes of those meetings were kept. However Mr Hanley said:

> *Some of those Minutes hadn't been drawn up and I think one or two of the meetings had been deferred given no outstanding issues, but we certainly tried for every two months.*

179. When Mr Newberry was asked about safety committee meetings, he responded that they occurred every month.
180. Mr Bongiorno, a former pilot with Avtex and subsequently Skymaster, gave evidence about the need to submit a SMS report as a consequence of suffering fatigue on a very long flight to Rockhampton. Mr Bongiorno said he submitted that report but did not know what subsequently happened to it because he ceased flying with Skymaster. He said that he was told by another pilot, Mr Callegaro, that at a meeting, presumably of the safety committee, Mr Hanley explained that Mr Bongiorno no longer worked for Skymaster and therefore he may not need to deal with the SMS report. In cross-examination Mr Bongiorno insisted that he had lodged the SMS report a few days or maybe a few

weeks after the flight which took place in January 2009. He left Skymaster in September 2009. It was only after he left that he heard from Mr Callegaro that the report he had submitted had been dealt with in the way I have mentioned above. While this evidence is clearly hearsay and carries little weight regarding the truth of what Mr Callegaro said to Mr Bongiorno, it discloses that the report was not discussed for at least eight months following the incident, if at all. This evidence casts serious doubt over the evidence given about the conduct of safety meetings, if they occurred at all.

181. Mr Weeks was asked where he considered the Avtex organisation to be (from a safety perspective) in 2008, and where it had come to after the Canley Vale Road accident in 2010. He said this was difficult answer because at the time of the Canley Vale Road accident, Avtex had processes in place, including the SMS. Avtex was also being audited by a third party. As he described it, Avtex met the technical criteria however, in his opinion, in terms of what was in fact happening, there was a disconnect between those processes and systems as they did not appear to be achieving what they were designed to achieve. The purpose of the SMS is to permit identification of a hazard before it occurs so the company can take predictive, proactive action to prevent an accident or incident occurring. Mr Weeks referred to academics who had written about safety management systems and safety culture, indicating they cautioned against these processes being simply *paper based.* He said that was the view he formed about Avtex. It had moved slightly above the level it was at in 2008 by having formal processes and systems in place, but they were not effective.

182. Avtex attempted to make much of the fact that it was not required under any legislative provision to establish a SMS. In fact, it was suggested that very few charter operators, the size of Avtex, operated under an SMS. However, as Mr Weeks, Mr Campbell and Mr Chambers explained, many charter operators have an SMS. Some of them have adopted it voluntarily.

183. Mr Chambers was asked in his evidence-in-chief to provide an opinion about Avtex's level of implementation of the SMS after the February 2010 audit. He said that his view was similar to that of Mr Piadasa. He noted that the key areas of training had not been addressed and that hazard identification risk management remained reactive. Mr Chambers was also asked whether he agreed that there was difficulty in obtaining training for persons who wanted to be involved in safety management systems. He said that was what Avtex told CASA but he did not necessarily agree. He pointed to the fact that charter operators, who had voluntarily adopted a SMS, had obtained training which was available in Australia. In fact, Mr Chambers said that ACS, which was auditing Avtex at the time, was a company that provided training. In cross-examination Mr Chambers was asked if he had completed an SMS course. He said he had completed a CASA run ICAO safety management course which lasted for one week. He also explained he had risk management training which was conducted by an external company, Aerosafe.

184. In summary, Mr Langmead submitted that Avtex had introduced a SMS within the very narrow timeframe required by CASA to comply with its AOC conditions. He said that in the ordinary event, CASA would allow a period in excess of one year to phase in a SMS and to *roll it out.* However, in my opinion, that is not an answer to CASA's more fundamental argument that although Avtex has gone through the motions in presenting a SMS, that system has not been adopted by the CEO and the evidence of its implementation is either sparse or nonexistent. Almost two years after it was required to do so, Avtex was yet to have a person trained in safety management who could be responsible for the SMS. I find it difficult to accept Avtex's argument that the training was not available in that period of time.

185. The evidence was that other organisations had managed to obtain training in Australia and many of those organisations where small charter operators. In fact, Mr Chambers' evidence was that ACS, Avtex's external auditors, provided such training. That evidence was not refuted. The problem for Avtex, as I see it, is that there is evidence of safety problems having arisen on a number of occasions while the SMS was supposedly functioning, and yet incidents and accidents nevertheless occurred. Furthermore, there was also some evidence that known safety issues were not being dealt with as and when they arose. While the issues regarding the development of the SMS might not, of themselves, seem to warrant what might be described as *heavy handed* CASA intervention, it is an indicator of the attitude to safety of key personnel. In fact, in my opinion, it is a significant factor in determining whether Avtex has an adequate safety culture throughout its organisation.

CULTURE OF SAFETY

186. My attention was drawn to academic papers written by Professor Patrick Hudson, who is recognised internationally for his work on safety management systems, and Professor James Reason, an academic from the Department of Psychology, University of Manchester, United Kingdom. Although Mr Langmead was rather critical of both Professor Hudson and Professor Reason, there was evidence before me to suggest that those two persons are expert in the field of work safety.
187. In a published paper entitled *Achieving a Safe Culture: Theory and Practice, Journal of Work and Stress, 1998, Vol. 12, No. 3 to 293-306,* Professor Reason stated there was no universally accepted definition of safety culture. However, he suggested that its essential elements include;

> *shared values (what is important) and beliefs (how things work) that interact with an organisation's structures and control systems to produce behavioural norms (the way we do things around here).*

Professor Reason explained that safety cultures evolve gradually in response to local conditions, past events, the character of the leadership and the mood of the workforce. He said that in almost in every kind of hazardous work, it was possible to recognise typical accident patterns. The fact that different persons are involved in these events clearly implicates causal factors relating to the workplace and the system at large. Professor Reason said, at 302:

> *In summary, the same cultural drivers – time pressure, cost cutting, indifference to hazards and the blinkered pursuit of commercial advantage – act to propel different people down the same error-provoking pathways to suffer the same kinds of accidents. Each organisation gets the repeated accidents it deserves. Unless these drivers are changed and the local traps removed, the same accidents will continue to happen.*

188. Professor Hudson, in an article captioned *Safety Culture: The Ultimate Goal, Flight Safety Australia, September – October 2001, 29-31,* explained that the possession of a SMS, no matter how thorough and systematic it may be, is not sufficient to guarantee sustained safety performance. Professor Hudson said that safety cultures are characterised by good communication between management and the rest of the company. He accepted that the notion of an organisational culture was difficult to define. In his view, organisational culture can be described as:

> *Who and what we are, what we find important, and how we go about doing things around here.*

From worse to best, Professor Hudson described organisations along the following path:

- Pathological: the organisation cares less about safety than about not being caught.
- Reactive: the organisation looks for fixes to accidents and incidents after they happen.
- Calculative: the organisation has systems in place to manage hazards, however the system is applied mechanically. Staff and management follow the procedures but do not necessarily believe those procedures are critically important to their jobs or the operation.
- Proactive: the organisation has systems in place to manage hazards and staff and management have begun to acquire beliefs that safety is genuinely worthwhile.
- Generative: safety behaviour is fully integrated into everything the organisation does. The value system associated with safety and safe working is fully internalised as beliefs, almost to the point of invisibility.

189. Similarly to Professor Reason, Professor Hudson described the development of safety culture as an evolutionary line. In his opinion, a true safety culture is one that transcends the calculative level.
190. Mr Quinn, in his written statement of 26 August 2010, referred to Professor Hudson's taxonomy which he described in the five levels I have referred to above. After interviewing key personnel and

examining both the Avtex and Skymaster operations in what he described as three core areas (systems, capacity and competency), he concluded that he would categorise the safety culture currently within Avtex as at the reactive to calculative stage. Despite this, he also stated that in his opinion, the Avtex operation did not currently present unacceptable risks and that the operation appeared to be generally sound. He said the changes in personnel within the organisation mitigated most of the significant risks which were previously evident. As I understood Mr Quinn, he was saying that individuals within the organisation had previously been responsible for what was, perhaps, an unacceptable level of safety culture. It should be borne in mind that, as Professor Hudson said in his paper:

> *A safety culture can only be considered seriously in the later stages of this evolutionary line. Prior to that, up to and including the calculative stage, the term safety culture is best reserved to "described formal and superficial structures" rather than an integral part of the overall culture, pervading how the organisation goes about its work. In the early stages, top management believes accidents to be caused by stupidity, inattention and, even, wilfulness on the part of their employees.*
> ...
> *A true safety culture is one that transcends the calculative level.*

191. In cross-examination Mr Quinn was asked about the similarities between Avtex and two Papua and New Guinea aviation companies with which Mr Quinn was concerned when he was deputy CEO of CASA. Mr Quinn's evidence was that those companies, which were involved in fatal accidents, were also involved in what appeared to be intentional breaches regarding training, type rating and instrument rating checks. He distinguished those cases from the problems Avtex had experienced on the basis that he did not observe any intentional violation by Avtex of any regulations. However, when it was put to Mr Quinn that similar issues regarding endorsement training by Mr Myles and proficiency maintenance and checking by Mr Couch may have been deliberate, Mr Quinn declined to comment about Mr Myles because he hadn't interviewed him. He said: *He disappeared from the organisation before I got involved ...* . He also said although he was briefed about Mr Couch's issues, he did not have the opportunity to interview Mr Couch. When it was put to Mr Quinn whether any inadequacy found in endorsement training would pose an aviation safety risk, he agreed.
192. With the greatest respect to Mr Quinn, I find it difficult to understand how he could come to the conclusions he has without interviewing Mr Myles and Mr Couch. Given that Mr Quinn was asked to advise Avtex for the purposes of the hearing before this Tribunal regarding the suspension of the Avtex and Skymaster AOCs, if his investigation was truly impartial, he would have interviewed not only Mr Myles and Mr Couch, but also Mr O'Brien and Mr Lynch. By doing so, he may have been able to determine whether those persons were acting from their own volition, or whether their acts regarding endorsement training, proficiency of flight crews, scheduling and defect recording was something which had become inculcated into those organisations. In my opinion, simply interviewing personnel who have a very strong interest in having the suspension of the AOCs overturned and examining documents produced by either organisation is unlikely to produce a balanced view. Furthermore, it may also have been possible for Mr Quinn to have interviewed pilots, whose actions ultimately bring to light the level of safety culture within an organisation, although I accept that current pilots would be reluctant to speak freely for fear of losing their jobs. However, former pilots, who have no interest in whether Avtex's AOC is cancelled or reinstated, are likely to be the source of valuable information regarding the safety culture of Avtex and Skymaster.
193. In Mr Quinn's opinion, several aspects of the Skymaster operation were deficient and, what he described as some latent conditions, existed. When he was asked what he meant by *latent conditions*, he particularly identified the flight training of Skymaster pilots. Why those pilots were referred to as Skymaster pilots is not clear. It appears to be an attempt to distinguish them from Avtex pilots. The reality was that as contract pilots, they operated aircraft from either company, as required. Mr Quinn suggested that there should be an external program with an ATO or a grade one instructor to run a program of flying training covering standard operating procedures, emergency procedures and refreshers on the technical aspects of the aircraft being operated.
194. In my opinion, the safety culture of Avtex is best identified by examining the way in which its operations have been conducted. To do that, I need to look more closely at *what was done*, rather than

what we say we do. There were a number of problem areas identified by CASA and they range across the spectrum of operations, including defect recording, flights in icing conditions and thunderstorm activity, flight scheduling and fatigue issues. Of course, also included under this broad topic of safety culture are the competency, proficiency and training of pilots. I have already dealt with those subjects.

DEFECT RECORDING

195. In its AOC cancellation notice dated 20 August 2010, CASA identified a number of instances where it claimed pilots had failed to record defects on aircraft maintenance releases in accordance with CAR 50. CAR 50 provides:

> *(1) This regulation applies to each of the following persons:*
> *(a) the holder of the certificate of registration for an Australian aircraft;*
> *(b) the operator of an Australian aircraft;*
> *(c) a flight crew member of an Australian aircraft.*
> *(2) If:*
> *(a) there is a defect in the aircraft; or*
> *(b) the aircraft has suffered major damage;*
> *a person mentioned in subregulation (1), who becomes aware of the defect or damage, must endorse the maintenance release of the aircraft or other document approved for use as an alternative for the purposes of this regulation, setting out the particulars of the defect or damage, as the case may be, and sign the endorsement.*
> *Penalty: 25 penalty units.*

196. A maintenance release ceases to be in force where an entry has been made on the maintenance release due to the fact that an aircraft has suffered major damage or has developed a major defect, other than damage or a defect that is a permissible unserviceability (CAR 47). A major defect is defined as a defect which may affect the safety of the aircraft or cause the aircraft to become a danger to persons or property.
197. CASA identified some seven defects in two of the turbine engine aircraft which, Avtex said, were all discovered in the course of routine maintenance. However CASA was satisfied that the defects were discovered by pilots but had not been recorded on the maintenance release. They included the following defects:
    - (a) very sensitive pitch problem;
    - (b) stall avoidance system inoperative;
    - (c) right wing strobe and tail strobe unserviceable;
    - (d) left propeller de-icing unserviceable;
    - (e) pressurisation control fault;
    - (f) faults in the EGT , torque and fuel flow indicators;
    - (g) right ammeter, EGT, torque and fuel flow indicators fault; and
    - (h) standby AH slow to erect.
198. Mr Simpson is a Team Leader Airworthiness, Sydney Region Office, General Aviation Operations Group. He provided a written statement dated 21 September 2010. Mr Simpson was part of the audit team which conducted the February 2010 audit of Avtex. Five RCAs and four ASRs were issued by CASA in respect of airworthiness issues.
199. In respect of CASA's claim that pilots had failed to record defects in accordance with the requirement set out in CAR 50, Mr Donoghue apparently responded to the RCA by stating:

> *Did not require endorsement in the M/R IAW CAR 50.*

200. The responses provided by Mr Donoghue to the RCAs dealing with airworthiness are disturbing. For example, regarding the pressurisation fault which was initially identified by the pilot as *pressurisation cabin differential being low*, Mr Donoghue's response was the aircraft could be flown unpressurised. He also stated the pressurisation system could be adjusted and that the aircraft was not unserviceable.

He then said that the defect was found as the result of a check by *engineering*. However, as Mr Simpson pointed out, an extensive maintenance entry regarding that problem discovered an incorrectly installed venturi. That was essentially the cause of the malfunctioning pressurisation system.

201. A proper understanding of CAR 50 makes it clear that it is not a pilot's responsibility when operating an aircraft to identify the nature of an equipment fault; to diagnose the reason for a malfunction; or to determine whether equipment requires maintenance. The pilot's role, as is plainly stated in CAR 50, is simply to endorse the maintenance release if the pilot becomes aware of a defect. The expression *defect* is not defined in the CARs and therefore it must be given its ordinary meaning. The Shorter Oxford English Dictionary defines *defect* as:

> ***1.*** *.The fact of being wanting or falling short; lack or absence of something necessary to completeness (opp. to excess); deficiency*
> ***2.*** *A shortcoming, a fault, flaw, imperfection*

Plainly, the requirement is to record anything which is not functioning as it should. Therefore, if a pressurisation system is indicating a lower than usual pressure differential, then it is not functioning as it should and it should be endorsed on the maintenance release. It is not the pilot's duty to diagnose whether the pressurisation system is faulty or that it is about to fail. If it is does not appear to be functioning as it should, that is frequently a warning of an impending failure.

202. A similar response was provided by Mr Donoghue in respect of the pitch control being sensitive. In his opinion, the aircraft remained serviceable. Again, it should be apparent to an experienced pilot such as Mr Donoghue, that that is not the test for entry of an item onto the maintenance release. In addition, as Mr Simpson said in his written statement, to identify this fault, the aircraft must have been airborne. Therefore, it is logical to conclude that the operating crew informed the maintenance organisation of a problem but they did not record it in the maintenance release, although the reasons for the crew not doing so were not in evidence. However, if a pilot had discussed this problem with an engineer, and was told by the engineer that it was not necessarily an unserviceability, that might provide an explanation for failure to enter that item on the maintenance release. As I have already said, it is not up to the pilot to determine whether something is unserviceable. The pilot's role is to record the defect.

203. Of grave concern to me was the response provided by Mr Donoghue in respect of problems with the SAS. According to Mr Newberry, a pilot *mentioned in conversation* that the indicator lights of the SAS had blinked on one leg of the trip but appeared normal on subsequent legs. Mr Newberry said he informed operations that he would have someone look at the SAS the next time the aircraft was available. When that occurred, it was discovered that the SAS had an intermittent fault. Mr Donoghue's response was:

> *Pilots did not think that they had the expertise to diagnose the suspect fault.*

It is the engineer's duty to diagnose and rectify faults. That is not the duty of the pilot.

204. The underlying rationale for Mr Donoghue's responses became clear in the course of his oral evidence. He made a number of references to equipment being *broken*. When questioned about his use of that expression regarding equipment on the aircraft, Mr Donoghue gave the example of a fuel flow gauge which was indicating but which might be *50 or 60 pounds out*. Mr Donoghue said that if everything else was indicating normal as far as the operation of an engine was concerned, then:

> *I'll operate within those parameters. If its not, you know, maybe they can look at it. I don't know.*

When this was further explored with Mr Donoghue, and he was asked whether such an item of equipment was serviceable, he said:

> *But the question is – it would then go down to what's the age of the engine, is it*

using more than it should, or whether its not.

He explained that he would seek clarification from someone with more knowledge about that equipment than himself. He would enter that on a maintenance release only if somebody else told him that this was outside the parameters for the engine.

205. With respect to Mr Donoghue, this is precisely what should not be done. It is not the pilot's role to analyse the serviceability or otherwise of a piece of equipment and to attempt to determine whether or not what has been observed by the pilot should be entered on the maintenance release. Even if, for example, a pilot were to make an entry on the maintenance release, only to be subsequently told by an engineer that the equipment was functioning normally and within prescribed parameters, it is a LAME who makes that decision because that person is qualified to do so. Moreover, it is the LAME who signs off on that item in the maintenance release stating that maintenance has been carried out and the problem rectified, even if that simply means checking the item and coming to the conclusion that it is operating normally. Making an inspection of a piece of equipment on the aircraft for the purposes of ascertaining whether the aircraft is in a fit state for flying is maintenance and is something to be conducted by the engineer, not the pilot.
206. Mr Newberry also gave evidence about pilots contacting him and operations, expressing concerns about the serviceability of some items of equipment. While there is clearly no problem with pilots discussing perceived unserviceable items with engineers so that the engineers are able to perhaps obtain a more complete picture of the problems experienced by the pilot, it is not the role of engineers or any other person, including Mr Newberry or operations staff, to make suggestions to pilots about whether the item is in fact serviceable. That is something that needs to be determined by a LAME upon inspecting and testing the equipment. Unfortunately, the evidence discloses that the practice of contacting operations and or engineers to discuss engineering problems has resulted in pilots not entering defects in the maintenance release as should have been done. In fact, Mr Newberry recognised a root cause of the problem in a response to the RCAs when he said that pilots should be made aware of their obligations under CAR 50. In his response, he said the chief pilot would be advised that this should be included at the next pilots' meeting. There was no evidence that this issue was raised at any meeting.
207. Following the Canley Vale Road accident, CASA conducted a special audit of Skymaster which included the airworthiness of the aircraft which it utilised in its operations. Mr Simpson identified a number of defects which, in his opinion, should have been recorded in the maintenance release but were not. Again, CASA submitted that Mr Newberry, as HAAMC of Avtex and Skymaster, had responsibility to ensure that aircraft maintenance was conducted in accordance with the Regulations and the Act. In fact, CASA submitted that because Mr Newberry was also the HAAMC of Avtex, the evidence regarding the recording of defects in Skymaster operations is a relevant matter for the purposes of this application. I agree. The evidence of Mr Newberry's handling of those matters is, in my opinion, indicative of his performance generally as the HAAMC of an AOC holder.
208. As CASA put it, the audit disclosed a less than rigorous approach to ensuring compliance with key regulatory obligations. The audit disclosed deficiencies in the recording of defects in no less than 11 aircraft and on multiple occasions. An example of this was aircraft VH-XLA where, on 10 April 2009, the left hand engine log book recorded *engine hard starting*. The work carried out required a magneto replacement. As Mr Simpson said in his statement, engine starting is not a regular task carried out by maintenance engineers except as part of troubleshooting for defects.
209. Although Mr Newberry testified that maintenance personnel sometimes *warmed up* aircraft prior to departure, when the pilots who gave evidence in this matter were asked that question, they answered that the engineers did not run the engines before departure on a flight. Mr Simpson concluded that the difficulty experienced starting the engine had been reported by a pilot but had not been recorded on a maintenance release. On balance, I agree with Mr Simpson. The evidence does not support a finding that this was an engineer discovered problem. Although Mr O'Keefe appeared to agree that engineers *warmed up* aircraft for pilots, he subsequently clarified what he meant by his answer. He said:

And just on this matter of, on occasions, finding aircraft warmed up for you, you mentioned about that others might do some flight planning and weather. On 10

occasions, would others also warm up engines so that there was no delay in actually getting airborne?---I don't recall completely of that happening, but I'm – when you say "warm up," there was other, you know, pilots that had flown that aircraft earlier that day, if what's what you're – I wasn't completely clear on that

.

210. In Mr Donoghue's terms, the aircraft may not be *broken* in the sense that once the engine is started, it may operate normally as far as the pilot is able to observe. Quite plainly, a faulty magneto could cause significant problems when airborne and the issue should have been dealt with by the pilot recording the problem in the maintenance release on the first occasion it was observed.
211. Mr Hanley was the chief pilot of Skymaster until October 2010. In an affidavit made on 5 October 2010, Mr Hanley said that he had never pressured pilots to defer recording defects on a maintenance release and in fact, he positively insisted they do so. In his evidence-in-chief, Mr Hanley was asked whether there was anything in the make-up of the organisation or the attitude of any members of the organisation which he observed that acted in any way as an inhibitor to proper defect recording. Mr Hanley said *not in my experience and certainly never in front of me*. He nevertheless went on to say that it was common throughout the aviation industry for inexperienced pilots to be reluctant to make entries on the maintenance release. Mr Hanley said that one of the pilots who flew for Avtex and Skymaster, Mr Bongiorno, lost his job because he did not enter defects on the maintenance release when he should have done. Mr Bongiorno disputed this evidence. In fact his termination letter seems to support his evidence. It stated that his employment was terminated due to a downturn in work. He was no longer required by Avtex.
212. Mr Hanley also said in oral evidence that he instructed pilots to always contact him before making an entry on the maintenance release or even after making an entry. When asked why he told pilots to contact him before making an entry on the maintenance release, Mr Hanley said that he did that sometimes so that he could help them not to make inappropriate comments. He said he also asked pilots to call him to make sure it was not *finger trouble* and *we could resolve the problem with extra knowledge*. With respect to Mr Hanley, while that sounds innocuous, it seems to be exactly the opposite of what is demanded under CAR 50. In fact, this approach could easily act as discouragement to pilots to make entries on the maintenance release, thinking that their chief pilot might subsequently consider their comments were inappropriate.
213. An example of this was given by Mr Bongiorno in his evidence-in-chief. Although Mr Hanley accused him of being a *serial offender* when it came to entering defects on the maintenance release, Mr Bongiorno categorically denied that. He said Mr Hanley never raised the issue with him. Mr Bongiorno recited an incident where he had a cross-feed fuel problem. This was a flight between Bankstown and Griffith and he noticed his left fuel gauge going down much faster than the right. The gauge got so low that he was waiting for the left engine to cut out and he started to track towards an alternate airfield. As it turned out, the engine did not cut out and so he continued to Griffith and landed. On landing at Griffith he spoke to the chief engineer, Mr Lynch, about the problem. After that discussion, Mr Bongiorno decided to fly the next leg when, not surprisingly, the problem recurred. He then made an entry in the maintenance release. Mr Bongiorno said he did not contact Mr Hanley after landing at Griffith. However, Mr Hanley later told him that he should have contacted him but Mr Bongiorno said he did not want to speak with Mr Hanley until he knew the facts, and had more information about what the problem was because *Peter Hanley is not the sort of person you want to speak to when you don't have all the facts*. When Mr Bongiorno was asked what he meant by that he said:

. . . If you ring Peter Hanley with questions and you're not exactly sure on the answers, he may be – he will get fairly abusive with you and say, "what are you calling me for if you don't know?".

Therefore, despite Mr Hanley's insistence that defects were entered on the maintenance release whenever they occurred, what happened in practice appears to be quite different to what Mr Hanley said he wanted pilots to do.

214. Another example of failure to record defects occurred when aircraft VH-HJK suffered a nose wheel

collapse on landing on 18 July 2010. Passengers on board that aircraft provided statements to CASA indicating that an engineer was working on the aircraft at Marree on the morning of 18 July 2010, ostensibly to rectify a light problem. Mr Gary Arnold, a CASA Airworthiness Inspector, recorded the events in his statement of 16 August 2010.

215. Mr Myles, who was the pilot of VH-HJK, apparently told CASA that Mr Lynch was in fact on site at Marree Aerodrome on the morning of 18 July 2010. He was there to inspect damage to another company aircraft, VH-XLA, which landed at Marree previously with the undercarriage retracted. He was there to assess the damage to that aircraft.

216. Mr Myles was then the chief pilot of Avtex. He approached Mr Lynch telling him that the aircraft exhibited symptoms of slow nose landing gear extension, similar to previously reported incidents. He asked Mr Lynch to look at the aircraft. Apparently Mr Lynch conducted a visual inspection and could not find any problems with the aircraft. This is what he told Mr Myles. The aircraft then subsequently took off for Tibooburra and on landing, the nose wheel collapsed. CASA confirmed that Mr Lynch did not make any entries on the maintenance release, nor did Mr Myles. In fact, Mr Arnold said that Mr Lynch advised CASA that he had not conducted any maintenance, *but had only had a look*. For that reason, he did not make any endorsements on the maintenance release. Again, that is a very disturbing approach by the chief engineer of the Avtex maintenance organisation. Inspecting an aircraft for the purposes of determining whether it is safe to fly is maintenance and should have been recorded (see CAR 2). At that point, the aircraft should not have been released from maintenance until a LAME signed off the aircraft as being serviceable. The pilot's only duty was to record the problem in the maintenance release and not to diagnose its cause or probable consequences on the operation of the aircraft.

217. Mr Campbell testified that between 2007 and 2009, CASA FOI's used Avtex aircraft to undertake their own endorsements and to maintain their currency requirements. He said that Avtex was frequently chosen because it was convenient, being based at Bankstown. He said he was involved in organising the hiring of aircraft from Avtex on possibly about 10 occasions.

218. Mr Campbell had in fact himself hired aircraft from Avtex. When asked about the condition of those aircraft, he said he came away without flying on more occasions than he went flying because of defects on the aircraft. He said they were obvious defects which hadn't occurred just prior to him getting to the aircraft, rather, they were defects which would have been obvious to the previous pilot. He said when he found defects, he would endorse the maintenance release and wouldn't fly the aircraft. He said he would report the problem, usually to the operations room, to Mr Donoghue. At that stage Mr Donoghue was the general manager of Avtex. He knew Mr Donoghue well and he said he had a reasonably friendly conversation whenever he spoke with him. He said Mr Donoghue's response was never negative, he simply indicated it would be fixed.

219. Mr Campbell recounted an event where he rented a Chieftain aircraft from Avtex to do some filming for CASA for one of its educational movies. On the pre-flight inspection, he inspected the engine cowls which have three fasteners each. Mr Campbell said that those fasteners are in the horizontal position whether closed or open, but they normally have a witness mark on the cowl and fastener so that a pilot can observe whether the cowls are properly fastened or are in the unlocked position. Those witness marks were not present on the aircraft and the cowls appeared to be closed. In the course of the flight, one of the persons on board told Mr Campbell that it appeared that there was a small panel coming open. He said he couldn't see it from the pilot's seat but on landing, he discovered that half of the cowl was unfastened and was open about six inches. If it had come off, the consequences could have been catastrophic.

220. Mr Campbell said that he spoke with Mr Lynch following this incident. Apparently Mr Lynch's response was that Mr Campbell had done an inadequate pre-flight inspection. According to Mr Lynch, Mr Campbell should have recognised that the cowls were unfastened. While Mr Campbell accepted his responsibility for the pre-flight inspection, he said that the cowls nevertheless appeared to be tightly closed and there was nothing to indicate that they had been left unfastened. The reason for them being unfastened was most likely that maintenance had been carried out and the cowls had not been properly refastened.

221. Mr Campbell also recounted another incident where the Metro aircraft had a fuel leak to such an extent that the dripping fuel had eaten away part of the tarmac. He was annoyed that Avtex had offered him this aircraft with a serious defect and so he looked more closely at the aircraft. He said he found wires

hanging out of the overhead panel in the cockpit, exposed control cables on the floor where the aircraft had been converted from a freight floor to a passenger floor without covering. He said he approached Mr Siewert at the time and his response was: *Malcolm, it is a very small industry.* He took that as a veiled threat meaning: *You do this sort of stuff, you won't ever get a job back in the industry.*

222. While Mr Langmead objected to this line of questioning because Mr Siewert had not had an opportunity to give evidence about this matter, Mr Harvey pointed out that it only recently came to light. Mr Langmead explained that Mr Siewert had now gone overseas and that this should have been put to him at an earlier stage. While mindful of the possibility for unfairness in these circumstances, there was other evidence admitted at a later time in the course of the hearing, to which I will refer presently, given by a different witness but eliciting a response in a similar indirect threatening fashion. In fact, in his evidence-in-chief, Mr Siewert was asked if he ever put pressure on pilots not to record defects and his answer was a categorical *no.* The inference I draw from that answer is that Mr Siewert's response to the evidence of Mr Campbell would similarly be negative. In any event, I offered to Mr Langmead that he recall Mr Siewert or give him the opportunity to respond in writing. At the time of writing this decision, I have heard nothing from Mr Langmead about this.

223. In cross-examination Mr Campbell was asked whether he could produce any documented evidence of any of the defects that he had referred to in his evidence-in-chief. Mr Campbell then recounted an incident which happened in February 2010 where he had undertaken to fly a Metro aircraft on a cross-hire arrangement. When trying to drain fuel as part of his pre-flight check, he found he couldn't get fuel out of the drain. In trying to establish the fault, the chief engineer had to remove the entire fuel drain unit only to discover that a previous fuel tank repair had resulted in fuel tank sealant flowing into the top of the drains, blocking the holes completely. Mr Campbell could not tell how long ago the previous repair work had been done but he was quite certain it wasn't simply since the previous flight. Mr Campbell was clearly of the impression that the fault had existed for some period of time and had been overlooked by both pilots and maintenance personnel. When it was put to him whether there was any negativity associated with the repairs, Mr Campbell said, not from Mr Donoghue but from the chief engineer, Mr Lynch. When asked what pressure Mr Lynch exerted on him, Mr Campbell said: *Just a hostile attitude to reporting a defect. It was along the lines of, "Oh you've done it – typical you've grounded another aeroplane". That sought of an attitude.*

224. Mr Campbell agreed that he did not have a recollection of either Mr Myles or Mr Siewert directly exerting pressure on pilots not to record defects. However, what he said was:

> *Well, I don't have recollection of exerting pressure as in saying, hey, just take that aeroplane, don't worry about the defect. There is nods and rolling of eyes back and sighs that can be just as much pressure, indirect on a pilot, ...*

Mr Campbell explained that the rolling of the eyes and walking off can be an indication to a pilot that there is displeasure in what was done. He said he had experienced that himself and as a casual employee it was likely to impact on whether persons who frequently reported defects were re-rostered. In fact, there was evidence from a former Avtex pilot to that effect.

225. In the course of further re-examination Mr Campbell expanded on the incident concerning the fuel drain in the Metro aircraft. He described Mr Lynch's attitude as: *is it a big deal?* It was an unpleasant job to take the fuel drain out and Mr Campbell said Mr Lynch was not happy doing the job. When the fuel drains were put back in, they still weren't functioning and Mr Lynch then suggested it would be okay to take the aircraft. Mr Campbell refused unless the drains were functioning properly. He described Mr Lynch's reaction to that statement as: *then there was the eyes rolled back, walking off in a huff, wasn't impressed.*

226. A number of former pilots who operated aircraft for both Avtex and Skymaster gave oral evidence at the hearing of this matter. These pilots are now employed elsewhere and they were asked by CASA to provide evidence about the operations in which they were involved. At least two of these pilots were summonsed to give evidence.

227. Mr O'Keefe is now employed as a first officer with QANTAS Link. He commenced working with Avtex in March 2008 as a casual pilot and remained there until December 2009. When asked whether he had issues of a technical nature during his time flying for either company, he responded that he had

experienced a raft of problems. He described problems with landing gear, a rough running engine, and issues with avionics including the weather radar and radios. When asked how frequently he encountered these sorts of problems he said: *frequent enough that, every time I went flying, I was worried.*

228. According to Mr O'Keefe, the procedure for bringing defects to the attention of either the AOC organisation or the engineering workshop was to first call operations and then operations would co-ordinate with engineering. Sometimes he suggested it was best to go straight to engineering. He described difficulties when dealing with the engineers. He provided an example where on a pre-flight inspection, he noticed a bald spot on one tyre which was about the size of a five cent piece. The canvas was showing through the rubber. After bringing that to the attention of an engineer, he said the engineer asked him how many landings he was going to do on that day. When told approximately six, the engineer said its good to go for another eight landings and he did not want to change the tyre. Mr O'Keefe said he insisted and he brought that to the attention of the chief pilot, Mr Myles. He entered it as a defect in the maintenance release and the tyre was changed. However, he said: *but it never came easy from engineering to get something changed, you know.*
229. In cross-examination Mr Langmead put to Mr O'Keefe that he in fact did not feel any need to leave Avtex until he had another secured job. Mr O'Keefe responded by stating that he wanted to leave Avtex as soon as possible, about nine months after he started working there, because he noticed problems with the operation and problems with the aircraft. He said he lost confidence in the aircraft and the operations. For him, it was a matter of gaining experience to get out as soon as he could. When Mr Langmead put to Mr O'Keefe that the problems were not such that they made him leave the employment of Avtex, Mr O'Keefe said that he really didn't have a choice.
230. In the course of cross-examination Mr O'Keefe accepted that avionics problems in general aviation aircraft are a fact of life and that Avtex and Skymaster made available resources to get those things fixed as they arose. When it was put to him that the internal combustion engine, while quite reliable was not perfect, he responded: *especially in Avtex, that's right, yes.* As is apparent, the number of engine problems experienced on Avtex and Skymaster operated aircraft is also a recurring theme.
231. Mr Langmead suggested to Mr O'Keefe that when he found the bald spot in the tyre and he told his chief pilot who supported him, the tyre was fixed. Mr O'Keefe said that was not quite what happened. He said that he brought the problem to the attention of the chief pilot who told Mr O'Keefe to write it up in the maintenance release, which he did. The fact that Mr O'Keefe did not immediately write the defect up in the maintenance release when he noticed it, apparently because of the pressure exerted by the engineer, illustrates that pressure, such as that experienced by Mr O'Keefe on this occasion, can dissuade a pilot from endorsing the maintenance release with a defect as is required by CAR 50.
232. Mr O'Keefe agreed that there was a company expectation that defects would be endorsed on the maintenance release. When it was put to him that there was a culture in the company that if a defect was found it had to be put in the maintenance release, while Mr O'Keefe initially responded that's right, yes, he then said:

> *no, well, that was me. Like, other pilots were a bit worried about putting defects on maintenance releases, because they felt that they would get in trouble and they wouldn't get – they wouldn't get work.*

Nevertheless, Mr O'Keefe agreed that he was never told not to record defects.

233. Mr Sill is currently a pilot with V Australia flying the Boeing 777 aircraft. He worked for Avtex and Skymaster between January 2008 and September 2009. Mr Sill said that when he first started flying operations with Avtex in 2008, if a pilot experienced a defect, it was not clear who should be contacted. Pilots would generally call operations who would tell the pilots to call the engineers. He said that if he had an engineering related matter, he was inclined to call engineering and speak directly to the engineers because he was concerned that operations could persuade him to take a different course of action. He said that to avoid this, he would write up a defect on the maintenance release first, and then speak with somebody from the company. He would explain that he had already grounded the aircraft because it was unserviceable and by that means he said he would not get himself into a situation where he might be persuaded otherwise.

234. Mr Sill was asked if he formed an opinion at the conclusion of his period of 20 months working for Avtex and Skymaster about their operations. He said:

> *In my last six months working there, I really decreased my working there because I didn't enjoy working there at all. I lost faith in the aircraft, the safety of the aircraft, after having numerous incidents. I lost faith in the aircraft, I was weary of management decisions and operational decisions and all I wanted to do was to get outside of Avtex and leave and – yes, and I felt that the company was poor and I was disappointed in the company that they operated in this way. I thought a company that had been operating for so long would have a lot more procedures and a higher safety culture than I witnessed when I was there and I determined that the only reason that, you know, we operate safely is the pilots are working to their own standards, their, you know, - the pilots are the ones saying no in every situation, determining the rules and regulations which is part of their role too but they are having an influence on the company and they can easily be swayed and, you know, pilots can make wrong decisions through pressure. So I wanted to leave and go and work in an airline where I knew they had better procedures and it wasn't really – my risk level in life was decreased.*

235. Mr Quinn asked Mr Sill in cross-examination about his refusal to talk with Avtex's representatives prior to this hearing. Mr Sill agreed that he had been contacted by CASA who told him that if Avtex made any attempt to contact him and he felt threatened, he should contact CASA. Mr Sill also said that he had received an email from Mr Donoghue saying that he, Mr Sill, had spoken to CASA and maybe they had taken it (his statement) out of context. Mr Sill told him he did not think that was the case. He said he chose to speak with CASA and he did so after receiving a summons.
236. In re-examination Mr Sill explained that he was told by Mr Rule of CASA that it was his legal right to speak with anyone he wanted to. He was told if he wanted to, he could speak with Avtex's lawyers. He chose not to do so.
237. Mr Bradley is now a pilot with the RFDS in Western Australia. He was employed by Avtex and Skymaster between August 2007 and February 2009. He made an affidavit dated 23 August 2010 which was admitted into evidence. In that affidavit, he referred to the affidavit of Mr Du Bois, which was withdrawn in the course of this hearing. In that affidavit, Mr Du Bois said that Mr Bradley told him he had witnessed Mr Donoghue and Mr Myles chastise pilots for writing up defects on company aircraft. In his affidavit of 23 August 2010, Mr Bradley testified that neither Mr Donoghue nor Mr Myles chastised any pilot, including himself, for writing up defects. In fact, he went further and stated that at no stage during his employment with Avtex did he ever witness Mr Donoghue or Mr Myles applying pressure or duress to pilots to perform duties.
238. In his examination-in-chief Mr Bradley was asked whether he had any flight incidents where he needed to clarify whether the problem was a defect. He said:

> *The – well, during my time there, if something was broken it basically got written up, irrespective. I can categorically to yourself and to that of the Court that Mr Myles and Mr Donoghue, at no stage, ever pressurised – or pressured anybody into carrying defects or, you know, chastising them for writing up defects.*

While he agreed that at times he discussed procedural problems with engineers, he nevertheless insisted that he would write up the defect, giving a description of the events as he observed them.

239. Mr Bongiorno is now a pilot with Air Freight Solutions, flying Chieftains and Airvans. He joined Avtex in April 2008. Mr Bongiorno recalled an incident where the auto pilot failed just prior to landing in Tamworth. He contacted Mr Lynch at engineering and told him the auto pilot was not functioning. Mr Lynch asked him to fly the aircraft back to Bankstown that night. Mr Bongiorno said he told Mr Lynch that he could not fly the aircraft back with a non functioning auto pilot unless Mr Hanley cleared that flight. He said Mr Hanley arranged for a second pilot from Tamworth to fly back to Sydney and

Bankstown, the second pilot being required where the auto pilot was not functioning.

240. Mr Bongiorno confirmed that the process of recording a defect was that pilots should speak to somebody first to see if the problem could be resolved. The first person to speak to was the engineer. Mr Bongiorno said that this was not a direction or a written instruction, just his understanding of how the system worked. Mr Bongiorno also confirmed that Mr Hanley expressed the view that he should be contacted first if anything went wrong, either with the aircraft or with the operation.

241. I have already referred to the incident Mr Bongiorno experienced on a flight to Griffith and Mildura where he had a cross-feed problem. I asked Mr Bongiorno why he made the decision to continue the flight to Griffith when he had already commenced a diversion to Temora. He said that he was speaking with other pilots who were on the same tour by radio and it seems he was influenced by their suggestion that Griffith was a better place to stop because it was scheduled and access to maintenance would have been better. I then asked Mr Bongiorno about the discussions he had with Mr Lynch after he landed at Griffith. When I asked him about the purpose of the discussions, he said it was to identify the problem. Mr Bongiorno suggested that in hindsight, he made a bad decision. When questioned further about the process, Mr Bongiorno suggested that is what the pilots did. If they didn't know what the problem was, he suggested it was hard to *write it up*. He said he thought that was the procedure. With the benefit of hindsight, he did not think that was the correct procedure.

242. Mr Harvey in re-examination asked Mr Bongiorno whether, when he spoke with the engineers, they offered to come to Griffith to fix his fuel problem. He said they did not. Rather, he said that they gave him *some tips* and let him go and experiment to see if it worked out or not.

243. Mr Sonter is now a pilot flying for Network Aviation. He joined Avtex in 2007 and flew for Avtex and Skymaster, leaving in September 2009.

244. Mr Sonter was asked if he was aware of any system within Avtex or Skymaster for the recording of defects on maintenance releases. He said that the only one that he was aware of was the one he was taught when learning to fly, which was, if there was a maintenance problem, write it up. He said he was never told not to record defects on a maintenance release. However, he recounted one incident where he had written a defect in the maintenance release grounding the aircraft. He then called Mr O'Brien from operations and notified him of that, which he said was the normal procedure. He said Mr O'Brien was upset that he had grounded the aircraft because he thought it made his job harder to find an aircraft for the next day's flying. He said: *He did let out a bit of a sigh and – as if I made his job harder, . . .*

245. Mr Latchman is currently a pilot working for CareFlight New South Wales. Mr Latchman joined Avtex in 2007 as a permanent pilot based in Dubbo. He left the organisation in 2009.

246. Mr Latchman said he had an incident with an engine which would not start. He had flown to Bathurst and all was normal. After loading the patient, he attempted to start the right engine but it would not start. He tried for about an hour to get it started but could not. He then rang operations to inform them of the problem and he also discussed the matter with Mr Hanley and Mr Lynch. He said that Mr Lynch told him that the magneto just *overheats a bit.* He told Mr Latchman to have a look under the cowl and identify a red wire. He said if the red wire was disconnected, the engine would start and he could get going and at least get the aircraft back to Bankstown. Mr Latchman said he refused to do what Mr Lynch asked as it was not part of his duties. He did not know what the consequences would be if he disconnected the wire, especially given that he had to fly over the Blue Mountains that night.

247. On another flight to Cobar, he said that the engines started but at idle, the right hand engine manifold pressure was high. He did a run up and found that the right engine was not developing full power. He said he contacted operations and was told *can you just take it up for a couple of seconds and see if you can get it flying*. Mr Latchman refused to do that and he spoke with the engineers and Mr Hanley. He decided to overnight at Cobar and the following day engineers came out to fix the problem. When Mr Latchman was asked whether there was a practice of trying to bring the aircraft back to Bankstown if it required maintenance, he said:

> *It was just in passing comment. You know, you're told always to try and see if you can get it back to Bankstown where we can fix it, that's where we have got the engineers. So if there's a minor issue, just write it up or say that it happened on the way back to Bankstown. It might not necessarily have happened that was just a passing comment that was said that yes you know, just ag (snag) it on your way back to Bankstown, so when you land, we can fix it.*

248. Mr Latchman said it was a passing comment made by Mr Lynch. Although Mr Langmead objected to this evidence on the basis that he had not had prior notice of it, Mr Latchman was in fact responding to a summons to give evidence. Nevertheless, because this matter was brought on for hearing with some urgency, and it was likely that evidence would be adduced which had not been the subject of a proof taken by one of the solicitors, I had in any event directed that the substance of evidence, if known to a party, should be disclosed to the other side. However, Mr Harvey said that he had spoken with Mr Latchman two nights prior to him giving evidence and there was nothing which was stopping Avtex's legal representatives from contacting him. I agreed to stand the matter down while Mr Langmead obtained further instructions. In the course of the break, Mr Harvey identified that a file note taken by, I believe, Mr Du Bois, which was included in the s 37 documents, referred to operations personnel placing pressure on Mr Latchman to fly with defects. I therefore permitted the examination of Mr Latchman to continue.
249. In cross-examination, Mr Latchman agreed that he had never had pressure exerted on him by Mr Hanley or Mr Siewert to omit writing up defects.
250. There were two further statements provided by pilots, Mr Thomas Hall and Mr Callegaro, but these persons were not called to be cross-examined. I understand these pilots were current pilots used by Skymaster at the time its AOC was cancelled. Mr Hall said he was never pressured into avoiding entering defects on aircraft maintenance releases or to defer entering defects on maintenance releases. He said that Mr Hanley was always adamant that defects were to be written in the maintenance release at the time they were discovered.
251. Mr Callegaro said in his statement that he always entered defects found on the aircraft in the maintenance release when they were found. He said in his experience, the maintenance organisation and the chief pilot always *backed me up in doing so*. That statement also repeats the fact that Mr Hanley was adamant that defects should always be entered on the maintenance release at the time (presumably of discovery).
252. Mr Henry Gorman also provided an affidavit dated 12 September 2010 but he was not called for cross-examination. I also understood Mr Gorman was a pilot working for Skymaster at the time of cancellation of its AOC. Mr Gorman said that the company had a culture, driven primarily by Mr Hanley, to enter all defects on maintenance releases as soon as possible after they were discovered. Mr Gorman also testified that he called engineering on occasions for the purpose of letting engineers know of the defect thus ensuring it was attended to in a timely fashion. With respect to Mr Gorman, and mindful of the fact that he was not cross-examined, that statement is curious indeed. Logically, the grounding of the aircraft would cease its operation while it was away from home base. Therefore, operations would have been notified immediately and a decision then made to either send a maintenance engineer to the aircraft to repair it; have an engineer at the location repair the aircraft; or substitute another aircraft to complete the operation.

FLYING IN ADVERSE WEATHER CONDITIONS – ICING AND THUNDERSTORMS

253. Flight into known or expected icing conditions in an aircraft which is not equipped with de-icing or anti-icing equipment is not permitted. In fact, CAR 238 provides:
238. ***Icing conditions***

> *(1) The pilot in command of an aircraft must not allow the aircraft to take off for a flight during which the aircraft may fly into known or expected icing conditions, if the aircraft is not adequately equipped with either de-icing or anti-icing equipment of the type and quantities directed by CASA.*
> *Penalty: 25 penalty units.*
> *(2) An offence against subregulation (1) is an offence of strict liability.*
> *Note For strict liability, see section 6.1 of the Criminal Code.*

254. The reference to expected icing conditions in CAR 238 is a reference to forecast icing conditions. Icing conditions will be known if aircraft have reported experiencing icing at particular flight levels in particular areas. Therefore, as I understand CAR 238, the pilot in command must not take off for a flight where that flight's track may result in flight into an area where icing has been reported or where

it has been forecast, if the aircraft is not equipped with either de-icing or anti-icing equipment. The build up of ice on an aircraft can be rapid and it affects the performance of propellers and the airframe to such an extent that it may result in severe degradation of aircraft performance and a dangerous situation could arise where altitude cannot be maintained.

255. Issues regarding flying into icing conditions seem to have arisen in about August 2008 when three pilots, Mr Sill, Mr Sonter and Mr Kristian Kauter, refused to take-off from Bourke due to forecast icing conditions. In his affidavit of 5 October 2010, Mr Hanley said he spent a great deal of time on the telephone to those pilots explaining that the *precursors to icing* are visible moisture (clouds) at or below freezing temperature (at particular flight levels). According to Mr Hanley, Mr Sill agreed with him that those conditions did not exist as far as could be seen at Bourke and he was confident the conditions were safe. However, Mr Sill did not want to disagree with the other two pilots. He said that eventually Mr Sonter and Mr Kauter realised there was a band of several thousand feet in which they could safely operate. He said he explained to those pilots methods of avoiding icing conditions in case the weather conditions deteriorated.

256. Mr Hanley said he was acutely aware of that date because another experienced pilot, Mr Michael Brett, together with himself, had a trip into the same region. He said the conditions were good and he could not understand how the actual conditions or the forecast would have prevented any pilot from flying on the grounds that they might encounter ice. Mr Hanley said he realised he needed to educate particular inexperienced pilots in the company about icing. He therefore asked one of the senior pilots, Mr Brown, to arrange a pilots meeting which was held on Sunday 26 October 2008.

257. Mr Hanley said that at the meeting, he discovered that pilots had a limited knowledge of icing conditions and in order to improve their knowledge, he organised several meetings between experienced and inexperienced pilots to prepare standard operating procedures on problem routes.

258. Mr Siewert also attended the 10 August 2008 meeting. His affidavit of 4 September 2010 simply repeats what Mr Hanley said in his affidavit. Mr Siewert also said that by the following year when icing again became prevalent, he had arranged for the aircraft allocated to those routes where icing conditions were commonly encountered, to be fitted with anti-icing equipment.

259. In his oral evidence, Mr Hanley said that as a result of the pilots' meeting on 26 October 2008, he produced a document called *Pilot Briefing Notes for the Cooma – Bankstown Run.* In that document, Mr Hanley suggested the following options:
    - (a) plan to fly above the cloud layer if the forecast indicates this is an option in terms of being able to safely and legally climb and descend; or
    - (b) plan VFR along the highway via Goulburn, if the cloud base indicates that this is sensible.

260. These options were qualified by Mr Hanley stating that there was always an escape route, by turning back or diverting to an alternate airfield. Mr Hanley also added a final paragraph indicating that if in doubt, the best way to proceed was to phone him to discuss the issue. He also suggested pilots should recognise their personal limitations (presumably based on experience). Mr Hanley said those procedures where reinforced at every pilot induction. He said after the publication of his briefing note, the pilots settled down although the briefing notes seemed to work more often with new pilots and less often as pilots became more experienced in the company. Mr Hanley suggested that less experienced pilots did not properly analyse or see the availability of opportunities to analyse the forecast in order to identify the extent of any restriction which it might impose. He also said that once all of this was explained, the pilots slowly seemed to accept his suggestions.

261. In cross-examination, Mr Hanley agreed that one of the alternatives to flying at levels where icing might have been forecast was to fly VFR. Mr Hanley said that was another opportunity to stay out of icing conditions. He denied that the pilots queried why they should fly VFR when they were IFR rated. Mr Hanley denied that saving money as a result of lower navigation fees was one of the motivators for suggesting VFR flight.

262. In cross-examination Mr Siewert acknowledged that he was present at the pilots meeting of 26 October 2008. He was referred to a statement made by a pilot, Mr Rajesh Sabapathy, regarding flying in icing conditions. He was asked whether he observed Mr Hanley ridiculing Mr Sabapathy and he answered no. Mr Siewert also denied that he expressed the opinion that pilots should get airborne, have a look to see what the extent of the icing was and, if the icing became too bad, to return to Bankstown. Mr Siewert was then asked what was discussed and he said:

Look outside the box; are there other options available? For instance, flying below the icing level. And I think the suggestion was made that if the conditions are deteriorating and you get into icing, you can always turn back, because you know the area you came from had no icing condition.

Mr Siewert said that the approach he suggested was *totally legal*. Mr Siewert explained that what he was attempting to convey was that if icing was forecast, it did not mean that pilots could not take off. Mr Siewert recalled Mr Bradley going onto a computer in the pilots' room and printing out CAR 238 dealing with flying into icing conditions, which he quoted from. Mr Bradley had indicated that Mr Siewert was not impressed. When asked about this, Mr Siewert simply said he didn't argue about regulations.

263. Mr Sill said he was present at the meeting of 26 October 2008 and that flying into icing conditions was discussed. Mr Sill recalled Mr Bradley printing out a copy of CAR 238 dealing with flying in icing conditions and he read it out to the persons present at that meeting. He said that Mr Hanley and Mr Siewert did not respond to the regulation but simply said that: *You can go and have a look. You can replan ...* . Mr Sill said although it was possible to replan, he was of the view that the rule insisted a pilot cannot take off into known or forecast icing conditions. He recalled Mr Hanley suggesting that the pilots could fly at a lower altitude for the route, and he agreed with that. Nevertheless, although Mr Sill said he could not remember the details of the discussion, he recalled that Mr Hanley had what he described as an apathy to the regulation.
264. Mr O'Keefe was referred to flying in icing conditions and he was asked if he understood the company expectation regarding flights into such conditions. Mr O'Keefe said that the company expectation was to leave the onus on the pilot to make the decision with respect to safety and adhering to the rules, but he said that in his opinion there was underlying threat to try and do the job, to try and get the job completed no matter what. When asked how that threat manifested itself, Mr O'Keefe said:

If I – I sometimes had issues with weather and I would call up operations or the chief pilot and in my opinion the company, you know, always said to me, Oh, try and – you know, go out there and try and do it and if not come back.

265. Mr O'Keefe also gave evidence about flights from Bankstown to Canberra and Cooma. He said there were a few occasions when there were known icing conditions in the area and, after ringing operations and telling them that he couldn't depart Canberra or Cooma because of the icing conditions, he said there was pressure to go down the valley quite low to get underneath the cloud. He said in his opinion that wasn't safe so he decided not to do it, although the pressure to do it was there. He did not attend the meeting of pilots on 26 October 2008.
266. Mr O'Keefe said that he did help Mr Hanley produce a document which looked at alternative routes for the fight from Bankstown to Canberra to try and achieve a lower safe altitude. He looked at calculating a lower safe altitude using different methods and different routing options. He suggested the difference was a couple of hundred feet. He said although he assisted Mr Hanley to produce the document, he did not think it was used by any of the pilots. He said they made their own decisions on the day. He agreed that pilots were not instructed to fly in accordance with Mr Hanley's document regarding flying in icing conditions.
267. Mr Bradley said he was present at the 26 October 2008 pilots' meeting. He said approximately 10 pilots attended the meeting. The meeting concerned a particular pilot, Mr Sabapathy, as a result of him refusing to fly in icing conditions. Mr Bradley said that the aircraft allocated to any particular task was the responsibility of Mr O'Brien, who headed up the operations group. Mr Bradley said that Mr Hanley explained to the pilot group that they should be looking at the commercial aspects of trying to get the job done. He said, in particular, the pilots should go out and have a look at the weather. He then said:

Pretty much if we are picking up too much ice, turn around and come back. Despite the fact that, you know, the aircraft wasn't equipped to be in that position in the first place.

268. Mr Bradley was asked if he had concern about *just going up and having a look and seeing if there was any icing accretion on the airframe.* Mr Bradley replied *absolutely.* He said that the idea put forward by Mr Hanley was that quite often the weather forecast was inaccurate and usually overly conservative when forecasting the extent of icing. He said the fact that he brought to Mr Hanley's attention CAR 238 was unwelcome and that it met with an uncomfortable silence at the time. He described Mr Hanley's and Mr Siewert's response as *not impressed.* In his opinion, Mr Hanley and Mr Siewert were not impressed about the fact that he challenged the statement that they should go and have a look. He said that Mr Hanley did most of the talking and in his opinion, Mr Hanley was trying to impress Mr Siewert. He kept talking over the top of Mr Bradley while he was trying to discuss the regulation and how it affected the statement he had made about *going to have a look.* Mr Bradley said that the voices became louder and louder and reached a point where he said he had had enough and he walked out of the meeting. Mr Bradley said he didn't discuss the issue of flying into icing conditions with Mr Hanley subsequently. He reached the conclusion that if one disagreed with Mr Hanley, there was no point in discussing anything with him. He deemed Mr Hanley to be unapproachable on matters where he was in disagreement.
269. Mr Bradley confirmed that Mr Siewert said very little at the meeting. Mr Bradley said Mr Siewert spoke about the times when he was flying in the 1970s but he did not indicate that he was directing the pilot group about what should or what should not happen. He said that all came from Mr Hanley. According to Mr Bradley, Mr Siewert recounted his flying time in the Kimberley region in the 1970s and that the pilots then had a different mindset, basically to get the job done. When it was put to Mr Bradley that his criticism of Mr Hanley was that although he professed at times to be doing things by the book, his suggestions about *go up and have a look* were not by the book, Mr Bradley agreed. He said that Mr Hanley professed one thing but then would tell you something else which was totally contradictory.
270. In cross-examination, Mr Langmead referred Mr Bradley to the memo Mr Hanley had produced regarding flying on the Bankstown – Canberra – Cooma run. Mr Bradley confirmed that he could not recall having seen the document but believed he would have.
271. Mr Langmead put to Mr Bradley that the fact that icing was known or forecast did not necessarily preclude the flight of an aircraft which did not have anti-icing equipment. Mr Bradley did not disagree with that. When Mr Langmead, referring to Mr Hanley's memo, read to him that a pilot could either plan to fly above the cloud layer if the forecast indicated that this is an option in terms of being able to safely and legally climb and descend, Mr Bradley explained that if you have a freezing level, at some stage you have to climb through it and you have to descend through it on the way down. He said the problem with that option was you didn't know what the weather would be like at the destination. You could get stuck on top of the freezing level and then you had to descend through the icing band because there was no other option. Although Mr Langmead suggested that was the reason not to take the fly on top option, Mr Bradley said that the option was simply untenable because the pilot did not know whether he could descend without flying into icing.
272. Mr Langmead then suggested that the alternative was to plan VFR at a lower altitude, staying below cloud and below the icing level. Mr Bradley pointed out that there was a requirement to remain 500 feet above terrain. There was no lowest safe altitude involved when flying under the VFR. He said the problem with this option was that he was unfamiliar with the terrain because he didn't operate at low altitude during the summer months and without experience at those low altitudes, he would not put himself in that position. However, Mr Langmead suggested that Mr Hanley had encouraged pilots to fly the lower routes in summer to become familiar with the terrain. Mr Bradley simply indicated he refused to do that.
273. Mr Langmead then directed Mr Bradley to CAR 238 and his statement that *you cannot even take off if there is known or forecast icing conditions which the aircraft is not approved to be operated in.* Mr Langmead pointed out that the CAR referred to not allowing the aircraft to take off for a flight during which the aircraft may fly into known or expected icing conditions. Mr Bradley insisted that those were the conditions that presented themselves on the day that Mr Sabapathy refused to operate. He also said that Mr Sabapathy was chastised by Mr Hanley for making the decision, both at the meeting and prior to that. When asked how he knew about the chastisement prior to the meeting, he said that Mr Sabapathy had told him so. Mr Bradley acknowledged that he had no knowledge of the weather conditions in which Mr Sabapathy refused to fly out of Bourke.

274. Mr Bradley was then taken to the final paragraph of Mr Hanley's memo and asked whether that was sound advice. Mr Bradley responded: *On the surface, it is.* He said it was like treating the pilots as if they had no idea how to conduct their operation. He also referred to Mr Hanley's statement that the pilot might agree that someone else should fly instead and said: *Now, look, if you can't do the job, why would anyone else be able to do it legally?* He said he took that to be an insult. In cross-examination, Mr Bradley agreed that his main complaint about flying into icing conditions was with Mr Hanley, who was the chief pilot of Skymaster at that time. His relationship with Mr Myles and Mr Donoghue was quite different. Although Mr Bradley also made statements about the safety culture of Avtex, the basis for that opinion was not clear nor was Mr Bradley's expertise in offering that opinion. I do not place much weight on that.
275. Mr Sonter also gave evidence that he was at the pilots' meeting on 26 October 2008. He said the meeting lasted almost three hours. He left the meeting with very low moral, feeling that the company was not looking after the best interests of its staff and in particular the pilots. He recalled Mr Siewert and Mr Hanley being at the meeting. He said that the issue of flying in icing conditions was discussed as well as pilot remuneration.
276. Regarding the icing problems which occurred on the Bankstown – Canberra – Cooma run, Mr Sonter said that having regard to lowest safe altitudes (which are quite high due to high terrain on these routes) and icing problems, pilots were regularly grounded at Canberra or at Cooma. This had an effect on the contracts that Avtex had with Toll, the freight company, because the freight was not being delivered. He said from his perspective, there was pressure from Toll on Avtex and that pressure was then placed onto the pilots to get the work completed. He said the discussion involved the possibility of other ways of completing the task, including flying VFR or flying a different route to get to the destination to avoid the higher lowest safe altitudes.
277. Mr Sonter said he recalled discussions about the CAR regarding flight in icing conditions and the fact that pilots must not take off where icing conditions existed. He explained that it was not a case of *take off and have a look* but that pilots could not take off at all. He said he felt, like a few of the other pilots, that they were fighting a losing battle. Mr Sonter recalled that Mr Bradley was vocal at that meeting. He said that he didn't say a word. He agreed that Mr Siewert was at the meeting but was not sure if he was there for the entire meeting. He recalled him being present when icing issues were being discussed. When asked if Mr Siewert said anything, Mr Sonter said a couple of questions from pilots were put to Mr Hanley and it appeared to him that Mr Hanley was upset by those questions. It looked as if he would have preferred to have answered the questions without Mr Siewert being present. I understood that to mean Mr Hanley appeared uncomfortable answering the questions in the presence of Mr Siewert.
278. In re-examination, Mr Harvey asked Mr Sonter whether he considered the view expressed by Mr Hanley at the pilots' meeting regarding icing to be his knowledge of the rules and their application. Mr Sonter said that Mr Hanley attempted to push his opinion regarding icing, although he and Mr Bradley disagreed. He said that Mr Bradley spoke for the other pilots and he recognised that other pilots were uncomfortable with what was being said. Mr Sonter did not believe that Mr Hanley's knowledge of the rules was superior to anybody else at the meeting.
279. The issue of flying aircraft not equipped with anti-icing equipment when icing conditions were known to exist or were forecast to exist raises difficult problems from a pilot's perspective. While I have no doubt that Mr Hanley was not simply expressing his views, but also the views of Mr Siewert because clearly his imperative was to find alternative ways of completing the task, it should have been apparent to Mr Hanley and Mr Siewert that ultimately the decision should be made by pilots without interference from either of them. What the pilots were doing was not unsafe and in fact, even if they had erred on the safe side, it should not have been the cause for complaint or admonishment if that in fact occurred.
280. I am disturbed by the expression Mr Hanley is said to have used, not only on this occasion, but in relation to flying in the vicinity of thunderstorms, that the pilot should *go and have a look.* As far as icing is concerned, you cannot see icing until you begin to observe its accretion on the airframe. In other words, it has nothing to do with *looking* but rather going up to test the environment to see whether in fact icing conditions do exist where they may have been forecast. That is unacceptable from a safety perspective and it is in breach of CAR 238. The suggestion that the pilots should attempt to fly above cloud thereby avoiding the icing conditions is also an unsafe procedure. As Mr Bradley pointed

out, one needs to subsequently descend and, if the forecast conditions include cloud and freezing levels at lower altitudes, it is almost certain that an aircraft will experience icing on descent. Furthermore, weather forecasts describe the extent of cloud cover in Octas. Therefore, if the weather forecast indicates 8/8 cloud cover at or towards the destination aerodrome, there is absolutely no purpose in planning at a higher altitude. As to flying at low level beneath the cloud cover and under the VFR, that also has increased hazards.

281. To begin with, aircraft flying under the VFR are required to keep a lookout to remain separated from other aircraft. They do not have the benefit of radar separation. There is also a problem with low and descending cloud over hilly terrain. The base level of clouds can alter significantly and over a very short space of time. The distance from cloud in these conditions can be deceptive. Aviation safety reports are replete with incidents of pilots flying into hills after they had inadvertently entered into cloud at low level. One also needs to ensure that there is sufficient room to turn through 180 degrees should that become necessary. However, it is also possible for the return path to become blocked by descending cloud at lower levels, thus prohibiting an escape route. Finally, visual navigation at 500 feet is a skill which needs to be learned and regularly practised. The pilot's field of view is substantially decreased and map reading at that altitude can be quite difficult. This is something of which I have had personal experience as an instructor pilot teaching trainee pilots to navigate at low level. Without experience, those pilots easily become disorientated and uncertain of their position.

282. Mr Gorman, in his affidavit of 12 September 2010 said that he conducted freight flights from Canberra to Cooma during winter when there was often icing forecast. He said he was never pressured by the management of Skymaster or Avtex to conduct or continue those flights when the aircraft would enter forecast or known icing conditions. However, as is evident from that statement, it discloses a misunderstanding of CAR 238. The prohibition relates to flights which may enter forecast or known icing conditions. Mr Hall in his statement of 10 September 2010 states that Mr Hanley instructed him not to fly into known or forecast icing conditions and that if that occurred inadvertently, he should immediately descend to the lowest safe altitude in the area or do a 180 degree turn to exit the icing conditions. He said that no one in the management of either Avtex or Skymaster encouraged him to fly into known or forecast icing conditions in aircraft that were not equipped for those operations, nor was he chastised for not doing so. Mr Christiaan Mulder, in his statement of 10 September 2010, also said he was never forced to fly into icing conditions whether known or forecast, nor was he chastised for not doing so. However none of those pilots explained their understanding of CAR 238 and whether the memo prepared by Mr Hanley assisted them in operations which may involve icing conditions.

283. A number of pilots also described operations in the vicinity of thunderstorms and the company expectations when such weather conditions existed. In his evidence-in-chief, Mr O'Keefe gave an example. He had landed at Wagga one night and there was a line of thunderstorm cells coming from the west and heading east. These cells were not going to pass for the next hour or two. He said this happened at 11.00pm. He had been on duty for about 12 hours at that time and in his opinion, it was too dangerous to leave Wagga for Bankstown. The aircraft was not equipped with weather radar or anti-icing systems. Mr O'Keefe said he rang Mr Hanley and expressed his concerns and he also expressed those concerns to operations. He thought it was best to stay overnight in Wagga to let the thunderstorms pass. In any event, he was feeling tired. He said that Mr Hanley said to him: *Go out and have a look and if it doesn't look good you can always come back.* He said that was the kind of pressure he faced. Mr O'Keefe also said he was tired because the weather had been coming in all day and he had already conducted about seven instrument approaches. He knew he was fatigued because he was missing a few items when going through checks but he picked them up on the check list.

284. Mr O'Keefe said he took off and tried to go north to track around the thunderstorms. By that time the thunderstorms were about 10 miles east of the airfield. Shortly after takeoff, he experienced lightning *right in front of my face.* Mr O'Keefe deemed it not to be safe and returned to Wagga. He said he did not have a lightning strike although he had lightning directly in front of him. He said there were no adverse consequences as a result of his actions on that night and he was not criticised for returning to Wagga. However, he described the nature of the pressure he felt was being placed upon him to try and return to Bankstown. He said:

> *Like, you ring up operations and they huff and they puff and they say," Oh, gees, you know, try and come back." And then I will ring up the chief pilot and I'd say*

"the weather is no good." And he would say, "Well, why don't you go up towards the north." And I knew – I pretty much knew 95% that it wasn't – it wasn't a viable option, however, I did try and track to the north and get around it and eventually I came back.

When Mr Langmead suggested to Mr O'Keefe that the aircraft was never at risk, Mr O'Keefe agreed. However, the fact that Mr O'Keefe experienced lightning directly in front of him which caused him to turn back to Wagga does not sit comfortably with that answer. Having experienced a lightning strike while airborne, I am able to say that it can cause considerable damage to an aircraft, particularly to the avionic and electrical systems. That would be extremely undesirable on a dark night with weather close by. Mr O'Keefe also explained that lightning, although occurring within a thunderstorm, can go from air to ground or air to air. He understood that a minimum clearance around a thunderstorm should be 10 nautical miles at bare minimum. There is often severe turbulence associated with and in the vicinity of thunderstorms. This creates additional hazards. Nevertheless, Mr Langmead suggested to Mr O'Keefe that he was *having a bit of a whinge.* Understandably, Mr O'Keefe disagreed. Mr O'Keefe said that there was always pressure to try and get the job done.

285. Mr Bongiorno also described an incident which involved thunderstorms. He said that he had flown from Coffs Harbour to Lismore and had to track a few miles left of his planned track to get around fairly severe thunderstorms. He said he was down to around 500 feet AGL and he was experiencing *fairly serious weather.* He just managed to get into Lismore and dropped a patient off. He then contacted operations and said there were thunderstorms around, that he would assess the weather in the next hour or two to see whether he could get back but he would not be going anywhere at that time. After a couple of hours, he saw a line of thunderstorms which were constantly building and dissipating along the coast through to inland for a few hundred miles. He told operations that he would not be returning but that he was going to have some dinner and then re-assess the situation. He did not speak with Mr Hanley at that stage. He said he returned to Bankstown the following day.
286. When he returned to Bankstown he had a brief conversation with Mr Hanley in the pilots' room. Mr Hanley asked him where he had been and he explained his overnight stay in Lismore. He said Mr Hanley then left and he continued completing the paperwork for the trip. Mr Hanley came back shortly thereafter, sat directly opposite him and asked why he had not contacted him when he was on the ground in Lismore. Mr Bongiorno said he told Mr Hanley that he was surrounded by thunderstorms and that he had made a command decision. He said Mr Hanley became aggressive and very angry. Mr Hanley said: *I get paid to make these decisions. You should have contacted me and I could have made the decision for you, ...* Mr Bongiorno said Mr Hanley became very abusive, pointing his finger at him and he said: *Its pilots like you that make Dieter want me to go out and get fucking pilots that will fly through weather.*
287. Mr Bongiorno also said that flying when weather conditions were unsuitable, particularly icing conditions, was talked about by the pilots and often discussed. In particular, they discussed what was meant by the phrase *go up and have a look* which was frequently used by Mr Hanley. When asked what he understood by the phrase, Mr Bongiorno said that his understanding was: *no matter what the conditions were you should get airborne with a view to successfully completing your flight.* He also explained that he was uncertain as to how one would actually *have a look,* because once in bad weather or in conditions where you can't see, you are there and stuck, so he didn't agree with the proposition that he should *go up and have a look.* When Mr Bongiorno was asked whether, if there were thunderstorms overhead and around the airfield, the pilot could go up and have a look, he explained that the company operations manual clearly stated that a pilot shall not depart an airport in the vicinity of thunderstorms.
288. Mr Sonter, in his evidence-in-chief said that he had many discussions, including some fairly heated ones, with Mr Hanley about thunderstorms. He said, relying on his experience, he was determined to stand his ground and he would not take off with thunderstorms in the vicinity of an aerodrome. Despite that, Mr Sonter said Mr Hanley's belief was you should be able to take off and have a look and then, if necessary, return. Mr Sonter said that even if you did that, you had about one hour's fuel to burn before being able to get back to maximum landing weight. While Mr Quinn objected to this evidence because it had not been put to Mr Hanley, I allowed the questioning to continue on the basis that Mr Hanley

could be recalled if he believed that was necessary.

289. Mr Sonter also said that in the course of the particular conversation with Mr Hanley regarding thunderstorms, which he had by telephone, there was a blackout at the airfield which he was at and he used that as an excuse for not taking off, as he feared for his employment.

290. Mr Latchman also recounted an incident when there was a thunderstorm over Dubbo and he contacted Mr Hanley telling him that he did not have weather radar in the aircraft and that he wasn't prepared to take off in that weather. He said that when he arrived at the airport, lightning was striking the runway. Some Regional Express aircraft had been diverted to Orange and he expressed his concern to Mr Hanley about flying. When asked about Mr Hanley's response, Mr Latchman said he was told to go out there and see what he can do. He was told to take off towards the north and have a look and see whether the thunderstorm would affect his flight path. According to Mr Latchman, Mr Hanley asked him how he knew it was a thunderstorm. He explained to Mr Hanley that he was looking outside at the time and lightning was striking the runway. Mr Latchman believed that Mr Hanley understood he was looking at a weather radar on a computer screen and that's why he raised the question. He said that the cloud base at the time over Dubbo was around 600 feet with a visibility of about 1000 metres.

291. Mr Latchman also had discussions with Mr Siewert about flying in adverse weather. He said that Mr Siewert told him: *back in the days we never used to have weather radar so, you know, why are you making the weather a bit of an issue. That, you know, we used to fly without radar or anything like that, so why can't you go?* Mr Latchman responded by saying that was fine when Mr Siewert was flying but he was not prepared to put a nurse and patient in those kinds of conditions and he was not prepared to go.

292. In cross-examination it was put to Mr Latchman that Mr Hanley was respecting his authority as pilot in command and that he didn't feel the need to file an incident report, make a complaint or ring CASA. Mr Latchman said that he did tell the chief pilot and he also told the safety manager of the company. However, by that time, he said he had been threatened with losing his job as a result of a previous incident, which I have referred to below, and he didn't know if he was going to get a call on the following day. When it was put to Mr Latchman that nothing in fact happened regarding his employment, he agreed, and said that it was as if nothing had happened. Mr Harvey, in re-examination, referred to Mr Latchman's evidence that Mr Hanley was a stickler for the rules. He asked Mr Latchman how that was consistent with his request to take off and see which way the thunderstorm was going and how it was developing. Mr Latchman agreed that was not consistent but he described Mr Hanley as having a practical approach. As chief pilot, he needed to get the job done safely and he took a practical approach when trying to get the job done, as long as rules were not broken.

FATIGUE

293. The FRMS was developed following trials in late 2001. It was designed to replace the existing requirements dealing with flight and duty times set out in CAO 48. Since then, organisations approved to operate under the FRMS are granted an exemption from compliance with CAO 48. An exemption is only granted if CASA is satisfied that the organisation is operationally capable of working at an equivalent level of safety to CAO 48. Generally speaking, it is the duty of a flight crew member and an operator not to permit a flight crew member to operate an aircraft unless the flight crew member is free from any fatigue, illness, injury, medication or drug which could impair the safe exercise of his or her licence privileges.

294. Mr Hanley was asked about the FRMS. He said he had no direct experience with that system although it had been in development for many years in other companies. He did not have any particular training on how to develop and use the FRMS. He made enquiries of CASA and was told that the company had to provide its own in-house training. He inherited the system as it was in place prior to his appointment as the chief pilot of Skymaster. In effect, the FRMS allowed Skymaster to manage its pilots' levels of fatigue. Mr Hanley said that all of the pilots who joined Skymaster were given one ground school session on the FRMS. He referred to pilots who were previously flying for Avtex and who, in 2008, commenced flying with Skymaster. Mr Hanley said he understood his role in fatigue management was total supervision on a day to day basis and to provide monthly reports. He also monitored pilots' understanding of fatigue limitations and that they had the necessary information for preparing their FAID scores. Mr Hanley said that the FAID scores or the peak fatigue scores were examined and

considered before rostering a pilot. He also said that fatigue risk management had become an aspect of recurrent training. Mr Hanley was asked whether he utilised other tools for determining if a pilot should be rostered for duty. He said he would check the pilot's demeanour regarding signs of fatigue, his performance, his number of duties over a period of time, his number of days off and all of the factors which can provide relief from fatigue. When asked what he would do if a pilot reported that he was too tired to take on an extra flight or particular flight, he responded *that's it, that's what we're looking for.* He said that if a pilot said that, it had to be accepted. Mr Hanley was then taken to an email which he sent Mr Callegaro on 4 June 2010.

295. Mr Callegaro had what appeared to be an extremely busy evening during which he had to replan his flight on a number of occasions. He needed to refuel a number of times. Because of the bad weather and the fact that he was flying at night in IMC, he conducted three NDB approaches to various aerodromes due to heavy rain and low cloud. In the course of the trip, he arrived at Williamtown and planned to return later that night. He missed a NOTAM indicating Williamtown was going to be closed later that evening. On his way back to Williamtown, air traffic control informed him that Williamtown was closed. He diverted and returned to Bankstown. After completion of the flight he had some dinner on the way home and he got to bed after 2.00am. The following morning, between 10.00am and 11.00am, he received a call from operations asking him to do a flight later that day. He said he was fatigued an unable to work on that day.
296. Mr Hanley said in cross-examination that the persons who tasked pilots were the operational co-ordinators who were employed by Avtex. They were headed up by Mr Ron O'Brien. Mr Hanley agreed that his communications with operations generated interest in the matter and therefore he asked Mr Callegaro for a report.
297. When asked whether he recognised that some issues may have arisen from that report which called for attention by him, he agreed. He said that a report about fatigue, like that provided by Mr Callegaro, should have generated a fatigue occurrence report from the pilot and in fact, he perhaps should have prepared the report. Mr Hanley agreed that the operation's co-ordinator should not have called Mr Callegaro early that morning.
298. Mr Cox, a FOI with CASA, said in his witness statement made on 16 August 2010 that Skymaster's FRMS required a report and an investigation into the circumstances described by Mr Callegaro.
299. Mr Cox also referred to an email Mr Hanley had written to Mr Siewert dated 11 June 2010. Relevantly, Mr Hanley said:

> *Just a note to let you know that for the last few months I have been experiencing a workload that is preventing me from doing my job correctly, and there seems to be no end in sight.*
> *A great deal of my regular required duties keep getting put off while I try to keep up with recruitment, dealing with incidents, and the daily demands required to do my job as the company seemingly does more work, then expects me to do even more line flying to take up the slack.*
> *A breakdown of my flight & duties in just the last 30 days shows 56.7 hours total flight time (includes ICUS), with 34.1 hours of those line flying, in 213.4 hours of duty, with a "two day break" being a rarity. From my experience these hours are unsustainable for a chief pilot in this size company. My statutory duties are suffering.*
> ...
> *Further, my workload at present is causing me to experience the effects of cumulative fatigue, and robbing me of the patience to perform my duties to a high quality and with the diligence required to withstand close scrutiny in the future. In my experience, the excuse "I was just too busy" will not be acceptable if my responsibilities are not carried out.*
> *Therefore to continue like this would be a recipe for disaster.*
> *The solution is for me to make myself unavailable for line flying until further notice. I will still be available for ICUS, and I shall re-assess when I have gotten back in control of my statutory required duties.*

300. After reading this letter, Mr Cox said:

> *I have formed the opinion that the chief pilot's workload is overwhelming him and has been for some time. As such I have formed the additional view that there are an insufficient number of suitably qualified personnel within the organisation to enable safe flight operations as required by CAA s 28(1)(b)(i) and (iii).*

301. Mr Hanley was also asked in cross-examination whether any of the nurses on the medical flights put pressure on pilots to take on additional work. Mr Hanley said no pilot ever came to him saying nurses were putting pressure on them.
302. In his oral evidence, Mr Cox said that in his opinion, Avtex's FRMS which was in place at the time was not functioning properly. It had not kept up with emerging fatigue signs and Avtex had not modified its system accordingly. He noted, by looking at the whiteboard in the chief pilot's office, that every pilot on that board had exceeded the 12 month limit for a recurrency training in the FRMS. He could not find any evidence of internal auditing or checking which was required by the system. Mr Cox was concerned about the fact that Mr Callegaro's incident regarding fatigue was not investigated as was required under the FRMS. He regarded that as a weakness in the system. Mr Cox also pointed to an incident involving a pilot, Mr Messner, where there was a letter of complaint by a customer to the company indicating that Mr Messner was up at 7.00am on a particular day and they arrived back at Bankstown at 11.00pm that day. That, according to Mr Cox, indicated he was entering a high risk area of personal fatigue due to sustained wakefulness. He believed that should have triggered an investigation into the circumstances of that period of duty. There was no evidence of any investigation.
303. Mr Cox was also asked about the letter Mr Hanley wrote to Mr Siewert on 11 June 2010. Mr Cox said: *It seemed to be a – almost a cry for help.* He described Mr Hanley as a person with multiple responsibilities and that he was not achieving his objectives in quite a lot of them. This affirmed Mr Cox's belief that there were insufficient key personnel in the organisation at the time. He said he did not discuss this with Mr Hanley then as he found him quite defensive and *very prickly* when he zeroed in on a problem and debated it with him. He said that Mr Hanley provided responses which attempted to rationalise a number of problems and that he was argumentative. Mr Cox was asked whether Mr Siewert was present on any occasion when Mr Cox found Mr Hanley to be defensive or prickly. Mr Cox said that when the audit report was tendered around about 19 July 2010, Mr Hanley *pretty much exploded and had to be calmed down by Mr Siewert.* Mr Cox said that he issued four RCAs dealing with the FRMS and he pointed out that in his opinion, the RCAs were designed to try and help an operator. Mr Cox suggested that he could have written fewer RCAs about the FRMS but it would have been easier for the company to respond where individual issues needed to be addressed. Mr Cox expressed some concern about the fact that operations personnel *were tasking pilots for duty when those pilots had not undertaken FRMS yearly training.*
304. In cross-examination Mr Siewert agreed that Mr Hanley was required to perform incident investigations under the FRMS.
305. Mr Weeks, in his evidence-in-chief, explained that the FRMS being used by Skymaster, and presumably Avtex, was the outdated FMS. He had refused to sign an exemption in October 2007 for the reissue of Avtex's FRMS. Mr Weeks said the company's FMS had not been fully upgraded to a FRMS and therefore he was not prepared to reissue the exemption from compliance with CAO 48. Instead, he substituted the standard industry exemption. Mr Weeks explained that the initial FMS relied heavily on a FAID score. However, the further development of that system required the establishment of an open reporting process and level of trust between the pilot and the operator. When a pilot stated that he was too fatigued or could not do the job, the operator simply responded in a positive and proactive manner and assigned another pilot. There should be no retribution for a pilot stating he cannot do a job. That should occur irrespective of whatever the FAID score might have been.
306. In cross-examination, Mr Weeks was asked whether as a result of the July 2008 audit he could recall anything that suggested a problem with pilots or operational staff working at normally high levels of overtime or otherwise showing signs of fatigue or overwork. Mr Weeks referred to the fact that one of the conditions placed on the AOC following that audit was that flight and duty times be kept in hard copy because CASA had difficulty accessing the flight and duty times and there were inconsistencies in those times. In fact, Mr Myles attempted to explain that there may have been some tampering with

his records.

307. Mr Sonter was asked in his evidence-in-chief what he understood was the system for pilots to manage their fatigue levels. Mr Sonter responded that there was no system. He said:

> *you're available for work as often as possible and that if you don't turn up... [or if] you say no or decline to work, well, then you're looked down upon in terms of future work.*

He also said:

> *They used a fatigue management system which – it's possibly not my place to comment on how the Civil Aviation Safety Authority approves these systems, but they're definitely not for the interests of pilots. They seem to be more for the interests of companies, and companies use them to their absolute... advantage... . This is exactly what the Avtex/Skymaster companies used it for.*

308. When asked what he meant by that, he said that pilots were scheduled to work long days. Pilots were required to be on standby for work every day. He said pilots were required to make known to the company their availability at the beginning of each month in respect of the days which they could work. Pilots would expect a phone call on the day prior to, or a few days prior to, work being allocated to them. Then the pilot could expect to work to the maximum of the fatigue system on those days irrespective of how tired the pilot might feel. *The company* (probably Skymaster) on a couple of occasions in his case, frowned upon him using his description of fatigue as a reason for not wanting to do more flying or not wanting to fly on the following day.
309. Mr Sonter described how the FMS worked. He said that after a day's flying a pilot would fill out the duty time and also the flying time; and a computer program would calculate the fatigue score. He recalled that a figure of 75 seemed to be the cut-off limit. That print out was then given to the operations personnel although he did not know what they did with it. He also said that the chief pilot required a copy of those fatigue scores on a monthly basis. After examining those scores, the chief pilot might discuss that with a pilot where there was a relatively minor exceeding of the limit. If it was major, he was of the view that a report had to be filled out for CASA. Mr Sonter said he could not recall any meeting of pilots where fatigue was discussed. He recalled having discussions with Mr Hanley about fatigue and he also submitted a SMS report regarding fatigue.
310. Mr Harvey asked Mr Sonter whether he had been chastised when he complained of fatigue. He said he had and he provided an example. He said he had finished a day's flying, was tired but at 8 o'clock that night there was a voicemail on his mobile phone to call operations when he returned to Bankstown. When he contacted operations, he was asked to fly the next morning. It was an early departure for a flight to Wollongong. He asked if anyone else was available and was told there was no one. He calculated that he could have the minimum sleep per the FMS, which was five hours, so he decided to do the charter. Two aircraft departed the following morning for Wollongong. When he agreed to do the charter, he did it on the basis that he would be put up in a motel room during the day to get some more rest because he believed that five hours sleep the previous night would not be sufficient. This was regardless of the fact that in terms of the FMS, he could do the flight. However, when he arrived at Wollongong and his passengers did not turn up, he was able to return immediately to Bankstown. He notified operations that he would be returning to Bankstown and going home to get more sleep. When he returned to Bankstown, he was asked if he could do some medical flying. He refused. He said he was followed into the kitchen by Mr O'Brien, who said to him: *Come on, mate, you can't expect to do an hours flying and then just go home.* Regardless, Mr Sonter said he went home and he noted Mr O'Brien instructed the other operations personnel not call him again for work.
311. Mr Sonter also recounted another incident which was a flight to Maroochydore with a stop at Port Macquarie. He said that he had done a days flying up to Maroochydore with the stop at Port Macquarie and then was tasked to do more flying. This was medical transfer work. He said he was tired and refused to do any more flying except for actually finishing the flying that he was originally asked to do. The operations person called Mr Hanley who then spoke with him. He told Mr Hanley he was tired, he

was more than happy to do what was originally asked, but he did not want to do any more. He felt he had been put in an awkward situation. Mr Sonter said Mr Hanley did not make any comment but he knew that he was being encouraged to do more flying. Mr Sonter said that in the weeks after that event, Mr Hanley called him on the phone and also had a meeting with him in his office where he was told that he was costing the company money.

312. In re-examination, Mr Sonter mentioned that he followed the rules and that may have upset operations personnel because they were trying to get work completed. He described Mr O'Brien's section as playing favourites when allocating work.

313. Mr Latchman said that while he worked for Avtex, he had an issue which caused him great concern. He said the air conditioning system in the aircraft was not working and had not been working for about a week. He had been tasked to pick up a patient, which he did. He returned and had *packed the aircraft up*. It was 5.00pm in the afternoon and a 42 degree day or thereabouts. He developed a migraine after landing and said it was probably due to the fact that there was no air conditioning in the aircraft. About an hour and a half after landing, he was asked to go back and drop off a patient at a particular airport. He told operations he was not feeling well, that he had a migraine, and that he was not going to do the task. Operations handed him over to Mr Siewert who was on the line. He said Mr Siewert said to him: *If I don't do the job then he'll get another pilot in Dubbo tomorrow.*

314. Mr Latchman asked him if that meant he was being fired. He said Mr Siewert replied: *That's all up to you.* He said he kept asking Mr Siewert whether he was fired and whether he had a job tomorrow. All that Mr Siewert said was: *Well, that's up to you, I just want another pilot in Dubbo tomorrow.* He said he went home and had a couple of hours rest, and feeling slightly better, he eventually flew the task, about four or five hours after he was originally scheduled to do the trip.

315. Mr Latchman said he did not look at his fatigue scores at that time and he did not think they were high because he had entered them the night before. He said the fact that he had developed a migraine was not reflected in his fatigue score.

316. Mr Latchman also described another incident where, normally, operations would give him one hours notice before being required to do a trip. He did his standby at home and the one hour notice would give him time to plan the flight, get to the airport, pre-flight the aircraft and be ready to take-off. On this particular occasion, he was told to be ready in 30 minutes. He said that was not adequate time as he needed to refuel the aircraft. There were also weather considerations at the time with a fairly significant thunderstorm over Dubbo and he said he was not prepared to take-off in those weather conditions. He was then put on to Mr Siewert who again said to him that if he did not get airborne in half an hour or if he was not at the airport and ready to go in half an hour he would have to find another pilot tomorrow. He again asked Mr Siewert did that mean he did not have a job tomorrow and whether he was being fired. Mr Siewert simply replied: *That's all up to you.*

317. Mr Sill gave oral evidence about the FMS in the course of working for Skymaster and Avtex. In his opinion, the system was poorly managed. He said that he had numerous days flying aero medical work where he would do 10 hours flying in a day in hot weather conditions and the fatigue scores would not reflect his level of fatigue. He said he would be flying on a number of days for lengthy periods of time, get back to Bankstown, put the score in and it would come out at something like 45. He could not work it out because he felt very tired. He said, for example, he might arrive back at Bankstown at 9.00pm and when he registered his fatigue score, it would say that he could be rostered for a flight at 5.30am the following day.

318. Mr Sill was asked whether he was ever asked to do a flight when he felt that he could not do it because of fatigue. He said he did, and he recalled the following flight. He said he was rostered for a freight run departing at 6.00am from Bankstown to go to Dubbo. He was to stay the day in a motel and depart Dubbo at about 5.30pm. Just before climbing into the aircraft to depart Dubbo that afternoon, he received a phone call from Mr O'Brian from operations telling him that he had a charter and asked him to accept the work. Mr Sill said he would and he asked where the flight was going to. He was told that it was to depart at 8 o'clock going to Hay. He said he would do it. Mr O'Brian then told him that he would have dinner waiting for him. Mr Sill then realised that Mr O'Brian was referring to the same day, the reference to 8 o'clock being 8.00pm. Mr O'Brian then told him that there was nobody else to fly the task. He told Mr O'Brian that when he arrived at Bankstown he would put his times into the computer to see if it was legal for him to do the extra flight. When he arrived at Bankstown and checked his FAID score, he found he was legal. Mr O'Brian had told him there was nobody else and he felt pressure

to do the flight in order to help the company. He said he recalled arriving at Hay and thinking *I will never do that again*. He said his fatigue levels were elevated due to his early departure that day and although he tried to rest during the day, he nevertheless felt fatigued in the evening. He was concerned that the FAID system and the company did not support him when he indicated his level of fatigue.

319. Mr Sill also gave an account of pressure put on him by one of the flight nurses. He said he had a long day flying in bad weather in New South Wales and was descending into Port Macquarie. From Port Macquarie he had planned to go to Williamtown and then return to Bankstown. On the radio he heard a Regional Express aircraft attempting an approach at Taree and then heard him conduct a missed approach stating that he was returning to Sydney. Mr Sill landed at Port Macquarie and then the flight nurse informed him that there was an extra patient to pick up from Taree. He explained to the nurse that he understood they were going to Williamtown and then back to Sydney. The nurse told him that there was another patient to pick up from Taree. He then said that given the bad weather, the fact that it was night and that he had been flying all day, he felt he did not want to do the flight to Taree as it was unsafe and in any event, he was not assured of a landing at Taree even if he made an instrument approach. He said that the nurse told him *you don't have a choice. You have to follow the direction of the company from operations*. Mr Sill said that he told the nurse that he was the pilot in command and that he would make the decisions. While he was refuelling the aircraft at Port Macquarie, the nurse stood beside him and continued to ask him to do the flight to Taree. She told him that he would have to report to operations if he did not do the flight. He phoned operations and spoke with Ms Lesley Kearns. Ms Kearns said that was fine and supported Mr Sill's decision to fly to Williamtown, where there was an ILS, and then back to Bankstown. Despite that, the nurse persisted. Mr Sill said that he reported this conduct to the head nurse. Apparently Ms Kearns then had a discussion with the nurse about the role of the pilot in command. There is no evidence that this was taken up further at any meeting of pilots or SMS meetings.

320. Mr O'Keefe was also asked whether he had experienced any incidents where he felt fatigued and yet was required to perform a particular flight. He said he recalled one incident where he came back from a flight and on arrival at Bankstown, the operations manager came out and said that he had to fly to Lismore. Mr O'Keefe said he was tired and he did not really want to do that flight. He said he did not want to fly up to Lismore, and then come back to Bankstown. He said he would fly to Lismore but stay overnight. Mr O'Keefe said that the operations manager pleaded for him to do the flight. There was no other pilot available. He said the patient that was to be taken to Lismore was on a stretcher in the apron area. He said he felt sufficiently concerned for the patient and thought about it, given the weather conditions that night were okay, and decided to do the flight. Nevertheless, he said he was pressured into doing the flight.

321. In cross-examination, Mr Langmead put to Mr O'Keefe that operations had not told him to do it but rather they pleaded with him to do it. Mr O'Keefe agreed. Mr Langmead suggested that meant he had a choice. Mr O'Keefe agreed. He said that implicit in such a request was the fact that he could reject it and Mr O'Keefe again agreed. Mr Langmead then suggested that was an example of operations recognising that the onus was on the pilot whether he complied and Mr O'Keefe again agreed. Mr Langmead suggested that Mr O'Keefe could have happily turned down that flight and Mr O'Keefe said that he could have if he really wanted to. However, he said the pressure was there. If he did turn the job down then he might not get called for work for the next couple of days or up to a week because of what pilots referred to as a *black list*. He said that if pilots turned down work and therefore annoyed operations, then they would not get called. He had financial commitments and therefore he felt the pressure to go along with operation's decision. He said: *But, I mean, certainly, I could turn it down, but it wouldn't look favourably, and then I might not be called for work for another five days, six days later*. Mr Langmead then suggested that Mr O'Keefe had knocked back a Canberra to Cooma flight and that there were no ramifications and he was not put on the *black list*. Mr O'Keefe responded by saying that he did not know whether that was the case. He said he did not recall getting a lot of work after that particular day but he would certainly turn down jobs if there was a safety issue.

322. When it was put to Mr O'Keefe whether he was seriously suggesting that he could not remember getting too much work after that, he said it might have been a couple of days, three or four days, where other pilots would be getting called every single day and then certain pilots, such as himself, would not get called for a couple of days. He said pilots always noticed that trend happening if certain events like rejecting a flight occurred. Mr O'Keefe also conceded that the company agreed to put him up in a hotel

in Lismore and that it happened. He nevertheless insisted the pressure was there.

323. When it was put to Mr O'Keefe whether, by constantly referring to pressure, he was trying to convey something to the Tribunal, Mr O'Keefe said:

> *Because there was – there was always pressure to get a job done or pressure to operate into conditions that weren't always favourable, were unsafe. Aircraft, you know, that were unsafe. We didn't have – we didn't have faith in the aircraft with all the problems that occurred.*

324. Mr Bongiorno gave an account of a flight to Rockhampton departing Bankstown around 11.00pm – 12.00am. Mr Bongiorno said that he was contacted by operations at about 10.00pm and asked if he was available to do that flight. He said he had plenty of sleep that day so he agreed. He then contacted Mr Hanley to discuss the possibility of having a second pilot because it was fairly late and it would be good to have the second pilot for the second part of the flight. According to Mr Bongiorno, Mr Hanley was not happy and became abusive. This was despite the fact that operations told him the company which had chartered the aircraft had agreed to pay for a second pilot. Mr Bongiorno believed it was normal to have two pilots because, not only was it a late night flight, there was poor weather in the area and there was an air traffic controllers' strike. Some sectors of the flight were not covered by air traffic control and that caused him some concern. He did not mention that aspect to Mr Hanley because he did not know there was an air traffic controllers' strike until he checked the NOTAMs and the weather on the computer.

325. Mr Bongiorno said he also asked Mr Hanley about the route he was taking and told him he decided that he would take the coastal route because there was too much weather inland, too much storm activity. Apparently Mr Hanley again became abusive and asked him why he was looking at the weather radar. That surprised Mr Bongiorno as he regarded the weather radar as one of his tools of trade. He said he did not get any flight planning guidance at all from Mr Hanley. This is despite the fact that Mr Hanley's evidence was that he met Mr Bongiorno on that evening and assisted him with flight planning. Mr Bongiorno categorically denied that to be the case.

326. Mr Bongiorno planned via Lismore and when he got there, the weather was not good and he could not get visual following an instrument approach so he completed a missed approach and went to the Gold Coast. He then had some difficulty getting refuelling because he could not find the Carnet (fuel credit card) to pay for refuelling. He spent an hour or so on the ground there and contacted operations who attempted to contact the refueler but could not get hold of him. Mr Bongiorno said he wanted to get some sleep and after an hour or so he had a friend of his who lived there pick him up and take him back to his house. He said he was a few minutes away from his friend's house when Lesley from operations called indicating that she had managed to get hold of the refueler and that he could go back and complete the flight. He told Lesley that he would like to get some sleep because he was very tired. He said Lesley said to him: *I can't tell you to go but if you don't go, the boss will have the shits with you.*

327. Following that conversation, Mr Bongiorno went back to the aeroplane and refuelled it. He then flew to Rockhampton. He said the time then was about 3.30 to 4.00am. The flight time between Coolangatta and Rockhampton was around two and a half hours. He said he lost communications after Brisbane because of the air traffic controllers' strike and just before Rockhampton he called on the Rockhampton frequency and reported that he was landing off a straight in approach on Runway 04. There was a car on the runway checking the lights and the car indicated that he would get off the runway and check the other runway while he was landing on 04. Mr Bongiorno then landed, subsequently realising that he had landed on Runway 33. The person checking the lights in the motor vehicle said that he was confused as he saw the aircraft approaching on Runway 33 and could not understand why he was calling for a straight in approach on Runway 04. Mr Bongiorno said he was tired and exhausted and he just called the wrong runway on the way in. Fortuitously, the person in the motor vehicle was watching him closely and moved off the runway so as not to conflict with the landing aircraft. Mr Bongiorno did not fly back from Rockhampton the following day as there was more bad weather coming in that afternoon so he slept. He could not recall what time it was but he departed Rockhampton just before the weather started again. He returned to Bankstown via Coolangatta to refuel. He said he had a discussion with Mr Hanley on his return and Mr Hanley was not abusive at all, he simply said he did not agree with the route that Mr Bongiorno had selected on that night.

AIRWORTHINESS

328. An AOC issued to an operator may authorise the flying or operation of aircraft by authorising the flying or operation of aircraft included in a class of aircraft described in the AOC (s 27(2A) of the CA Act). Avtex's AOC, which was current immediately prior to cancellation by CASA, listed the various classes of Australian registered aircraft in which it was authorised to conduct charter operations and aerial work operations under Avtex's AOC. On applying for the AOC, the applicant is required to provide CASA with a copy of a certificate of airworthiness for the aircraft. An owner, operator or pilot of an Australian aircraft must not commence a flight in the aircraft or permit flight in the aircraft to commence if there is no certificate of airworthiness under the regulations in force in respect of the aircraft, and if the regulations do not authorise flight without the certificate (s 20AA(3) of the Act).
329. In essence, certificates of airworthiness are issued for the purpose of establishing that the aircraft is safe to fly, taking into account its design and construction, and also that the aircraft has been properly maintained. In fact, CASA may suspend or cancel a certificate of airworthiness of an Australian aircraft, not being an aircraft used in RPT operations, if maintenance is not carried out in according with Part IVA of the CAR. It is for these reasons that one of the key personnel identified in s 28 of the CA Act regarding the issue of an AOC is a person described as the head of the aircraft airworthiness and maintenance control part of the organisation holding the AOC.
330. In the case of Avtex, this position was occupied by Mr Newberry. He was also the HAAMC of Skymaster, even thought Skymaster did not have a maintenance part to its organisation. It used the services of Avtex's maintenance section which held a COA under CAR 30. Because Mr Newberry occupied the HAAMC position in both organisations, it seems to me that it is appropriate to examine any maintenance problems experienced by aircraft used in the Skymaster operation as well as those in the Avtex operation. This position clearly highlights the overlap between the two organisations, both of which have Mr Siewert as its CEO. Mr Newberry has occupied the position in respect of Avtex for about 23 years. In his affidavit made on 26 August 2010, Mr Newberry said that the chief engineer of Avtex, Mr Lynch, assisted him in the performance of those duties. According to Mr Newberry where any defects are reported in aircraft, these are passed on to him and he in turn is required to advise Mr Lynch. Rectification of defects is arranged by himself or Mr Lynch. Mr Newberry said he maintains a trend monitor on a daily basis for the aircraft used in the AOC operations. Mr Newberry has no formal engineering qualifications.
331. In an affidavit made on 6 October 2010 Mr Newberry referred to the defects identified by Mr Simpson, an airworthiness inspector with CASA, who was responsible for the airworthiness aspects of the February 2010 audit of Avtex. Mr Newberry's responses to the items identified in the RCAs issued by CASA on that audit essentially correspond with what Mr Donoghue said when acquitting the RCAs. Mr Donoghue said in his affidavit that the Avtex operations manual did not require pilots to defer recording defects on the maintenance release. Rather, the manual recommends that pilots contact someone qualified to accurately define what the relevant defect is before recording a defect incorrectly.
332. There are a number of problems with this statement. The first is that in the course of his cross-examination by Mr Harvey regarding what is stated in the operations manual requiring approvals of amendments to be in writing, Mr Newberry answered: *I don't know what the Ops Manual says. Its an Operations Manual.* Either Mr Newberry had not read the operations manual entirely or he had only read selective parts. Mr Newberry did not attach to his affidavit the relevant pages of the operations manual to which he referred. The second problem is that it is difficult to understand how a defect can be *incorrectly recorded.* While I accept that there may be insufficient information given by a pilot recording a problem, or that what the pilot records might be cleared by an engineer without the item requiring rectification, that is hardly an incorrect recording. It seems to me that if insufficient information was given by a pilot, it would not be difficult to contact the pilot by telephone and ask for further details. In fact, there is ample evidence that operations contacted pilots at all hours of the day and night without difficulty.
333. Mr Newberry also said in his affidavit that the pilots should contact someone to accurately define the relevant defect because some pilots did not have engineering knowledge sufficient to diagnose the defect. I have already dealt with that above. It is not the role of a pilot to diagnose a defect. The only role the pilot has is that which is stated in CAR 50, that is, to enter a defect as observed by the pilot, on the maintenance release. If in fact what is entered in the maintenance release, after examination by a

LAME turns out not to be a defective component, it is up to the LAME to make that assessment and then to clear the defect endorsement in accordance with the CARs. Mr Newberry also stated in his affidavit that the purpose of the section in the operations manual is to avoid breaching regulatory requirements and incurring RCAs for incorrectly recording defects. There was no evidence at all before me that any RCA was issued for incorrectly recording a defect. With due respect to Mr Newberry, this is a bizarre statement.

334. In his examination-in-chief, Mr Newberry was asked whether CASA had ever threatened his role as HAAMC and he said: *not that I know of*. However, in cross-examination it was put to him that he did not hold any approvals from CASA. Mr Newberry agreed. He also agreed that it was not a matter for CASA to *fire* him.

335. In his affidavit of 21 September 2010, Mr Simpson referred to a review of the maintenance records for the aircraft operated by Skymaster which was carried out in the special audit in June 2010. One of the matters which concerned CASA was that Skymaster could not demonstrate that all of the Piper and Aerostar aircraft used for the purposes of conducting its operations under its AOC had been maintained in accordance with service bulletins issued by the manufacturers of those aircraft. Mr Simpson identified this as serious maintenance control deficiency and CASA issued a SA. In addition, CASA identified a number of maintenance issues which affected 11 of the aircraft used by Skymaster under its AOC. I have already referred to this issue above.

336. In response to the claim concerning non-compliance with issued service bulletins, Mr Newberry said that he did miss a *couple*. He put this down to a period when Piper was relinquishing ownership of the Aerostar type certificate and Avtex was not receiving the information from either Piper or the new owners. Mr Newberry also said in his affidavit of 26 August 2010 that his research confirmed that two Piper service bulletins had not been addressed. In respect of those, because they did not apply to the types of aircraft operated by Avtex or Skymaster, he was required to write the words *Not Applicable* in the log books of the aircraft. However, the fact that service bulletins may not have been applicable to the type operated by an AOC holder is not to the point. That may have been merely fortuitous. Had the service bulletins addressed something more significant and which had direct effects on the safety of an aircraft, they would have also been missed. It is the fact that they were missed which is of concern. There were also five bulletins which referred to the Aerostar which had not been addressed. Again, Mr Newberry said that in any event, no safety issue arose from that omission. With respect, that is not to the point. It indicates, as CASA submitted, an undisciplined approach to the maintenance of aircraft.

337. Mr Simpson testified that as part of the February 2010 audit, he tasked another airworthiness inspector, Mr Arnold, to review an engine life extension program operated by Avtex for a number of years. It appears that in 2002 a CASA team leader in the airworthiness section, Mr Herb McFarlane, approved an extension of engine TBOs under CAR 42R regarding 16 engines listed by serial number. The approvals were subject to a number of conditions, including:
    - (a) the engines were to be operated by Avtex only, they were not transferrable;
    - (b) several engines were included in the program which were not included in the original approval, and there were no subsequent approvals;
    - (c) four engines were found to have exceeded the manufacturers' recommended TBO;
    - (d) the original approval required the aircraft to be maintained in accordance with an approved system of maintenance but the log book statements indicated they had been maintained in accordance with manufacturers' schedules; and
    - (e) the original approval required weekly certifications in engine log books specifying that the engines continued to meet manufacturers' specifications.

338. Following the audit, CASA issued a Class A ASR in respect of engines fitted to four PA-31 aircraft.

339. The conditions set out by Mr McFarlane also included the clear statement that CASA must approve any additional engines.

340. Mr Michael English, an airworthiness inspector with CASA, was responsible for oversight of the Avtex COA between August 2001 and 2005. During that period, he was responsible for overseeing the Avtex engine 288 life extension program. In a statement made on 21 October 2010, Mr English said that while performing his functions as the assigned inspector in relation to the extension program, he documented all decisions, permissions and directions regarding the Avtex program. In a letter dated 16 October 2003, Mr English advised Avtex that it was feasible, in principle, to allow the addition of a Wingaway PA31-350 to the Avtex engine reliability program. There was no mention of Skymaster in

that letter. Mr English said he required further particulars of the procedures which would be put in place to ensure that Wingaway operations would be varied to ensure compliance with the CASA approval letter of 7 January 2002. Mr English said he had no record of the requirements being met or of a permission being granted to add to the extension of time program.

341. In a letter dated 12 May 2005 Mr English notified Avtex that under no conditions were any engines to be added to the extension of time program. That statement is in block capitals and bolded. It could not be clearer.

342. In his evidence-in-chief, Mr Newberry said he was told by Mr English that he could nominate extra engines and aircraft in the maintenance system. He said he did that. Mr Newberry said if he provided strip reports regarding the engines to be nominated, then it would be okay to add them to the program. However, quite plainly, the addition of engines contemplated by Mr English's letter of 16 October 2003 requires information to be provided to ensure that Wingaway operations would be varied to ensure compliance with CASA's requirements. In fact, the letter also indicates that the Wingaway operations manual would need an amendment to include the additional procedures required under the program. Mr Newberry made no mention of those requirements.

343. When it was put to Mr Newberry that the original approval required weekly certifications in the engine log books, specifying that the engines continued to meet the manufacturer's specifications, he said he could not remember being asked about that. He said he may have been. He agreed those certifications had not been entered on a weekly basis. He said he did a check every one hundred hours. This is despite the fact that he agreed that the original approval required weekly certifications. Mr Newberry was taken to statements made by Mr McFarlane. He agreed that as HAAMC of Avtex, he dealt with Mr McFarlane. When Mr Newberry was asked whether Mr English approved the addition of new engines, he said: *That's correct, yes.* He said most of that was done verbally. He recalled receiving Mr English's letter of 12 May 2005 but said that was after he had added engines. He said he had nothing in writing to confirm the approval to add further engines. With respect to Mr Newberry, I cannot accept his evidence about this matter. It is simply implausible, particularly as there appeared to be non-compliance with the original conditions under which the extension of TBO was granted. Mr Newberry could not say when he was told that he could add further engines.

344. In Mr Newberry's affidavit of 26 August 2010 he said that it was his opinion and Mr Lynch's opinion that the nose landing gear collapse at Tibooburra was caused by a rod end failure, a manufacturing fault in the relevant component. The problem with this statement is that Mr Newberry is not an engineer, nor does he have any engineering qualifications. Mr Lynch, for unexplained reasons, was not called to give evidence about the numerous maintenance issues which have arisen since the 2008 audit. Clearly, I cannot give any weight to Mr Newberry's evidence regarding the cause of the nose landing gear collapse.

345. In fact, Mr Newberry's affidavit also incorrectly states that in the course of a one hundred hourly inspection performed on 13 June 2010, two nose gear idler arm ends were replaced. That inspection in fact took place on 13 July 2010, some five days prior to the nose landing gear collapse. Mr Arnold made a witness statement dated 16 August 2010 and attached to that statement is the relevant log book entry. As I have mentioned above, on 18 July 2010 Mr Lynch was at Tibooburra and he inspected the nose landing gear after the pilot, Mr Myles, reported problems. Despite getting information second hand from Mr Lynch, and not being an engineer, Mr Newberry nevertheless ventured opinions about the cause of the problem even though he has not been able to provide the correct sequence of events in his witness statement. On the other hand, Mr Arnold, who is a LAME and has worked on PA-31-350 aircraft as the chief engineer of Hawker Pacific's Bankstown maintenance facility, is likely to have a much better understanding of the engineering problems encountered. He also examined the aircraft at Tibooburra. Mr Arnold ventured some possible explanations for the failure including:

    - (a) mis-rigging of the NLG retraction mechanism;
    - (b) binding of the NLG retraction mechanism; and
    - (c) mechanical (metal) fatigue.

Mr Arnold was also of the opinion that hydraulic system problems may have been relevant to the retraction mechanism failure. Mr Newberry noted that the left hand side hydraulic pump was replaced on 12 June 2010 and 14 July 2010. He put that down to a faulty batch of hydraulic pumps imported from the USA and he said those were reported to CASA through the defect reporting system. He did not elaborate as to what the

problem with those pumps might have been.

346. In my opinion, it is significant that in his witness statements Mr Newberry made no mention at all about the inspection conducted by Mr Lynch on 18 July 2010, immediately prior to the nose landing gear collapse. In cross-examination he agreed that a micro switch adjustment was made on that day, presumably by Mr Lynch. In fact, as CASA submitted, had it not been for CASA obtaining statements from witnesses who were on the flight when the nose landing gear collapsed, CASA would never have known that Mr Lynch in fact inspected the aircraft immediately prior to the accident. Although Mr Newberry said that the micro switch adjustment is recorded in the log book, it certainly was not entered in the maintenance release. In the absence of Mr Lynch giving evidence, I am none the wiser about what he in fact did and observed. That may well be important for the purposes of determining the cause of that incident. For the purposes of this application, it simply again highlights the undisciplined and somewhat haphazard nature of maintenance control by Mr Newberry.

KEY PERSONNEL

347. The operations of an AOC holder are managed through its key personnel. Section 28 of the CA Act sets out those persons positions. As far as Avtex is concerned, the key personnel are Mr Siewert who is the CEO; Mr Donoghue who is the head of flying operations or the chief pilot; and Mr Newberry, who is the HAAMC. Those three persons would retain their positions if Avtex's AOC were reinstated. The HOTC, who was formerly Mr Couch, would be taken up by Mr Moncrieff, assuming him to be acceptable to CASA. Mr Moncrieff has not played any part in the operations of Avtex previously and his relationship with Mr Donoghue and Mr Siewert is unknown. CASA's concern in this case is specifically directed to Mr Siewert, Mr Donoghue and Mr Newberry. Those three key personnel have occupied those positions since 2008 and, in fact, Mr Donoghue was the General Manager of Avtex for some considerable time prior to that. In my opinion, it is the influence of these three persons on the AOC which requires close scrutiny as they are the persons who have had the power to make decisions directly affecting the safety of Avtex's operations.

MR SIEWERT

348. Ultimately, all decisions regarding the operations conducted by Avtex need the approval of Mr Siewert. Avtex, along with the other companies, are essentially owned and controlled by Mr and Mrs Siewert. Although Mrs Siewert, as a Director of Avtex, has played no active role in the operations of Avtex, she is nevertheless a person who is also responsible for Avtex conducting its operations with a reasonable degree of care and diligence (see s 28BE(2) of the CA Act).
349. Although Mr Siewert's evidence was that he had little to do with the day to day operations of Avtex, leaving that up to the Chief Pilot and the General Manager (when Mr Donoghue occupied that position), as CASA submitted, that notion does not stand up to close scrutiny. In fact I find that the evidence discloses the pervasive influence of Mr Siewert on every aspect of Avtex's operation.
350. Mr O'Brien, who headed up the operations group, reported directly to Mr Siewert. The evidence discloses that Mr O'Brien, and on occasions some of his staff, exerted pressure on pilots to fly when they should not have been flying due to fatigue. I also find operations staff put pressure on pilots to fly aircraft back to Bankstown with defects so that the maintenance required could be conducted at home base. There was no reason why Mr O'Brien could not have been called to give evidence about the matters alleged against him and other operations staff by former pilots. From that I infer that his evidence would not have assisted Avtex. There is nothing in the evidence which would suggest that Mr O'Brien or any of the operations' staff had anything personal to gain by exerting pressure on pilots. Therefore, it is logical to infer that the pressure came from Mr Siewert as a result of the commercial imperative to get the job done. There was also evidence that operations *blacklisted* pilots' and therefore reduced their flying hours where those pilots had objected to conducting flights due to fatigue or, for reasons associated with the weather.
351. Following CASA's audit in 2008, Mr Siewert became directly involved in identifying pilots who had not had complete endorsement training on PA-31 aircraft. Perhaps more accurately, Mr Siewert gave

the appearance of being involved. For reasons which remain unexplained, I find Mr Siewert attempted to distance himself from the endorsements and training provided by Mr Myles. He was aware that Mr Myles was conducting endorsement training and endorsing pilots on the PA-31 using Avtex aircraft. But it seems he never thought to enquire as to the basis upon which that activity was being conducted, although it was conducted out of Avtex's premises. He was also aware of CASA's Delegation and Approval Instrument issued to Mr Myles. Mr Donoghue told CASA in a letter that Mr Siewert had contacted all pilots. However, it transpired that Mr Siewert had done no such thing. Despite being told what happened, Mr Siewert nevertheless indicated his support for Mr Myles and he made a vague attempt to suggest that all of the pilots identified no longer worked for Avtex but were working for Skymaster. He subsequently accepted that they were probably previously working for Avtex before the transfer of the piston engine operations from Avtex to Skymaster.

352. It is also remarkable that Mr Hanley, who became the chief pilot of Skymaster after the 2008 Metro crash in Botany Bay, said that he was not aware of the faulty endorsement issue until June 2010. After all, he had become responsible for pilots operating PA-31 aircraft under his supervision who possibly had faulty endorsements. This was clearly something that Mr Siewert should have explained to Mr Hanley and the issue of faulty endorsements should have been resolved immediately. Some two years later, the issue was still alive. Of course Mr Siewert denied any legal responsibility for those endorsements. Mr Siewert's subsequent suggestion about retaining the services of Mr Myles as chief pilot after having him counselled by Mr Donoghue is seriously disturbing. This entire episode was compounded by the fact that Mr Myles was not called to give evidence.

353. When threatened with cancellation of Avtex's AOC in 2008, Mr Siewert readily accepted the eight conditions recommended by CASA in order to avoid cancellation. However, within two months, Mr Siewert was already applying for the removal of some of those conditions. While one condition was resolved with Mr Myles being stood down as the chief pilot, the second condition sought to be removed related to multi-crew procedures for the Metro aircraft. This was clearly directly in response to the Metro accident which involved a single pilot operation.

354. Mr Siewert was present at the pilots' meeting held on 26 October 2008. While the evidence was that Mr Siewert did not say much at that meeting, Mr Hanley, who did most of the talking, was described by Mr Sonter as being *a little bit upset by those questions.* Mr Sonter's description was it appeared to him that Mr Hanley would have preferred to answer the questions himself without the presence of Mr Siewert. This discomfort was also picked up by Mr Bradley, who said that both Mr Hanley and Mr Siewert were not impressed by his reference to CAR 238 regarding flying in icing conditions. He described Mr Hanley as trying to impress Mr Siewert. In my opinion, the behaviour of Mr Siewert and Mr Hanley at that meeting demonstrates the influence Mr Siewert had over the operations of Skymaster as well as Avtex. As the CEO of both companies, that should come as no surprise, although it indicates a far greater influence over the operations of both Skymaster and Avtex than Mr Siewert was willing to concede. According to Mr Bradley, it also resulted in Mr Hanley espousing one view which was very strict compliance with the rules and at other times making statements which were totally contradictory to that position.

355. Mr Campbell, a CASA officer, also described graphically the way in which Mr Siewert attempted to exert his influence. When Mr Campbell complained to Mr Siewert about the state of a Metro aircraft which he sought to hire, Mr Siewert made a statement indicating that general aviation is a small industry and that he should take more care when voicing complaints because he may need to be employed in that industry at a future date. If this kind of threat was only made on one occasion, one might be prepared to overlook it as simply an aberration. However, that was not the case. Mr Siewert testified that he never put pressure on pilots to fly in icing conditions or where thunderstorm activity was present, and that he never told pilots not to record defects on maintenance releases. Despite that, I find the evidence discloses Mr Siewert most certainly exerted pressure, but in an indirect way. The incident described by Mr Campbell is one of those. These indirect forms of pressure were described by various former Avtex pilots. They were also exhibited through the responses of operations' staff and Mr Lynch.

356. Examples of this indirect pressure include the following:

    a. Mr Siewert at the meeting of pilots in 2008 telling pilots of his flying time in the 1970s and that the pilots then had a different mind set, to get the job done;
    b. Mr O'Keefe's evidence that operations would huff and puff if a pilot said the weather prevented

the flight back to Bankstown and they would encourage the pilot to fly the return leg;

c. Mr O'Keefe's evidence about the chief pilot, encouraging pilots to *go and have a look* whether it involved icing conditions or thunderstorm activity when, quite plainly, aircraft should not have been getting airborne at all;
d. Mr Hanley's statement to Mr Bongiorno after he made a decision to stay overnight in Lismore due to bad weather, that pilot's like Mr Bongiorno made him and Mr Siewert want to go out and get pilots that would fly through weather;
e. Mr Latchman's episode when he felt too ill to do the return flight to Dubbo and he was told by Mr Siewert directly that if he did not complete that flight, Mr Siewert would get another pilot in Dubbo the following day and when Mr Latchman asked him if he was being fired, Mr Siewert responding *that's all up to you;*
f. Mr Siewert's direct conversation with Mr Latchman about getting airborne within half an hour of being notified of a flight and if he didn't, Avtex would need to find another pilot the following day; and
g. Mr Bongiorno's episode where he had a long night flying and felt he couldn't continue the flight, he was told by Ms Kearns of operations that she could not tell him to go but *the boss will have the shit's with you.*

357. There was also the extraordinary event where, following the Canley Vale Road accident, Mr Siewert, via operations, arranged for a replacement flight immediately when he was made aware of the accident. As CASA submitted, this was purely for commercial reasons and without regard to the fact that the problems experienced by Mr Wilson which led to the fatal accident may have been something to do with the particular aircraft or fleet of aircraft. He gave no consideration to whether any safety issues should have been examined prior to recommencing operations with the PA-31 aircraft.
358. It is also significant in my opinion that following Mr Couch's failure to satisfy an examiner regarding his proficiency on the Metro III, no steps were taken by Mr Siewert to remove Mr Couch from the organisation. This is also despite the fact that on two occasions, independent sources were certain they detected the smell of alcohol on Mr Couch when he was about to go and fly the aircraft. These events should have been fully investigated and, if Mr Couch was found to have breached the *eight hours between bottle and throttle* rule, he should have been dismissed immediately. This is a very serious safety issue which seems to have been, like many other issues, simply swept under the carpet.
359. Another serious concern which I have relates to defect recording. While Mr Siewert testified that he had never told pilots not to record defects, and I have no reason to doubt that statement was true, there was clearly indirect pressure put on pilots to bring the aircraft back to the Bankstown base for maintenance. While much of the reluctance to record maintenance might be sheeted home to advice given by Mr Lynch and also Mr Hanley's and Mr Donoghue's views about recording defects on the maintenance release, it is difficult to accept that Mr Siewert was not aware of the unusual approach to defect reporting by all of those persons. The views put by Mr Donoghue, Mr Hanley and Mr Newberry that a pilot needed to substantiate equipment was unserviceable before recording it in the maintenance release is clearly counter to the requirements set out in CAR 50. The very strange explanation given by Mr Newberry regarding *incorrect recording of defects* and the fact that CASA would issue a RCA if a defect was incorrectly recorded is astonishing.
360. Mr Hanley's approach, asking pilots to contact him so that the precise nature of the defect and its effect on the operations of the aircraft might be ascertained before entering it on the maintenance release, is not dissimilar to the approach of Mr Donoghue. I find it remarkable that two very experienced pilots arrived at such an improbable interpretation of CAR 50 of their own accord. The most likely explanation is that those persons were instructed, probably by Mr Siewert, to ensure pilots did not record defects on the maintenance release unless they could establish that the item of equipment being referred to was in fact unserviceable. This of course usurps the role of the LAME but, no doubt, it is a means of saving on operating costs. It is also highly unsafe.

MR DONOGHUE

361. In my analysis of the main problems referred to by CASA, I have not referred to the three occasions when it is alleged Mr Donoghue flew without the requisite night currency. There was some dispute about that and Mr Donoghue's explanation, indicating it was an error, was probably correct. Also, the

allegation about not having instrument flying currency was disputed. It is not an issue which goes to the heart of the safety concerns for Avtex. However, there are a number of matters which most certainly do.

362. Mr Donoghue's role in rectifying the faulty endorsements of pilots who received their training from Mr Myles leaves a lot to be desired. Although it is true that Mr Donoghue had not at that time accepted the position of chief pilot of Avtex, he was its general manager. It was Mr Donoghue who wrote to CASA on 2 July 2008, stating that on the previous afternoon, Mr Siewert had contacted all pilots who had been endorsed by Mr Myles to establish the level of training they received and to make arrangements for retraining. He also stated that a number of pilots had been stood down pending retraining. In fact, Mr Siewert had not contacted any of the pilots. Although at one stage Mr Donoghue said that he, Mr Siewert and Mr Coakley had undertaken the task of contacting pilots who were endorsed by Mr Myles, Mr Donoghue later said Mr Coakley was placed in charge of contacting all of the pilots on the list provided by CASA. Also, despite Mr Donoghue having identified Mr Meinecke as having had no previous asymmetric training on the PA-31, he did not follow that up to ensure that Mr Meinecke did not return to line flying prior to remedial training. He also admitted that Mr Latchman had flown a line sortie prior to conducting retraining. The conclusions which must be drawn from this conduct are either that Mr Donoghue did not consider it his responsibility to follow up on the endorsement training because those pilots were now flying under the Skymaster AOC, or he considered that it raised no serious safety concern. Whichever it was, I find that his conduct in dealing with this problem was unsatisfactory.

363. The role of Mr Donoghue in ensuring that Mr Couch had maintained proficiency on the Metro III aircraft was also unsatisfactory. The consequence was that any proficiency checks conducted by Mr Couch when he ceased to be proficient were invalid. Mr Donoghue maintained that if the new TCM had been approved by CASA, as he thought it had, then no issue arose. This view is wrong for two reasons.

364. First, compliance with the eight conditions imposed by CASA only required submission of amendments to the TCM to be submitted for acceptance by 30 September 2008. Mere submission did not indicate acceptance. The issue of a new AOC on 16 December 2008 could not indicate CASA had accepted the amendments to the TCM. It simply signified compliance with the conditions on the AOC.

365. Secondly, Mr Donoghue formed the view that a CIR check conducted by a CASA FOI constituted a proficiency check. Quite plainly, the chief pilot of an organisation such as Avtex needed to be thoroughly conversant with the regulations and orders regarding training and checking. Also, as CASA submitted, he should have been aware that approvals to amendments of the TCM by CASA were required in writing. In any event, the amendments to the TCM did not satisfy CAR 217 or CAO 82.1. Avtex's TCM provided that proficiency and currency checks were to be conducted by a qualified TCO pilot in conjunction with a scheduled en route flight. Plainly, a CIR check by a CASA FOI did not satisfy this requirement.

366. Although CASA has also referred to Mr Donoghue's failure to comply with night recency requirements set out in CAO 82.0 by flying as a supervisory pilot for another pilot, Mr Donoghue accepted that he was in error in considering he could do so. It is a relatively minor point although I accept that it does point to Mr Donoghue's lack of knowledge of the regulatory material involved in aviation. CASA also pointed to a number of other minor errors made by Mr Donoghue in relation to recording instrument flying time, indicating that as chief pilot, a higher level of awareness and responsibility should have been demonstrated. While I accept that to be the fact, the errors made by Mr Donoghue were relatively minor and no doubt serve as a reminder to Mr Donoghue to take more care in recording flight instrument times.

367. Mr Donoghue's response to CASA's finding that Mr Barker was not qualified to conduct an international passenger carrying flight in a Merlin III aircraft because he had not accrued 10 hours experience as pilot in command in that aircraft type prior to undertaking the flight is of greater significance. Although aware of the class endorsement provisions contained in CAO 40.1.0 and the requirement for a pilot to be competent when operating different aircraft models in accordance with CAO 82.1, he overlooked the provisions in paragraph 4 of CAO 82.1. That paragraph requires persons acting as pilot in command in charter operations under the IFR to have 10 hours experience as pilot in command of the aircraft type. This is clearly a safety related provision which, in my opinion, Mr Donoghue should have been aware of. As the chief pilot, it was his responsibility to ensure that charter

flights conducted by Avtex pilots were both lawful and safe. I find that he failed to do so.

368. Mr Donoghue expressed the view that pilots on board, but not sitting in either of the seats which provide access to the flying controls of the aircraft, nevertheless constituted operating crew as that expression is defined in the CAR. He denied that passengers were ever carried on training flights, although there were pilots on board for the purpose of taking a turn in operating the aircraft at some stage during the flight. In fact, in his evidence-in-chief, Mr Donoghue insisted that although pilots were on board for the purpose of retraining and should be considered as operating crew, they nevertheless were only ferried to Wagga where one of the pilots got out and then the training continued. After the first pilot had completed his training, presumably the aircraft landed and the second pilot for training got in and completed his training. However, there was also other evidence given by Mr Donoghue that in fact three pilots were onboard on a training flight which went to Richmond and he was onboard the aircraft when Mr Myles was undergoing training by Mr Couch. If Mr Donoghue was genuinely of the view that the expression *operating crew* included pilots who were waiting their turn to exchange seats with the pilot then undergoing training, there of course would have been no need for the landing at Wagga and the disembarkation of the non-operating pilot or pilots. As I have already indicated above, the note to the definition of the expression *operating crew* must be read in context. It does not include a pilot who is sitting in the aircraft awaiting his or her turn to undergo proficiency checking or training. Perhaps the most significant aspect of this issue is the fact that until the problems were brought to Mr Donoghue's attention, he appeared to be unaware of the prohibitions regarding the carriage of passengers on certain flights as set out in CAR 249.

369. Mr Donoghue was responsible for ensuring that Avtex pilots' did not exceed RTOW in the course of their operations. To do so is to breach CAR 235 and CAO 20.7.1B. Despite being aware that the Aleda data had not been updated since 2008, he allowed pilots to continue to use that information. It had the potential to result in a safety issue. I find that simply attempting to supplement the Aleda charts by using ERSA and NOTAMs was, as CASA submitted, unsatisfactory.

370. CASA was also critical of Mr Donoghue for his lack of familiarity with the 2004 TCM and the subsequent proposed 2009 TCM. Mr Donoghue's subsequent assumptions regarding acceptance by CASA of the amendments made to the TCM are cause for serious concern. One would reasonably expect the chief pilot of an AOC holder to take significantly greater care to ensure all operations are conducted in accordance with approved documents. This is particularly so with the statutory requirements for proficiency checking.

371. Mr Donoghue said in evidence that he enlisted the help of ACS, Mr Couch and a Mr Arthur White to develop the SMS. Despite that assistance, some 18 months after the condition was placed on Avtex's AOC to implement the SMS, it remained at an unsatisfactory stage of development. The safety manager, Mr Morgan, did not receive training under the SMS until June 2010 and no other key personnel had attended any SMS training course. Mr Donoghue said that he was involved in the steps and processes in the course of development of the SMS. Overall, the SMS development has been unsatisfactory and there was no evidence of strong support from Mr Donoghue for that. I find that the lack of meetings and action taken in respect of safety reports is evidence of the company simply going through the motions, without being committed to the development of an SMS.

372. I have already mentioned above the extensive problems I have found with the process of defect reporting and the entry of defects on maintenance releases. It seems to me that Mr Donoghue should have actively and strongly supported pilots to endorse maintenance releases with whatever they considered to be defects and, when pilots expressed difficulty with the chief engineer about having maintenance work conducted, he should have actively supported the pilots and reported the conduct of the chief engineer to Mr Siewert. In my view, this aspect of Mr Donoghue's performance as a chief pilot was wholly unsatisfactory.

373. CASA submitted that Mr Donoghue's evidence and manner of presentation of evidence left the impression that he was prepared to readily accept the suggestions of others and adopt them as his own. CASA cited a number of examples of this behaviour. I agree with that submission. Furthermore, Mr Donoghue's conduct as chief pilot strongly suggests that either his views were closely aligned with that of Mr Siewert, or he adopted Mr Siewert's views in spite of understanding that they might have safety consequences. The chief pilot's role has often been described as *having a foot in both camps*. By that I understand that the chief pilot acts as CASA's observer of the operations of the AOC holder with a view to keeping CASA informed before safety issues arise. On the other hand, he is also an employee

of the AOC holder and has duties to that entity. However, the chief pilot's primary role, in my opinion, is the oversight of the safe operation of the AOC holder and its compliance with all regulatory material. The chief pilot must not be persuaded by any person's views which might jeopardise the safety of the operation. In my opinion, Mr Donoghue failed to meet this standard.

MR NEWBERRY

374. Mr Newberry's role as HAAMC for Avtex and Skymaster and also of the certificate of approval section of Avtex, places him in a pivotal position regarding the airworthiness of aircraft operated by the AOC holder. With respect to Mr Newberry, and I mean no criticism of him at all, that position should be occupied by a LAME. My concern is that a person without engineering qualifications placed in such a position will almost invariably be influenced and possibly controlled by the engineer who heads up the engineering operation of the AOC holder, if it has one. As the legislation currently stands, there is no formal qualification required for a person in this position. In fact, CASA approval for the appointment of the HAAMC is not required, unlike that for the chief pilot. It may be that CASA should examine this issue with a view to making appointments to this position subject to its approval.
375. While there was evidence before me about the resources available to Avtex, particularly in relation to the maintenance of the aircraft, at the conclusion of hearing all of the evidence regarding the maintenance of the aircraft used by the AOC holder, I am seriously concerned about the state of airworthiness of those aircraft. There was ample evidence from former pilots of Avtex and one of CASA's flying operations inspectors, Mr Campbell, about the serviceability of aircraft used in the operation. In my opinion, the evidence also discloses a significantly large number of serious mechanical failures which cannot be attributed to causes outside the maintenance organisation.
376. With respect to Mr Newberry, his responses regarding the engine life extension program for the PA-31 aircraft were unsatisfactory. His somewhat carefree assessment about receiving verbal approval to add further engines to the program is not the approach one would expect of a competent and conscientious HAAMC.
377. Mr Newberry's understanding of the legislative provisions regarding airworthiness issues was demonstrably deficient. His explanations for why defects had not been entered on the maintenance release because they had been detected in the course of conducting maintenance were simply unbelievable. Mr Newberry's evidence about the reasons for certain failures in components cannot carry any weight. He was not qualified to offer those opinions. The person who was qualified, Mr Lynch, was not called to give evidence. That, in my opinion, was very significant.
378. In summary, Mr Newberry is an inappropriately qualified person to hold the position of HAAMC. His performance in this role does not meet the standard required for the position and it has resulted in poor airworthiness control of the aircraft used by the AOC holder.

CONCLUSION

379. The decision which I must make is discretionary. CASA's decision in this case was made under the serious and imminent risks to air safety provisions contained in Division IIIA of the CA Act. The decision under review was made under s 30DI of the CA Act. Under that section, if CASA is satisfied that a serious imminent risk to air safety would exist if the AOC were not varied, suspended or cancelled; and the grounds for CASA's belief are related to the circumstances that gave rise to CASA's decision to suspend the authorisation under s 30DC, then CASA may vary, suspend or cancel the authorisation. While that was in fact the decision taken, CASA submitted that I could nevertheless proceed to affirm CASA's decision if I were to find that Avtex had breached a condition of its AOC (at s 28BA(3)). For the reasons I have already set out above, I agree with that submission. Nevertheless, whether I proceed under s 28BA or s 30DI of the CA Act, the decision remains discretionary.
380. I have come to the conclusion that CASA's decision to cancel Avtex's AOC was correct. It was the correct response to the safety problems it discovered when closely examining the operations of Avtex. In fact, I am of the view that the decision was correct whether it was based on the serious and imminent threat basis or the breach of AOC conditions basis.
381. Although Avtex seemed to operate for a considerable number of years without any serious problems, for reasons that are not entirely clear, by 2006 CASA was becoming aware of safety issues within

Avtex. At that time, both the turbine and piston aircraft operations were conducted by Avtex. The original complaints received were regarding poor maintenance practices. While of course it could be said that these only concern the certificate of approval holder, that is not the case here where Avtex is also an AOC holder. It has a duty to ensure the airworthiness of the aircraft used in the AOC operation. While it need not have its own maintenance organisation to support the airworthiness of the aircraft used in its operation, where it does, it would be reasonable to expect a greater degree of control over maintenance practices thereby ensuring the airworthiness of the aircraft. Unfortunately, the evidence before me indicates the opposite.

382. In 2007 CASA refused to issue an exemption to Avtex from duty time requirements by issuing a FRMS. It had failed to update its existing FMS. Shortly after this, one of Avtex's Metro III aircraft crashed after take off killing the pilot. That prompted CASA to undertake a special risk based audit of Avtex. The audit disclosed numerous safety problems and CASA issued two SAs as well as a number of RCAs. It also identified problems with the chief pilot of Avtex and it resulted in CASA taking steps to cancel Avtex's AOC. However, in order to give the company a second chance, Avtex agreed to eight conditions being placed on its AOC, including removal of its then chief pilot, Mr Myles. Avtex then separated its piston engine aircraft operations from Avtex, moving those to Skymaster under a new chief pilot, Mr Hanley.

383. As CASA became more involved with Avtex as a result of monitoring compliance with the AOC conditions and responding to requests by Avtex to remove some of those conditions, it discovered further significant safety problems. This culminated in a second risk based audit being conducted in February 2010. To the concern of CASA, it discovered that many of the issues raised in the June 2008 audit remained. This was despite the fact that Avtex now had a new chief pilot, Mr Donoghue, the former general manager of that company. While on the surface it appeared that Avtex was dealing with the issues raised by the audit, closer examination of its operations revealed nothing much had changed.

384. Matters came to a head in May 2010 when CASA served on Avtex a show cause notice referring to some 28 RCA's and one SA. However, on 15 June 2010 a PA-31P Mojave aircraft crashed while attempting an emergency landing on Canley Vale Road near Bankstown airport. That accident claimed the life of the pilot and a flight nurse. It resulted in a special audit being conducted of the Skymaster operation. Avtex made strenuous efforts throughout the hearing of this matter to quarantine issues involving Skymaster operations. It was apparent from the evidence that while some matters could be excluded, there was a significantly large overlap between the two organisations as a result of common key personnel. Many issues raised in the Skymaster audit became relevant because they involved the same key personnel.

385. The evidence disclosed that the operations of both Skymaster and Avtex were unsafe. While Mr Siewert testified that he was not involved in the day to day operations of Avtex, the evidence disclosed the extent of his influence, particularly over key personnel. That is quite likely why, despite some changes to key personnel following the 2008 audit, nothing changed. I have found that major decisions about the way in which Avtex operated were driven by Mr Siewert. His influence is pervasive in all aspects of Avtex's operations. While that, from the commercial perspective, comes as no surprise, it does become a problem when commercial imperatives override safety considerations. In my opinion, this is what was happening in Avtex and Skymaster.

386. As Professor Reason explained in his academic paper, it is possible to recognise typical accident (or incident) patterns. The fact that different key personnel are involved in events simply implicates causal factors relating to the workplace and the system at large. Simply changing key personnel without changing the safety culture from the very top of an organisation will not ensure a safe system of working. In my opinion, as CASA submitted, Avtex has a poor safety culture and it cannot change without there being change at the very head of this organisation. There was no evidence before me which might indicate that was likely to happen.

387. I have dealt in some detail with the significant issues which were also highly contentious. Despite close examination, I was unable to find any significant redeeming features about the behaviour of the key personnel in respect of those issues. I preferred the evidence of former pilots of Avtex, because they have no interest in the outcome of this decision whatsoever. The same could not be said of pilots who, until the cancellation of the AOC, continued to fly for Avtex. Also, the former pilots who gave evidence were cross-examined, while those pilots who continue to be associated with Avtex were not. Their statements were also extremely brief and of course, not tested by cross-examination.

388. As for the independent expert evidence given by Mr Quinn, while I have no doubt that Mr Quinn provided a forthright account of his findings when examining Avtex's operations, it was based on very limited material. He interviewed Mr Siewert, Mr Hanley, Mr Donoghue and Mr Newberry but he did not interview any pilots who were then flying for Avtex. Nor did he attempt to contact any former pilots who had operated either under the Avtex or Skymaster AOC's. He did not interview Mr Lynch, Mr O'Brien, Mr Couch or Mr Myles. His interviews were with persons who had an interest in putting forward the best possible view of Avtex's operations. He nevertheless concluded that Avtex's operation was between reactive and calculative on Professor Hudson's scale. Despite that, Mr Quinn provided a favourable report regarding Avtex's safety culture. He arrived at this conclusion even though Professor Hudson explained that safety culture can only be considered seriously in the latter stages of his evolutionary ladder. He said that prior to that, up to and including the calculative stage, the term safety culture should be described as formal and superficial structures, rather than being an integral part of the overall culture. In my view, Mr Quinn's assessment was correct, but his conclusion is plainly incorrect.
389. In addition to the evidence disclosing the existence of a serious and imminent risk to air safety, it also disclosed many breaches of the conditions of Avtex's AOC, both those conditions expressly stated on its AOC and those imposed by the operation of Subdivision E of Division II of the CA Act. I find that the directors' of Avtex did not take all reasonable steps to ensure that every activity covered by the AOC and everything done in connection with those activities was done with a reasonable degree of care and diligence. I also find that Avtex did not at all times maintain an appropriate organisation with a sufficient number of appropriately qualified personnel and a sound effective management structure having regard to the nature of its operations. Therefore, I am also of the view that if CASA were minded, it could have relied on s 28BA(3) of the CA Act for the purposes of coming to its cancellation decision.
390. In my opinion, CASA's decision to cancel Avtex's AOC was correct. I affirm that decision.

I certify that the three hundred and ninety [390] preceding paragraphs are a true copy of the reasons for the decision herein of

Mr Egon Fice, Senior Member

Signed:

.....[sgd] Elise Montalto.....

Associate

Dates of Hearing 23, 24 September 2010

5, 6, 7, 8, 18, 19, 20, 21, 22 October 2010

15, 16, 17, 18, 19 November 2010

Date of Decision 4 February 2011

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