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National Transportation Safety Board

Washington, D.C. 20594

Safety Recommendation

Date: February 14, 1994

In reply refer to: A-94-13

Mr. Walter Coleman
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Regional Airline Association
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On April 28, 1993, at 2350 central daylight time, a Beech Aircraft Corporation C-99, N115GP, operated by GP Express Airlines, crashed near Shelton, Nebraska. The airplane was destroyed, and the two pilots on board sustained fatal injuries. The purpose of the flight was for the pilot in the right seat (the check pilot) to administer a 6-month competency/proficiency check, required under the provisions of title 14 Code of Federal Regulations (CFR) Part 135, to the pilot in the left seat (the flying pilot). Both pilots were qualified check airmen with the airlines. The flight, which was conducted under 14 CFR Part 91, originated at the Central Nebraska Regional Airport, Grand Island, Nebraska (GRI), at 2343. No flight plan was filed, nor was one required, and visual meteorological conditions prevailed at the time.[1]

The National Transportation Safety Board has determined that the probable causes of this accident were the deliberate disregard for the Federal Aviation Regulations (FARs), GP Express procedures, and prudent concern for safety by the two pilots in their decision to execute an aerobatic maneuver during a scheduled check ride flight, and the failure of GP Express management to establish and maintain a commitment to instill professionalism in their pilots consistent with the highest levels of safety for an airline operating scheduled passenger service.

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[1]For more detailed information, read Aircraft Accident/Incident Summary Report--"Controlled Flight Into Terrain, GP Express Airlines, Inc., N115GP, Shelton, Nebraska, April 28, 1993" (NTSB/AAR/-94/01/SUM)

The conversations between the pilots recorded on the cockpit voice recorder (CVR) during the accident flight support the conclusion that there were no flightcrew physical problems or airplane problems that would have affected their control of the airplane. Their conversation and the discovery of the completed grade sheet also demonstrate that neither pilot intended to conduct an airman check on the flight. The recorded cockpit discussion clearly reveals that the flying pilot of the accident airplane performed a prohibited maneuver (apparently a barrel roll) at night and at an altitude insufficient to reasonably assure recovery of the airplane. Furthermore, the check pilot exercised no authority to oppose the intentions of the flying pilot while the flying pilot described and performed the maneuver.

Other than the very challenge of its performance, the Safety Board could find no readily apparent reason to explain why the pilots attempted to perform this maneuver. Both pilots were characterized as well-adjusted individuals who enjoyed their families, friends, and community. Neither was experiencing life events that could be characterized as negative. Both had young children and, by all accounts, were active participants in good spousal and familial relationships. Both were living within their financial means. Both appeared to have every reason to avoid unnecessary risks.

The Safety Board believes that, given the sum of the evidence regarding the accident flight, the willingness of both pilots on the CVR to perform the unauthorized maneuver, and the completed Form 8410-3, that the pilots exhibited contempt for adherence to the very FARs and company requirements that they were responsible for instilling in others. Further, even overlooking the violation of the most fundamental rules governing the conduct of flight proficiency checks, the pilots showed a self-destructive disregard for common sense by performing a highly demanding maneuver at night, less than 2,000 feet above the ground.

Before the accident flight, the airplane had been flown from Kearney, Nebraska, (EAR) to GRI as a repositioning flight, under the provisions of 14 CFR Part 91, after completing several legs of scheduled revenue service. It was flown by a different crew than the pilots on the accident flight, and it arrived at GRI about 2300.

The CVR of the repositioning flight indicates that at the beginning of the flight, the captain asked the first officer if he was up for a "vertical thing." The

captain then contacted the EAR station and told the station agent to "look out the window." The station agent, who later told Safety Board investigators that she did not see the airplane flown in an unusual manner on takeoff, asked the crew if it could perform the maneuver again. The crew did not comply with the request and proceeded to GRI.

Throughout the flight, transmissions from a local radio station could be heard on the CVR. In addition, the crew engaged in a great deal of conversation not pertinent to the flight, such as singing with the music that was being broadcast. At one point in the flight the captain remarked on the interphone, "just about 5 minutes ago I was telling you, I said hey, I ain't going to be doing any more of this aerobatics...5 minutes later, here we are." The recording ended with the first officer remarking, "Oh gee. We laid the seats down pretty." The captain responded with, "Just like I wanted them to." The airplane landed without incident at GRI.

While the Safety Board was unable to conclusively determine that the pilots of the repositioning flight had performed aerobatic maneuvers, the conversation recorded on the CVR during the flight, specifically the references to "vertical thing" and "aerobatics," suggested that unauthorized maneuvers were conducted. At the very least, the CVR reveals that the pilots displayed immaturity and a lack of professionalism and responsibility about the aircraft with which the airline had entrusted them.

In citing management in the probable cause, the Safety Board believes that GP Express could have taken stronger action before this accident that would have demonstrated to its personnel a management commitment to safety. Some areas that warranted improvements were identified after the GP Express C-99 accident on June 8, 1992, at Anniston, Alabama.[2] However, even after the Anniston accident, there were few substantive changes that would have been apparent to line pilots. The Safety Board believes that the evidence indicates that GP Express met the letter but not the spirit of the FARs. This was most evident in the scheduling of pilots for the administration of competency/proficiency checks on the last possible day allowed. The Safety Board believes that the checks may have been

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[2]Aircraft Accident Report--"Controlled Collision with Terrain, GP Express Airlines, Inc., Flight 861, A Beechcraft C99, N118GP, Anniston, Alabama, June 8, 1992." (NTSB/AAR-93/03)

given more to establish records of FAR compliance than for actual proficiency or competency verification. Moreover, the circumstances of this accident illustrate the inherent danger posed when colleagues are assigned to administer training or check flights to each other. It is not reasonable to expect that two friends with nearly equal piloting experience and stature within the company would perform a comprehensive check flight when they know that the flying/check pilot roles may be reversed on another flight.

The Safety Board recognizes that an airline cannot oversee the performance of each flightcrew on every scheduled flight. Thus, to assure that pilots are aware of their responsibilities to act professionally at all times, it is necessary for the company to promote a safety philosophy as the opportunity arises through its training and flight check structure. By requiring instructor pilots to demonstrate their performance to pilots more senior in the company hierarchy, the airline can be more assured that professional attitudes and safety philosophy are being passed to line pilots. Without such company oversight, airlines have no assurance that their check airmen are demonstrating the standards of judgment and behavior expected of them. GP Express had a third check airman, the chief pilot, on its staff, and the Safety Board believes that, as the immediate superior of the airman needing to be checked, he should have been the individual designated to conduct the check flight. Therefore, the Safety Board believes that airlines operating scheduled passenger service should, where feasible, attempt to schedule training and check flights so that they can be administered by pilots who are higher in the company's hierarchy than the pilots being checked.

The nature of this accident leads the Safety Board to consider the possibility that other pilots operating aircraft certificated for 14 CFR Part 135 operations, in circumstances similar to those of this accident, have considered performing aerobatic maneuvers. To ensure that other pilots are aware of the potential consequences of such irresponsible acts, the Safety Board believes that all pilots operating under 14 CFR Part 135 should be informed of the circumstances of this accident to dissuade them from considering such actions.

Therefore, the National Transportation Safety Board recommends that the Regional Airline Association:

> Inform its members of the circumstances of the GP Express Airlines accident in Shelton, Nebraska, on April 28, 1993, and of the Safety

Board's safety recommendations to the Federal Aviation Administration regarding this accident. (Class II, Priority Action) (A-94-13)

Also, the Safety Board issued Safety Recommendations A-94-11 and -12 to the Federal Aviation Administration.

The National Transportation Safety Board is an independent Federal agency with the statutory responsibility "...to promote transportation safety by conducting independent accident investigations and by formulating safety improvement recommendations" (Public Law 93-633). The Safety Board is vitally interested in any actions taken as a result of its safety recommendations and would appreciate a response from you regarding action taken or contemplated with respect to the recommendation in this letter. Please refer to Safety Recommendation A-94-13 in your reply.

Chairman VOGT, Vice Chairman COUGHLIN, and Members LAUBER, HAMMERSCHMIDT, and HALL concurred in this recommendation.

By: Carl W. Vogt
Chairman