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National Transportation Safety Board

Washington, D.C. 20594

Safety Recommendation

Date: June 15, 1992

In reply refer to: A-92-50 and -51

Honorable Barry L. Harris
Acting Administrator
Federal Aviation Administration
Washington, D.C. 20591

On December 10, 1991, a Piper PA-31-350 Navajo Chieftain, N350MR, operated by Las Vegas Airlines, under the provisions of 14 Code of Federal Regulations (CFR) 135, engaged in regularly scheduled scenic tour operations in the Grand Canyon, crashed on a ridge of Mount Wilson, Arizona. Evidence indicated that the airplane struck the ridge in nearly level flight in instrument meteorological conditions (IMC) during an "area arrival" while operating under visual flight rules (VFR).[1] The captain and four passengers sustained fatal injuries and the aircraft was destroyed.

Although the investigation is not yet complete, no anomalies have been found in the airplane's structure or powerplants. Investigators determined that both engines were probably operating within the normal range at impact.

The investigation has found significant deficiencies in the training of the pilot by the operator and Aërleon, Inc., which is a 14 CFR Part 141 flight school, the conduct of operations by the operator, and the oversight of operations, training and airworthiness by the Federal Aviation Administration (FAA) Flight Standards District Office (FSDO).

The investigation has revealed that the pilot had accumulated little, if any, instrument flying experience following an 8-year hiatus from flying. He had returned to flying status to work for the tour operator after retiring from military service in 1991. All pilot employees were, by company policy, former U.S. Air Force pilots. Evidence indicated that the pilot, as well as other newly-hired pilots, received "training" in the form of 33 observer flights while occupying the right seat of the PA-31-350, which is certificated for single-pilot

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[1] The airplane had received a VFR clearance into the Las Vegas Terminal Control Area (TCA); however, it was observed on radar by the air traffic controller to have turned and descended, impacting in mountainous terrain outside the TCA.

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operation, prior to receiving formalized instruction. Formalized instruction consisted of three dedicated training flights with the president/instructor and an in-house 14 CFR Part 135 check flight for VFR qualification by the operator's check airman.

Interviews with instructors, pilots and FAA operations inspectors, have revealed that training in instrument flying and judgment, which is required of commercial multiengine airplane pilots, was almost nonexistent. No evidence was found that the operator held any ground school classes or provided more than a minimum of technical documentation for training or pilot reference.[2] In interviews with the operator, Safety Board investigators were told that past experience as military pilots was sufficient for employment, and that a few hundred hours of transitioning to the PA-31-350, under VFR conditions, would satisfy the operator's requirements for an instrument flight rules (IFR) captain's rating. The Safety Board believes that the deficiencies in transitional training, especially in instrument flying and judgment, are significant in this accident.

Initial training for the purpose of certification as an airline transport pilot (ATP) was provided by Aërleon, Inc. The Safety Board found that instruction in "advanced, multiengine and instrument" subjects was provided by an instructor who did not possess a certificate as a certified flight instructor (CFI). An interview of this instructor regarding material covered during instruction flights with the accident pilot, and examination of records of that training, disclosed that the instructor provided little training in subjects required of an ATP applicant. After less than 6 hours of instruction in an airplane for which he was not licensed,[3] the accident pilot attempted and failed the ATP check flight. The flight school then provided another instructor, who also did not possess a CFI certificate for instruction in the multiengine category airplane that he was assigned to teach. After one instructional flight, this instructor recommended a recheck of the pilot. The accident pilot again failed the check flight, proving unsatisfactory in areas of judgment and instrument proficiency. After a third instructional flight with yet another instructor, the accident pilot successfully passed the ATP certificate check flight. Subsequently, the pilot was recommended, by his original flight school instructor, for employment with Las Vegas Airlines.

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[2] Investigators found that Las Vegas Airlines operated airplanes without complete and accurate Airplane Flight Manuals (AFM) that are required by Federal Aviation Regulations (airworthiness), Part 23, Subpart G. Required operational supplements were not attached to the AFM aboard the accident airplane.

[3] The accident pilot possessed a Commercial Pilot Certificate, with multi-engine rating limited to centerline thrust. Evidence indicated that his experience was limited to centerline thrust military jet aircraft.

The Safety Board's investigation has found several operator deficiencies in the hiring practices and operational control of airplanes and flightcrews. Pilots were hired without an examination of their records, and the only stated criterion was former military service. The instrument instruction was also determined to be inadequate and undocumented. FAA FSDO staff characterized the operator's instruction as "very weak, the bare minimum for a commuter airline." The investigation has also identified deficiencies in direction given to the pilots, equipage of the airplanes, and documentation of pilot flight time and training.

Operational control of flights appears to be driven by economics with insufficient regard for safety. Pilots are not salaried, but are compensated for each revenue flight. As an example of this economic pressure, on a flight occurring only 12 days before the accident, the accident pilot was directed by the owner/operator to fly the same PA-31-350, N350MR, which had been placarded against flight under IFR, to pick up passengers at an airport which was reporting below IFR landing minima conditions. While the operator did not specifically direct the flight to be conducted in IMC, the order to "try and get in when the weather got good enough," undoubtedly conveyed pressure to the pilot to return an airplane full of passengers. On that flight, the pilot, who was showing a lack of judgment consistent with his earlier transition training and the accident scenario, requested an instrument clearance and flew an approach into low visibility conditions of clouds and snow. That attempt ended in a missed approach. Following that flight, the owner/operator debriefed the pilot with praise for his attempt.

Throughout their examination of pilot training and conduct of operations, investigators have found a marked absence of effective oversight by the FSDO. The Safety Board believes that this deficiency could be the result of a long-standing adversarial and uncooperative relationship that has existed between the operator and the FSDO, culminating in a breakdown of communications and surveillance effectiveness. Examination of FSDO records has revealed numerous unresolved reports citing the operator for deviations from Federal Aviation Regulations and standards established for Part 135 operators. The Principal Operations Inspector (POI) having responsibility for the surveillance of Las Vegas Airlines characterized his oversight efforts with the operator as "inadequate."[4] He also stated that his workload involving 15 additional Part 135 operators did not allow him time to provide adequate surveillance of certificate holders. Moreover, the POI stated that the accident operator complicated his efforts by "a lack of cooperation, and an unwillingness to support his suggestions."

[4] The POI also had responsibility for oversight of the 14 CFR Part 141 flight school.

In interviews with the owner/operator, an almost total breakdown in trust and confidence in the FAA became evident. Investigators were told by the owner/operator that he viewed the local FSDO as "unhelpful" and that, "nothing could be gained from dealing with the FAA." Moreover, the POI stated he believed that the operator had the influence to "have him removed" from his position. He said that the relationship was "difficult" and that it may have contributed to his avoiding contact with the operator. The Safety Board believes that this adversarial relationship with the FAA created an atmosphere in which productive FAA surveillance was significantly curtailed.

The Safety Board is concerned that the deficiencies in FAA oversight of this tour operator's training and flight operations may be the result of longstanding and unresolved safety issues. In a sightseeing accident on August 17, 1983, Las Vegas Airlines flight 88, PA-31-350, operating under 14 CFR Part 135, encountered deteriorating weather conditions and impacted a near-vertical mesa wall in the Grand Canyon. The airplane was destroyed, and the pilot and all nine passengers were killed. As a result of its investigation of that accident, the Safety Board recommended that the FAA examine the operating procedures used by Grand Canyon sightseeing tour operators and, if necessary, develop and publish standards for operating procedures, including route selection, flight scheduling, and altitude selection for sightseeing flights in the canyon, and require that operators incorporate these standards in their operating specifications. A Safety Board recommendation to the FAA following this accident remains classified as "Closed-Unacceptable Action."[5]

The Safety Board believes that the deficiencies evident in the December 1991 accident relating to the quality of the pilot's instrument and judgment training with the operator and the local flight school, the conduct of operations by the airline, and the oversight of these conditions and policies by the FAA FSDO warrant immediate corrective action.

Therefore, the National Transportation Safety Board recommends that the Federal Aviation Administration:

> Conduct a National Aviation Safety Inspection Program (NASIP) inspection of Las Vegas Airlines and Aërleon Inc., a flight school at North Las Vegas Airport, and require that the majority of participating team members be from FAA regions outside the Western-Pacific Region.
> (Class II, Priority)(A-92-50)

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[5] NTSB recommendation to FAA, A-84-052, 5/31/84.

Immediately evaluate the management, staffing level, enforcement effectiveness at the Las Vegas Flight Standards District Office (FSDO), as well as the records of Enforcement Investigative Reports and adequacy of surveillance of 14 CFR Part 135 sightseeing tour operators by the FSDO, and implement necessary changes.
(Class II, Priority Action)(A-92-51)

Acting Chairman COUGHLIN, and Members LAUBER, KOLSTAD, HART, and HAMMERSCHMIDT concurred in these recommendations.

By: Susan M. Coughlin
Acting Chairman