Australian Transport Safety Bureau – Supplement

ATSB Australian Transport Safety Bureau

Air Safety Investigations

Recently completed investigations

As reports into aviation safety occurrences are finalised they are made publicly available through the ATSB website at www.atsb.gov.au

Published September–October 2001

Occ. no.	Occ. date	Released	Location	Aircraft	Issue
200104684	28-Sep-01	24-Oct-01	Latrobe Valley Vic.	Cessna 172F	Ground impact after go-round
200103962	20-Aug-01	23-Oct-01	Perth WA	Fairchild Ind. SA227-DC	Smoke and fumes in cabin after landing
200003093	1-Jul-00	16-Oct-01	12 km SSW Alice Springs NT	Piper PA-28R-201	Pilot misinterpretation of controller's instructions
200003412	1-Aug-00	16-Oct-01	Tennant Creek NT	Cessna 404	Response to aileron control input reduced
199905646	25-Nov-99	15-Oct-01	41 km NE Hayman Island Qld	Robinson Helicopter R44	Forced landing after burning smell and shudder
200006013	11-Dec-00	12-Oct-01	East Sale Vic.	Sikorsky S-76C	Infringement of separation minima
200100346	28-Jan-01	12-Oct-01	1.3 km NW Canberra ACT	Beech A23A	Ground impact following stall after takeoff
199901073	12-Mar-99	8-Oct-01	Melbourne Vic.	Boeing 737-377	Right roll and thump during landing gear extension
200100905	15-Feb-01	2-Oct-01	56 km SW Sydney NSW	Boeing 737-33A	Failure of spoiler cables
200004191	12-Sep-00	2-Oct-01	9 km NW Inverell NSW	Cessna A152	Loss of control during solo aerobatic flight
200101952	3-May-01	27-Sep-01	Cooma NSW	Beech 1900D	Extensive damage by six ducks during takeoff
200000893	13-Mar-00	27-Sep-01	15 km WNW Bankstown NSW	Beech D55	Forced landing following double engine failure
200002700	27-Jun-00	27-Sep-01	Broome WA	Cessna A185F	Ground loop during gusty cross wind
200000868	10-Mar-00	27-Sep-01	11 km SW Warragul Vic.	Gippsland GA-200C	Collision with terrain during spraying operations
200003793	30-Aug-00	27-Sep-01	Cairns Qld.	Cessna A150L	Go-round due to aircraft on runway
200103089	13-Jul-01	27-Sep-01	Warnervale ALA NSW	Cessna 182G	Separation infringement during parachute ops
200000932	18-Mar-00	27-Sep-01	2.5 km NNW Moorabbin Vic.	Cessna 210E	Ditching following power loss after takeoff
200102697	18-Jun-01	25-Sep-01	Cooktown Qld	Fairchild SA227-AC	Single engine landing
200003023	5-Jul-00	24-Sep-01	56 km S Maitland NSW	Saab AB SF-340B	Unsuccessful flight data coordination process
200003091	16-Jul-00	24-Sep-01	13 km NNW Sydney NSW	Saab AB SF-340B	TCAS Resolution Advisory during approach
200101405	26-Mar-01	21-Sep-01	59 km WNW Devonport NDB Tas.	Piper PA-31-350	Engine failure in flight
199903995	9-Aug-99	14-Sep-01	Sydney NSW	Boeing Co 737-377	Electrical fault during APU performance monitoring
200000520	9-Feb-00	5-Sep-01	AGAGO (IFR) SA	Boeing Co 767-338ER	Loss of air situation display
199902419	6-May-99	5-Sep-01	9 km ENE Perth VOR WA	Boeing Co 737-376	Infringement of radar separation

You might learn about flying from this

"THE information I give you is as a concerned pilot. The problem is associated with a lack of parts and a loyal desire to keep the aircraft flying," the report reads.

In another report: "I was concerned for the safety of the pilot on two occasions…however I am concerned most about the safety culture of the [parachuting centre]."

Yet another report outlines a personal experience: "I got my weather and NOTAM from NAIPS. I did not receive a NOTAM on [destination]. I joined mid-downwind for the runway and the windsock confirmed this. I did not fly over the windsock and so did not see the white cross when I landed."

Another report relates an incident when an electric wheel chair was unloaded from the hold and wheeled to the stairs for the passenger. "The battery had not been correctly packed for air transportation," the ground crew said.

In another, a concerned pilot reports the behaviour of others – airline pilots using 121.5MHz as a chat frequency. 'Two pilots from [airline] continued a lengthy conversation on their forthcoming layover. Lately pilots from [another airline] have also been chatting on this frequency."

These reports all have something in common: they were all submitted confidentially.

More than three hundred reports are submitted every year through the Confidential Aviation Incident Reporting System, known as CAIR, by pilots, air traffic services personnel, cabin crew, maintenance workers, aircraft passengers and others.

In many cases, pilots have learnt about flying from their experiences and want to share them with fellow pilots. In others, reporters may only be able to highlight problems through a CAIR report, knowing that it would escape the mandatory reporting route. In some cases, it is whistle blowing.

Australians have generally embraced the idea of reporting - covering a wide variety of issues that they see as genuine safety concerns willingly and voluntarily.

Chris Sullivan, CAIR Manager

But do CAIR reports make a difference?

CAIR is the only system that captures information that would otherwise go unreported and where lessons can be learnt from others. It is therefore well placed to help identify and rectify aviation safety deficiencies. The reporter's identity always remains protected.

But it is not the only method of reporting - many companies have their own internal safety reporting programs. What CAIR does offer is an alternative process when the company program or system is ineffective.

Perhaps the last word comes from the following report. The pilot was flying a general aviation aircraft from Camden for a Sydney Victor One via Stanwell Park and after some radio talk with Sydney was cleared to enter the harbour area approaching South Head. With two radio frequency changes made, and at 600 feet, the pilot recounts: "Suddenly I recognised a pair of landing lights, a flash of white with a blue haze, a set of floats and a Cessna engine cowling.

A numbness swept over me as I realised that I had not had time to swear. A float plane had passed within metres of my aircraft, tracking south between me and the coast and I had no warning of it.

Who was at fault? I felt I had kept a reasonable look out at all stages of the flight. However, this was obviously not the case. Throughout the flight I had been preoccupied with Sydney Terminal and had not kept a listening watch out on 120.8Mhz. Perhaps I should have had the other radio on and maintained a dual listening watch, something I will do in future.

In hindsight I am neither angry nor indignant, just relieved that a misadventure did not occur."

If you would like to make a confidential report, call the ATSB's CAIR manager, Chris Sullivan on 1800 020 505, or complete a CAIR form, which is available from the internet site at www.atsb.gov.au.

He's only too happy to hear from you. And so might others in the industry. ■

Did you know?

You are now reading a special supplement prepared by the Australian Transport Safety Bureau which is independent of CASA editorial.

We aim to keep you informed of the latest published reports, and accident and incident findings and we're keen to hear from you.

You can contact us by email atsbsupp@atsb.gov.au or on 1800 621 372.

Safety briefs

Harness safety heightened

Safety Brief 200000893

Three significant factors were found during the investigation into the forced landing of a Beech Baron on 13 March 2000 in which the pilot suffered severe head and facial injuries.

The pilot was not adequately prepared for an assigned instrument approach in instrument meteorological conditions (IMC); did not change fuel tank selection when the auxiliary tanks were exhausted; and the shoulder harness was not correctly installed.

The pilot had entered controlled airspace without a clearance 20 NM north west of Bathurst. Issued a clearance, the pilot tracked for Bankstown and entered IMC and requested a Bankstown Radar Two arrival. The pilot was instead cleared for a Runway 11C Radar/Bankstown NDB/Sydney DME instrument approach and acknowledged the instruction. The controller told the pilot the aircraft was right of track and cleared it to track to Bankstown on that procedure. The pilot then contacted Bankstown tower and was asked which approach the aircraft was flying. The pilot confirmed flying a GPS approach.

The pilot later reported not having flown the assigned approach before. When not visual at 600ft the pilot commenced a climbing turn onto a reciprocal track to divert to Bathurst.

After turning the left engine failed followed by the right. The aircraft impacted the ground in a grass-covered gully. ■

Maintenance fatigue issues

Safety Brief 200100905

Maintenance engineers had worked excessive hours and were fatigued when they mis-routed Boeing 737 spoiler cables during their replacement following an incident in which a cable failed on 15 February 2001.

The cable failure became apparent during the descent into Sydney when the aircraft rolled to the right after the speed brake was selected with the autopilot engaged. The autopilot was disengaged and the speed brake reselected with the same result. The flight continued and the aircraft landed without incident, was repaired and returned to service.

The mis-routed cables were found when the aircraft was inspected during routine maintenance thirteen days later. The operator's investigation found that the engineers who had replaced the cables had worked more than 24 hours and flown from Brisbane to Sydney that same day.

In February 2001, the ATSB released an Air Safety Information Paper, *ATSB Survey of Licenced Aircraft Maintenance Engineers in Australia*. One of the safety deficiencies identified was a lack of programs to limit the extent of fatigue experienced by maintenance workers. As a result of that deficiency, the ATSB issued safety recommendation R20010033 to the Civil Aviation Safety Authority (CASA) in February 2001 which stated:

> 'The Australian Transport Safety Bureau recommends that CASA ensures through hours of duty limits, or other means, that maintenance organisations manage work schedules of staff in a manner that reduces the likelihood of those staff suffering from excessive levels of fatigue while on duty.'

CASA has addressed the issues of a fatigue management program through a Notice of Proposed Rule Making. ■

Centurion power loss mystery

Safety Brief 200000932

A number of factors were considered but no firm conclusion reached in the investigation into the ditching of a Cessna 210 Centurion after take off on 18 March 2000.

The aircraft was successfully ditched in a quarry filled with water when it was unable to climb beyond 100ft after takoff. The pilot and both passengers exited the aircraft but one passenger drowned.

The aircraft had used more runway than book figures indicated for the conditions during take off, however the pilot did not notice the reduced aircraft performance until the landing gear was retracted shortly after becoming airborne. There was no sudden loss of power.

No faults were found with any of the aircraft's systems, engine, and propeller or in its handling by the very experienced pilot. Even though a defect was found in the fuel selector valve that restricted the flow of fuel to the engine, this would not have resulted in the performance loss that was observed in the accident.

The loss of performance was consistent with a restricted fuel supply. ■

Pilot incapacitation likely

Safety Brief 200004191

Pilot incapacitation leading to a loss of control was a likely factor in the accident involving a Cessna A152 Aerobat on 12 September 2000.

The pilot was on a solo aerobatic training flight to practise for a competition and had been having problems conducting stall turn manoeuvres during a previous dual instruction flight. There were no witnesses to the impact.

Examination of the accident site revealed that the aircraft impacted the ground in balanced flight at high speed in an attitude of approximately 70 degrees nose down. The engine was producing high power at impact. Examination of the wreckage did not reveal any technical defect that would have contributed to the accident.

The pilot had a long history of hiatus hernia and had taken medication but had not undergone surgery. At the time of the accident the pilot was not taking prescribed medication. For about 10 years the pilot had been prone to fits of coughing after eating and drinking. During these attacks, the pilot's ability to perform other tasks was impaired. About 45 minutes before the dual flight, the pilot had eaten a hamburger and chips. During the dual flight, the pilot had suffered a fit of coughing during which time attention to flying the aircraft was reduced.

Toxicological examination of the pilot revealed the presence of the drug doxylamine, at a concentration of 4.7 mg/kg in the liver.

The reason for the pilot's loss of control of the aircraft was not conclusively established. Significant factors identified in the investigation were that the pilot suffered from a medical condition that could have adversely affected the ability to fly the aircraft, and the pilot lost control of the aircraft and did not regain control before the aircraft impacted the ground. ■

Ground loop

Safety Brief 200002700

A gusting crosswind and aircraft centre of gravity close to the aft limit were the key factors in the ground looping of a Cessna 185 on 27 June last year.

The pilot reported that following a normal landing, and after the tail wheel had been lowered to the runway, the aircraft nose commenced to yaw to the right. The pilot estimated that the aircraft was travelling at about 20 KTS and despite applying full rudder and the use of differential braking it was not possible to regain directional control and the aircraft ground-looped.

The left main gear-leg collapsed and the outboard portion of the left wing was substantially damaged when it struck the surface of the runway. The propeller was also damaged on contact with the runway. The pilot and three passengers were not injured and vacated the aircraft without assistance.

The pilot had been endorsed on the aircraft approximately one week before the accident and had significant experience operating other tail-wheel equipped aircraft. The pilot had logged 18 hours on the Cessna 185.

The weather at the time of the accident was a southerly wind with gusts recorded up to 11 KTS. The report concluded that the pilot could have encountered a right crosswind of up to 10 KTS during the landing. Although this was within the aircraft manufacturer's demonstrated crosswind limit of 15 KTS the investigation calculations showed the aircraft centre of gravity was close to the aft limit although still within published limits.

The weather conditions prevailing at the time of the accident would have made the aircraft more difficult to control, especially during the later stages of the landing roll as the aircraft slowed down and the rudder became less effective. Directional control at lower speeds becomes increasingly dependent on tail-wheel steering and the use of differential braking. The directional instability would have been further exacerbated with any sudden increase in crosswind component due to the gusty crosswind conditions. ■

Stall during climb fatality

Safety Brief 200100346

A Beech Musketeer stalled during the climb after takeoff on 28 January 2001 and was not recovered before it impacted the ground fatally injuring all four occupants.

After the aircraft took off it climbed at a shallow angle, which witnesses reported was below the normal climb profile. When the aircraft reached a point about 100 m beyond the upwind threshold of the runway, the tower controller informed the pilot of inbound traffic directly ahead of the aircraft. The controller noticed that the aircraft was exhibiting 'wobbles' and became concerned.

Witnesses reported that the aircraft slowly climbed to about 300 ft and then seemed to lose altitude. The aircraft then continued tracking outbound in a shallow climb on runway heading before the right wing dropped. The aircraft then rolled to the right, assumed a steep nose-down attitude and began rotating. After one turn the aircraft impacted the ground in a steep nose-down inverted attitude. The pilot and passengers had arrived at the pilot's home in the early hours of the morning after driving from interstate. The pilot was up at 0630 EST on the day of the accident.

During the investigation no aircraft defects were found and the aircraft was operating within its correct weight and balance limits. It was considered that operating just under maximum gross weight at a density altitude of 3,400ft would have reduced the aircraft's acceleration and climb performance.

As the aircraft was lower than the normal climb profile, rising terrain ahead might also have affected the pilot's assessment of the aircraft's nose attitude with respect to the horizon or its rate of climb with respect to terrain. Consequently the pilot may have selected a higher nose attitude. The pilot may have been distracted while looking for inbound traffic during the initial climb. ■

Safety first –

aircrew, ground personnel and passengers

by Peterlyn Thomas

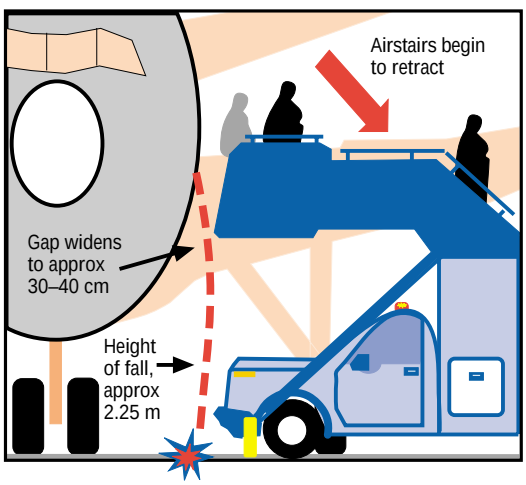
The ATSB collects and analyses data from accidents and incidents involving aircrew, ground personnel and passenger safety. In this issue of the ATSB Supplement, a selection of Australian cabin safety occurrence briefs are summarised and one from the Transportation Safety Board of Canada.

THIS report from the Transportation Safety Board of Canada (A99AO046) highlights the need for continued care and vigilance in the use of ground-handling equipment to ensure safe movement to and from aircraft for passengers, aircrew and ground personnel.

In March 1999 a five year-old child was injured during disembarkation from a B767 at a Canadian airport. The aircraft was parked on the open ramp away from an aerobridge.

After the first 10 passengers had left the aircraft a flight attendant exited the aircraft carrying an infant in a car seat. When the flight attendant stepped on to the passenger stand he noticed it was descending slowly away from the aircraft. As he turned to tell the in-charge flight attendant, the infant's five year-old brother, who was following with his mother, stepped out of the aircraft and fell between it and the stairs to the apron below. The child suffered a broken arm and lacerations to the head in the fall and was taken to hospital for treatment and observation.

The locking mechanism used to hold the upper stairs in position is a fairly simple mechanical device. The pawl that prevents the stairs from descending is held in place against the dog rail by a spring and released by energising a solenoid. In this occurrence the pawl had only partially engaged the dog rail and after several passengers had travelled over the stairs had slipped off. This allowed the upper stairs to descend away from the aircraft. According to the report it was unclear whether this was due to a weakness in the spring, a mechanical resistance in the mechanism or a combination of both. In any case proper functioning of the locking mechanism was impeded.



Investigation findings: The locking mechanism was not functioning properly and as a consequence disengaged and allowed the upper stairs to descend away from the aircraft. There was no policy in place requiring the passenger stand operator to do a close visual inspection of the locking mechanism to ensure full engagement.

Passenger stand operators reported that they would take only a cursory look at the locking mechanism when leaving the vehicle. Any visual inspection would have been impeded because the pawl, the dog rail, and the background were all painted the same dark green colour and on this particular vehicle a support brace impeded the operator's view. Operators of the passenger stand reported that they had not received formal training on the operation of the equipment.

Other contributing factors to the occurrence were the failure to follow the maintenance schedule and the absence of a requirement to visually inspect the locking mechanism of the passenger stand before use.

Safety action taken: Since the occurrence the company has completed a comprehensive inspection of all company passenger stands. All pawl mechanisms were painted in contrasting

Photographs of the burnt out Saudi Arabian Airlines Lockheed Tristar at Riyadh on 19 August 1980 following an emergency landing. All 287 passengers and 14 crew on board died from smoke inhalation from a fire in the aft cargo hold which started shortly after takeoff. Despite the successful landing the crew were unable to open the doors. Emergency services took 20 minutes to open one door. A serious breakdown of crew coordination was cited as one of the significant factors in the disaster.

Source: www.airdisaster.com

colours to facilitate determination of the pawl position and support braces were relocated to prevent the impediment of the operators' view of the pawl. All airstairs units were put on a weekly follow-up routine to ensure all checks are completed on time.

The company, the TSB and the Canadian regulator Transport Canada, have disseminated details of the occurrence to local and international air transport operators regulators and industry associations to alert other operators using similar equipment of the potential for injury and the steps that may be taken to avoid similar occurrences.

Occ No. 200100741, 22 February 2001
At top of descent to Los Angeles the cabin crew of a Boeing 747 aircraft reported smoke and fumes emanating from the cabin ceiling located in the vicinity of the rear right side (R5) emergency exit door. Smouldering paper tissues were found in an overhead light fitting. Cabin crew removed the tissues and discharged a fire extinguisher onto the light fitting, tissues and surrounding area. The cabin crew remained in the vicinity and monitored the area until passengers disembarked at Los Angeles.

The company reported that the light fitting is a night light and is always on. The light has a blue plastic cover that should always be in place and which was not fitted on this occasion.

The investigation was unable to determine why or who placed the tissues in the light fitting.

Safety action: The company issued an 'Important Information' bulletin to flight attendants advising that any visible cabin light fitting must have a protective grill or glass covering the bulb.

Occ no. 200104168, 21 August 2001
During the cruise the passenger seated in 56C was warned several times for lighting cigarettes. Most cigarettes were extinguished and confiscated by the crew but one was dropped and ignited a blanket. The cabin crewmembers were quick to extinguish the smouldering blanket. The passenger was offloaded in Bangkok.

Occ No. 200104464, 5 Sept 2001
During a flight between Melbourne and Sydney a smouldering fire was detected and extinguished in the waste bin of the aft toilet of the aircraft. A particular passenger was strongly suspected of smoking in the toilets during flight and the pilot in command requested that security staff meet the aircraft upon arrival in Sydney. The aircraft landed without further incident.

Occ No. 200103578, 10 July 2001
The aircraft was on climb passing FL200 when a passenger sustained a head injury from a bottle of liquor that was accidentally dropped from an overhead locker by another passenger who was removing a piece of luggage. The injury was treated immediately by the cabin crew to stop the blood flow. A paramedical team met the aircraft on arrival at Rome.

Occ No. 200103478, 15 July 2001
During disembarkation a passenger was struck on the head by a metal scooter that fell from on overhead storage bin. The passenger received a bleeding cut to the head, was given first aid and attended by the Rescue Fire Fighting Service. The passenger was later transported to a local medical centre for treatment.

Occ No. 200100393, 24 Jan 2001
During the cruise cabin crew were required to abruptly cease cabin service when the flight crew turned on the 'fasten seat belt' sign due to severe turbulence associated with thunderstorm activity. They were not able to secure the cabin prior to landing and as a result the aircraft landed with the cabin insecure. The pilot in command reported later that he did not consider it safe to turn the sign off during the descent.

Occ No. 200103943, 8 August 2001
During the cruise a passenger seated in 20C was struck on the head by a plastic bottle full of water, which had been stored in the overhead locker by a cabin crew member. The passenger later collapsed, became ill and required medical attention. An ambulance was organised to meet the aircraft on arrival at Darwin.

Occ No. 199902180, 24 April 1999
The aircraft was cleared for takeoff when the flight attendant advised the pilot that a cat had escaped from a cage in the cargo hold and was loose in the cabin. The flight attendant locked the cat in the toilet while the pilot returned the aircraft to the ramp. The cat was removed through the toilet door without further incident.

Occ No. 200102090, 3 May 2001
During the cruise the crew noticed smoke in a rear toilet. The cabin crew found a smouldering tissue box that appeared to have been used to extinguish a cigarette and then water used to extinguish the potential fire. At the time the 'no smoking' sign was extinguished. ■

Confidential Aviation Incident Reporting

THE Confidential Aviation Incident Reporting (CAIR) system helps to identify and rectify aviation safety deficiencies. It also performs a safety education function so that people can learn from the experiences of others. The reporter's identity always remains confidential. To make a report, or discuss an issue you think is relevant, please call me on 1800 020 505 or complete a CAIR form, which is available from the Internet at www.atsb.gov.au

In the Jul-Aug 2001 issue, three reports were published that highlighted concerns with the use of mobile telephones in the vicinity of aircraft. At the time of publication, responses had not been received from the airlines concerned or from CASA. I am pleased to advise that the issue is being addressed by CASA and two of their responses are reproduced below.

Chris Sullivan
Manager CAIR

CAIR reports

Mobile telephones

First response from CASA (CAIR 200100004)
Regarding the use of PEDs (personal electronic devices), current regulations relate only to safety in flight. CASR 91.105 requires the operator and the pilot-in-command to prohibit or limit the operation of a PED on board an aircraft if there is reason to believe the PED may adversely affect the safety of the aircraft. CASR 91.15 provides the pilot-in-command with the necessary authority to control the use of potentially hazardous PEDs on board his/her aircraft and obliges persons on board to comply with legitimate safety instructions.

Legislation to control the use of mobile phones during refuelling is currently being developed. The draft NPRM for Part 91 states:

> Rule 3.7 The aircraft operator and the person in charge of the aircraft fuelling operation must take all reasonable steps to ensure that all devices capable of emitting radio-frequency energy are turned off when within six metres of the aircraft's fuel filling points or fuel vents, or the fuelling equipment, unless the devices have been designed or certificated to an industry standard for use in fuelling zones.

The examples provided in the FYI will be prohibited once the new legislation relating the use of PEDs during refuelling is introduced (planned for November 2002).

Second response from CASA (CAIR 200102506)
I thank you for your letter of 8 June 2001 requesting information to address concerns raised in a CAIR report relating to mobile phone use.

The regulation to control the use of mobile phones is contained within the proposed CASR Part 91 NPRM (Notice of Proposed Rule Making), which is to be released for public comment within the next three months.

The proposed regulation that controls the use of mobile phones by a passenger during flight provides for a penalty of up to 25 units (currently $110 per unit) for knowingly breaching this regulation. The operator and the pilot-in-command are required to enforce this requirement. Failure to do so may incur a penalty of 25 units. Operators who hold an Air Operators Certificate will be required to establish procedures acceptable to CASA to ensure these regulations are enforced.

I trust this provides you with the necessary information to address the concerns raised by the author of the CAIR report.

Flight in poor weather conditions

(CAIR 200100463)
A very heavy thunderstorm with an associated squall line had passed over [regional location] *and was moving to the south. Although it was still daylight at 1900 EST, the sky was very dark associated with the weather. As I watched the storm moving south towards the Ranges, I was amazed to see* [aircraft type] *appear from out of the storm on a wide (7-8 NM) right base to runway 07.*

Was air traffic control putting this aircraft at risk or was it the crew putting their passengers at risk? The dangers of windshear and microbursts associated with thunderstorms are well documented. Has the airline been placing too much emphasis on the commercial imperatives to the detriment of passenger safety?

Response from Airservices Australia: I am writing in response to the above report, which relates to an alleged flight at [regional location] during adverse weather.

Airservices is unable to comment on the circumstances of this report. Suffice to say that the ultimate decision on the suitability of flight during adverse weather rests with the pilot. The air traffic system provides the pilot with flight information to assist the pilot to make this decision.

Response from operator: I am in receipt of your letter regarding a safety concern expressed about one of our aircraft conducting an arrival into [regional location] on [date]. The answer to the question 'was the crew putting their passengers at risk?' is no.

[Airline] provides ample educational documentation to our flight crew on the problems of windshear and microbursts associated with thunderstorms. Our crews regularly conduct windshear and microburst training and are checked by our training department on the correct identification and response to encounters with windshear and thunderstorm avoidance.

The implication the airline has been placing too much emphasis on the commercial imperatives to the detriment of passenger safety is nonsense, and to be dismissed as simply ill-informed speculation.

MED 1 priority vs Noise abatement (CAIR 200100543)

Re: AIP Australia Noise Abatement Procedures, Brisbane, Queensland - Page 1 - Note 2.

I always believed MED 1 indicated a life-

threatening situation - are there now to be levels of this? Surely, duty of care dictates that MED 1 aircraft are afforded every assistance.

I would have hoped to see MED 1 operations given a blanket exemption from noise abatement, not treated as this note in the AIP treats them.

CAIR note: The Note 2 that was referred to in the above CAIR report was in AIP DAP East Amendment 79 effective 22 February 2001. It was detailed as follows:

Note 2: Pilots of MED 1 priority aircraft shall advise ATC if they have a level of urgency that requires exemption from compliance from Noise Abatement Procedures. This notification should be made as early as practicable. If exemption is requested ATC will facilitate this request.

Response from Airservices Australia: I am writing in response to the above report, which relates to concerns with MED 1 category operations.

Airservices agrees in principle with the reporter's notion that medical priority aircraft should be afforded all consideration possible to achieve the nature of their task.

We cannot however provide carte blanche exemption from legal obligation based purely on the category of operation. Our obligation to ensure compliance with a raft of legal requirements can only be varied as a result of a specific request from the pilot.

The management of Brisbane Centre Air Traffic Management has instigated a change to MATS to reflect maximum cooperation to MED 1 category aircraft. We will continue to do everything in our power to assist these operations.

Problems at uncontrolled aerodrome (three reports)

CAIRs 200101733, 200101938 & 200101942)

Report 1 (CAIR 200101733)

The main operator at [regional aerodrome] *is* [name of organisation]. *The instructors and some of the students are a law unto themselves and often use the MBZ frequency for other than standard calls and have abused other MBZ users over the radio. For a training environment, this is extremely bad practice and encourages poor attitudes and airmanship. CASA should monitor this frequency occasionally and counsel offenders.*

Report 2 (CAIR 200101938)

During the last 18 months I have observed [operator] *flight training operation and noted numerous breaches of regulations and poor airmanship. I am submitting this CAIR as I believe* [their] *operational standards have deteriorated further in recent months to a point where I consider them to be a hazard to other operators at* [location] *and a danger to themselves. I have a record of aircraft registrations, dates and other witnesses names for many of these occurrences.*

These observations include the following:

1. *Simulated engine failure in a PA-44 Seminole after take-off (200ft AGL) at night.*
2. *Practice circling approaches in VMC in a C90 Kingair and turning final 200–300ft AGL over the airfield fence.*
3. *Continuing practice instrument approaches through the circuit area rather than discontinuing the final approach no closer than 2 NM from the airfield as per 'Special Procedures' in the ERSA.*
4. *Using a cross runway to practice rejected take-offs in a PA-44 in a direction towards the active runway where touch and go circuits were being conducted. They appeared to use maximum braking to pull up just short of the active runway. (I carried out a go-round as I had doubts about the ability of the PA-44 to stop short).*
5. *Conducting crosswind circuits and subsequently having simultaneous runway operations with five aircraft in the circuit. (Max. allowed is three aircraft)*
6. *Not following the requirements for conducting straight-in approaches.*
7. *Giving false position reports in the circuit. For example, I recently gave a base call and an instructor in a PA-44 then called on a two-mile final. When I finally sighted the aircraft it was obvious that it would have been six miles out and tracking for a straight-in approach at the time of the two-mile call.)*
8. *Commanding other non-company aircraft to go-round to facilitate their own arrival.*
9. *Flying excessively large circuit patterns, inconveniencing other users. When conducting circuits on RWY 35 aircraft are up to five miles off the coast, outside gliding range to land and life jackets are not worn.*
10. *Total lack of R/T discipline. This includes abusing and lecturing other operators, accusing other operators of breaching regulations over the radio and using the MBZ frequency as a company chat frequency. This abuse over the radio creates a hostile operating environment and is particularly intimidating to solo students and inexperienced pilots.*

Report 3 (CAIR 200101942)

At approximately 12:40 on [date], *I was number two at the holding point for runway 17, at* [location]. *There were a number of aircraft in the circuit.* [Aircraft A] *called turning base for a stop and go. It landed, came to a complete stop, a person who I believe was an instructor stepped out of the aircraft onto the runway and strolled across the airfield.*

This caused two aircraft to go around one being [aircraft B]. [Aircraft B] *asked the pilot* [of aircraft A] *his intentions, as he was causing traffic to go-round. Words were exchanged between* [B] *and another pilot (unknown identity – I believe he may have been a fellow instructor).*

Due to the nature of the airspace at [location] *there is often non-compliance of the regulations particularly in the circuit area and bullying over the radio particularly between* [different] *operators.*

Response from CASA: It has been difficult to substantiate many of the claims made in the CAIRs. We have spoken to the operators and conducted surveillance at the airfield without seeing anything untoward.

There have been three meetings between the various operators at the airfield and the airport management in order to improve procedures and create a better working relationship between the parties. They have resolved many issues and have produced amendments to the local operating procedures to improve the safety,

[Location] is a very busy training airfield. A few years ago an MBZ was imposed because of increased training traffic and consideration has been given to requiring a tower facility during busy periods. The operators have been reminded of this fact and encouraged to take steps to improve the operations at the airfield if they wish the MBZ procedures to be retained.

We intend to continue close monitoring of operations at [location]. ■

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