CITATION:	*Inquest into the death of Robert John Baxter* [2003] NTMC 010.
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0016/2001
DELIVERED ON:	21 March 2003
DELIVERED AT:	Darwin
HEARING DATE(s):	10 – 14 February 2003
FINDING OF:	Ms Lyn McDade Deputy Coroner

CATCHWORDS:

Aircraft Accident – Cessna 210

REPRESENTATION:

CounselAssisting:	Mr Thomas Berkley
Counsel for the family:	Mr Todd Alexis (instructed by J.A. Brown & Co.)
Counsel for the Air Frontier:	Mr Ron Lawford

Judgment category classification:	B
Judgement ID number:	NTMC 010 [2003]
Number of paragraphs:	32
Number of pages:	18

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0016/2001

In the matter of an Inquest into the death of

ROBERT JOHN BAXTER
ON 4 FEBRUARY 2001
AT 600 METRES EAST OF GAPUWIYAK (LAKE EVELLA) AIRSTRIP, ARNHEM LAND

FINDINGS

(Delivered 21 March 2003)

MS LYN MCDADE:

1. Robert John Baxter ("the deceased") was pronounced dead at 1815hrs on 4 February 2001. He was 26 years old at the time of his death. He was a Caucasian male born on 10 April 1974 at Dubbo in New South Wales.

2. Section 121(1) of the *Coroners Act* ("the Act") defines a "reportable death" to mean a death that:

> "appears to have been unexpected, unnatural or violent, or to have resulted directly or indirectly from an accident or injury."

3. For reasons that appear in the body of these findings, the death fell within the ambit of that definition and this Inquest is held as a matter of discretion pursuant to s15 (2) of the Act. Section 34(1) of the Act details the matters that an investigating Coroner is required to find during the course of an Inquest into a death. That section provides:

> (1) "A coroner investigating –
>
> (a) a death shall, if possible, find –
>
> (i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

(iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

(v) any relevant circumstances concerning the death."

4. Section 34(2) of the Act operates to extend my function as follows:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

5. The duties and discretions set out in ss34(1) and (2) are enlarged by s35 of the Act, which provides as follows:

1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.

2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

3) A coroner shall report to the Commissioner of Police and the Director of Public Prosecutions appointed under the Director of Public Prosecution Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner.

6. The public Inquest in this matter was heard at the Darwin Coroners Court between 10 and 14 February 2003 inclusive. Counsel assisting me was Mr Thomas Berkley. Mr Todd Alexis sought leave to appear on behalf of the deceased's family and Mr Ron Lawford sought leave to appear on behalf of Air Frontier. I granted that leave pursuant to s40(3) of the Act. The court heard from 16 witnesses viz.

1. Acting Sergeant Scott Burness – Officer In Charge of the Investigation

2. Senior Constable Timothy Sandry

3. Senior Sergeant Steven Raymond Bradley

4. Mr Darryl Anthony Stace

5. Ms Toni Laffin

6. Mr Rodney Robertson

7. Sally Mununggurr

8. Paul Wunungumurr

9. Mathew Overell

10. Arun Thompson

11. Roger Kerville

12. Richard Hunt

13. Geoffrey Hunt

14. David Cunningham

15. Alfred Tremain

16. Clive Phillips

and received written statements into evidence. A number of exhibits were admitted into evidence. An exhibit list is attached.

Exhibit A	Stat Dec – Scott Burness
Exhibit B	Investigation Diary
Exhibit C	Statement – Toni Laffin
Exhibit D	Affidavit of identity
Exhibit E	Autopsy Report
Exhibit E1	Provisional Cause of Death
Exhibit F	Toxicology Report

Exhibit G	Gapawiyak Health Centre Report
Exhibit H	Stat Dec – Smallbridge
Exhibit I	Stat Dec – Osbourne
Exhibit J	Stat Dec – Smith
Exhibit K	ATSB Report
Exhibit M	Tape – Sally Mununggurr & Transcript
Exhibit N	Tapes (x 2) – Darryl Stace & transcript
Exhibit O	Tape – Margaret Lewis & transcript
Exhibit P	Tape – Mickey
Exhibit Q	Tape – Paul Wurrumurra
Exhibit R	Photographs
Exhibit S	Video tape
Exhibit T	Maintenance record / Inspection sheet
Exhibit U	Flight sheet
Exhibit V	Videotape
Exhibit W	Stat Dec – Timothy Sandry
Exhibit X	Stat Dec – Steven Raymond Bradley
Exhibit Y	Plan of airstrip & marks by Darryl Stace
Exhibit Z	Documents relating to Bravo-Bravo-India
Exhibit AA	Statement – Matthew Overell
Exhibit BB	Statement – Rodney Robertson

Exhibit CC	Plan of airstrip marked by R Robertson
Exhibit DD	Statement – Arun Thompson
Exhibit EE	Company Searches
Exhibit FF	Bundle of documents – CASA (investigation into Air Frontier)
Exhibit GG	Letter – 20.10.00 – R Hunt
Exhibit HH	Statement – Geoff Hunt
Exhibit II	Bundle of Documents
Exhibit JJ	Statement – Scott Cunningham
Exhibit KK	Expert witness qualifications – Alfred Tremain
Exhibit LL	Report – Alfred Tremain
Exhibit MM	Supplementary report – Alfred Tremain
Exhibit NN	Report (x 2) – Clive Phillips
Exhibit OO	Documents – Clive Phillips (15.3.02 draft), (17.3.02 facsimile)
Exhibit PP	Birth Certificate Robert John Baxter
Exhibit QQ	Letter – Johnson Aviation
Exhibit YY	Extracts of Legislation (Civil Aviation Regulations)

FORMAL FINDINGS

7. Pursuant to s34 of the *Coroner Act*, and upon the evidence adduced at the Inquest, I find that:

i) The deceased is Robert John Baxter, a male Caucasian who was born on 10 April 1974 at Dubbo in New South Wales.

ii) The deceased died 600 metres east of Gapuwiyak (Lake Evella) airstrip on 4 February 2001.

iii) The cause of death was multiple injuries. These injuries were sustained as a result of the deceased being involved in an aircraft accident.

iv) The particulars required to register the death are:

a) The deceased was a male;

b) The deceased was a Caucasian;

c) A post mortem examination was carried out and the cause of death was multiple injuries sustained as a result of an aircraft accident;

d) The pathologist viewed the body after death;

e) The pathologist was Dr Michael Zillman, from the Royal Darwin Hospital;

f) The father of the deceased was John Harry Baxter;

g) The mother of the deceased was Suzanne Margaret Baxter;

h) The deceased resided at the Gapuwiyak (Lake Evella) Community at the time of his death; and

i) The deceased was employed as a Senior Base Pilot by Air Frontier at the time of his death.

RELEVANT CIRCUMSTANCES CONCERNING THE DEATH INCLUDING COMMENTS, REPORTS AND RECOMMENDATIONS

8. On 4 February 2001 Robert John Baxter, the deceased (hereinafter referred to as the deceased) was the pilot of an aircraft VHBBI (hereinafter referred to as BBI) a Cessna 210. He was to complete a charter from Lake Evella to Elcho Island on the afternoon of 4 February.

9. The deceased had never piloted the aircraft known as BBI until he assumed command of it that afternoon. Another Air Frontier pilot, Darryl Stace, had flown BBI throughout the day. Mr Stace handed over the aircraft to the deceased for the charter because the aircraft the deceased had been flying apparently would need to be refuelled, whereas BBI had sufficient fuel for the task.

10. Mr Stace in his evidence at the inquest indicated that he had not perceived any problem with BBI that day. He indicated that when the deceased took over the aircraft he told him about the fuel state and about the differences between the aircraft the deceased had flown that day, a Cessna 206 and the Cessna 210. In particular he informed the inquest that he told the deceased about the difference in the undercarriage and that he had not heard the stall-warning device go off in flight (transcript p115, p117, p118 & p119).

11. The deceased took control of the aircraft without conducting a pre-flight inspection of it; notwithstanding that Darryl Stace had not completed the daily maintenance report. This document marked as Exhibit T indicates whether or not a plane has been pre-flighted and whether or not there are any defects such as would render it unsafe. Of particular relevance to this inquest was the issue of the stall warning device, which I will come to later. It was not shown as being defective in the daily maintenance report. However more importantly Mr Stace had not completed the maintenance release report for the 3rd or the 4th of February. In those circumstances the deceased should have conducted his own check of the aircraft and satisfied himself that there were no outstanding defects so as to render the plane unsafe. Again referring to the stall warning device my understanding is that it can be easily checked whilst on the ground, and whilst in flight provided the checking is done at a safe height.

12. Mr Baxter taxied down the runway, and Mr Stace and another pilot, Mr Robertson watched as he readied for take-off. It is clear from the evidence of both Mr Stace and Mr Robertson that the deceased did not undertake a

normal take-off, rather that he gathered speed quickly and kept the plane low to the runway preparing the aircraft for flight. That is he lifted the undercarriage very close to the ground and probably reached a speed of about 100 knots at the end of the runway before he caused the aircraft to ascend very steeply. There is some conjecture in the evidence as to how steep the climb the deceased undertook was. Mr Stace in his evidence indicated that is was probably about 60°, but it could have been more. Mr Robertson talked about it being almost vertical, as did the eyewitness Sally Mununggurr, Paul Wurrumarra and Margaret Lewis. It is clear that the aircraft climbed very steeply to a height of about 400 – 500 feet, at which stage the aircraft stalled. It then pivoted and descended almost vertically towards the ground albeit that before impact some recovery had taken place. The experts generally agreed that the plane hit the ground at probably a 45° angle at speed. It was also agreed generally that at the time the plane stalled that the deceased was in an irrecoverable position, and no matter what he did he was not going to be able to recover control of the aircraft.

13. The above is a brief summary of what occurred on 4 February 2001. On the face of it quite straightforward, however, the investigation of this particular accident was made more difficult by the failure of ATSB (Air Transport Safety Bureau) to attend the accident site, at the time, and conduct an investigation. ATSB apparently acting on the advice of others determined that they would not attend the accident because it appeared to be an accident involving pilot error only. The basis for that determination could not be explored as the family may have wished because Mr Heitman the ATSB representative who made that determination was not able to be called to give evidence, because he could not be located. This has deprived the family of the opportunity to test Mr Heitman and ascertain why he formed the view about the accident that he clearly did, without attending the scene or conducting any other enquires other than telephone contacts with it appears Senior Sergeant Bradley and nobody else. Nonetheless

even though Mr Heitman did not give evidence I am comfortable in forming the view that it was an inappropriate and wrong decision and probably not based on any clear direct evidence from any eyewitness to the accident. Having said that Acting Sergeant Scott Burness of Nhulunbuy Police together with Constable Clay Evan initially conducted the investigation into the accident. They attended the scene and ensured that it was secure, subsequently arranged for it to be videoed and a number of photographs to be taken. They spoke to eyewitnesses, and over time managed in my view to conduct an adequate investigation of the accident.

14. I am satisfied from the evidence that has been adduced at the inquest that mechanical failure did not contribute to this accident. I refer in particular to the evidence and reports of Mr Clive Phillips the expert engaged by the Northern Territory Police, Mr Tremain the expert engaged by the family and Mr Overell who purchased the wreckage and subsequently made salvage parts available to Mr Phillips for inspection. Mr Overell was also able to provide a strip report in relation to the engine of BBI undertaken by Hawker Pacific after the accident, which found and I quote: (ExhibitAA)

> "The engine has not suffered any internal mechanical failure, and all parts other than those suffering external damage are in a normal condition for an engine with this T.S.O."

15. It was unfortunate that ATSB did not attend the site of the accident at the time. Notwithstanding I am, as I have indicated, satisfied that a proper investigation did take place and that the circumstances of this accident have been properly and fully investigated. That this happened is largely due to the perseverance of Acting Sergeant Scott Burness, and I commend him for his efforts. I note that the Coroners in all States and Territories are currently negotiating with ATSB to develop a Memorandum of Understanding (MOU) which will ensure that ATSB works with Coroners and assists in the investigation of all transport accidents, including aircraft accidents.

16. Eyewitnesses gave evidence at the inquest in particular Darryl Stace, Rodney Robertson, both pilots, and two residents of Lake Evella namely Sally Munungurr and Paul Wurrumurra. A statement made by Margaret Lewis, a resident of Lake Evella, was tendered, Exhibit O. Their version of the events, even given the elapse of time and their different viewing angles are remarkably similar. Those that saw the take-off described it as the pilot keeping the plane very low to the runway and obtaining greater speed than usual and then the plane ascending steeply. The variance really centred on the steepness of the climb from the end of the runway. Mr Stace thought the angle of attack was around about 60° but Mr Robertson, who is also a pilot, said it was more like a vertical ascent and this was corroborated by Sally Munungurr and Paul Wurrumurra, and Margaret Lewis.

17. What happened at the apex of the ascent was also subject to some conjecture in the evidence. What is clear is that prior to the descent of the plane the deceased had lost control for whatever reason. It is likely that the left wing stalled as indicated by Mr Robertson who had a good view of the incident and made this comment as he saw the left wing stall "he's fucked it" (transcript p148). The deceased appears to have done everything he could to regain control.

18. One of the issues that were raised in relation to the accident was the condition of the stall warning device in BBI. This device is used to warn a pilot of impending stall. It is a horn that sounds in the cabin of the aircraft to inform the pilot that they should taken action to avoid stalling. The evidence was generally that in those circumstances an increase in airspeed by lowering the nose of the aircraft was the desired remedial action.

19. Evidence was given about conversations that took place between Mr Stace and other pilots after the accident about the status of the stall-warning device. In particular there was evidence of a conversation with a pilot by the name of Cunningham who flew Stace and Robertson back to Darwin on

5 February. Mr Stace could not recall that conversation and neither could Mr Robertson. Mr Cunningham could not attribute the comment he made in his statement "that the stall warning device in BBI was unserviceable" to Mr Stace. He indicated that it could have been Mr Stace or Mr Robertson and the conversation may not have taken place in the plane coming back to Darwin, but could have occurred at the accommodation of the Frontier pilots at Lake Evella. Another conversation was related that took place at the Lizard Bar between Mr Stace and another pilot by the name of Arun Thompson. Mr Thompson asked Mr Stace about the status of the stall warning device and was given a response by Mr Stace "if it was not working I did not know". Certainly no entry had been made in the daily maintenance release relating to BBI that the stall-warning device did not work. There was evidence that Mr Stace at the hand over of the aircraft to the deceased warned him that he had not heard the stall warning device go off in flight (transcript p118 – p119). Mr Robertson in his evidence indicated that he had played a trick a couple of days before the accident, by putting a stone in the vane which made the stall warning device go off in the cabin whilst Mr Stace was in the cabin on the ground. He was confident that it did work. Mr Stace was adamant that the stall warning device was functional in BBI.

20. BBI was almost due for its 100 hours service. A defective stall-warning device is a defect that grounds an aircraft. The deceased and the other pilots at Lake Evella knew that. The evidence in this regard was clear and beyond doubt. The pilots employed by Air Frontier Pty Ltd at the time of this accident were not paid unless they were flying; and they were paid by the hour to fly. They also received in addition to this hourly flying rate a small retainer, so in the words of Mr Hunt junior "they could survive". It may be that the circumstances of their employment arrangements put pressure on the pilots not to enter defects in planes that they became aware of, particularly those that rendered a plane grounded. It may also be that because the 100-

hour service was imminent that the defective stall-warning device was not recorded as defective in the daily maintenance release.

21. Two Aviation Safety Consultants gave evidence in relation to the accident. Mr Clive Phillips, engaged by the Northern Territory Police, and Mr Tremain who was engaged by the family. Both experts produced written reports in relation to the accident and gave oral evidence. The main divergence in their evidence was in relation to the angle of ascent of the aircraft. Mr Tremain who was engaged by the family, in his evidence in chief was keen to connect the operation of the stall warning device to the circumstances of the deceased's death. In saying that I mean Mr Tremain was of the view that the deceased would have been surprised and not expected the stall, because the stall warning device in the plane was not operative, and that its failure to operate diminished his chances of successfully completing whatever manoeuvre it was he was undertaking. That opinion was dependant upon the stall warning device in BBI being unserviceable, and the aircraft not being flown at an angle of ascent that would render it inoperative in any event.

22. It is my understanding from the evidence that if the plane had been flown at an almost vertical ascent, even if the stall warning device was fully functional, it probably would not have sounded. Whereas if the plane was flown at an angle of attack of 60° as was maintained by Mr Tremain, (though he did concede that was the minimum angle of attack Transcript p295), the stall warning may have gone off. In his opinion the deceased was relying upon the stall warning device to go off to avert a stall and continue the manoeuvre. Transcript p301, p309, p314.

23. To the contrary Mr Phillips at Transcript p347 – p349 says and I quote:

> "Mr Alexis….Now can I seek to explore with you some rational explanations as to why Robert found himself in a position of unexpected or inadvertent stall and in doing so could I ask you to draw on your rather insightful assessment of the pilots at Lake Evella of the calibre that you spoke of

earlier. Do you think that some reliance may have been placed by Robert on the functioning of the stall warning indicator to indicate that moment at which he ought to take recovery action by pushing the nose forward so as to avert the stall? Mr Phillips……..If he had thought through his manoeuvre he would have known that climbing the aircraft vertically unloads the wing from its lift-carrying job and converts the energy in the aeroplane to going vertically upwards. The wing at that stage if it had any lift on it and the airflow across it was normal the aeroplane would be flying like that, if you understand what I mean. Instead of when it flies along here the weight of the aeroplane is being held by the lifting capacity of that wing. The airflow over the wing has a logical form and pattern and maintains the lift because if it stopped doing that the aircraft drops. Now when you're doing that and you're flying vertically you don't have any lift on the wing because it will be going this way if you get my point. The wing is not supporting the aircraft's weight against the force of gravity. So consequently if he had thought this manoeuvre through when the wing is unloaded from its lift capacity and the airflow across the wing will be absolutely symmetrical there will be no stall warning.

Mr Alexis....That assumes two things doesn't it, firstly a vertical or almost virtually vertical attitude of the plane and secondly some prior consideration or thought by the pilot.

Mr Phillips….Absolutely.

Mr Alexis….Could I invite you to just reflect for a moment on what Mr Stace told us about his experience in the execution of this manoeuvre, and by this manoeuvre I mean the manoeuvre whereby the pilot takes off, climbs at a steep angle, gets to a point where the nose is pushed over and then there's a turn to do a low run over the airstrip. Do you recall that he told us when I asked at what point in time do you know when you ought to push the nose forward to avert a stall and his response was to tell me that he did that with the stall warning device. Now do you think that his explanation of that which you heard provides you with a rational explanation as to why Robert found himself in a situation of unexpected stall, simply because he was relying upon an instrument that wasn't functioning at the time.

Mr Phillips…My recollection of Mr Stace's evidence was that this particular manoeuvre was different from the others that I had seen. That wasn't taken any further and while it dangerous to hypothesis I would looking at the results of the

manoeuvre would consider one of the reasons that it looked different was because it was steeper and yes, if you're doing a normal zoom climb and you're actually causing the aeroplane to lift up and you're using that lift against gravity then yes you're going to get a stall warning. But if this was such an unusual event as Mr Stace said it was different, if that difference were that the aircraft was going up, essentially vertically and I'll use – there'll be enough variation in that to say that you could be from there to there sort of thing, then the wing is not doing what its designed to do and the operation of the stall warning at any of those attitudes is problematical. But again we don't know what the angle was and all I can base my judgement on is that Mr Stace said it was different and unfortunately it wasn't taken up. Why was it different? The other witness Mr Robertson said the aircraft went up vertical. Quite categorically and it would appear to me that that is probably the difference. Again we don't know."…….

Mr Alexis…3 August 2002 you replied to some comments made by Mr Tremain in his report of 23 March 2002. I'm looking in particular at paragraph 11 on the third page where you deal with the subject matter of the stall warning device?

Mr Phillips…..Yes Sir

Mr Alexis…..And you refer to the question of whether or not the pilot had carried out the daily inspection and if he had he would have been aware of the condition of the stall warning system and may I pause there. Have you ever encountered a circumstance whereby the stall warning system on a Cessna 210 is found to be serviceable on the ground but unserviceable in the air?

Mr Phillips…No Sir.

Mr Alexis…..Thankyou. Now just continuing on with that. You tell us that the manoeuvre should not have been attempted if reliance was to be placed on the stall warning system?

Mr Phillips….Yes Sir.

Mr Alexis….You then proceed to express disagreement with Mr Tremain's opinion in relation to that being a factor with respect to this accident. Now would it be correct to understand that your point of disagreement on the stall warning system being a factor is really one of your different

assessment as to whether or not the pilot was in fact relying on it as an indicator of imminent stall?

Mr Philip's…Well also on whether or not it was unserviceable. It has been given in evidence that it worked on the ground and there's various reasons why Mr Stace may not have noticed it go off in the air and among those he may never have flown it to a situation where it needed to go off in the air and that includes landing. I don't know how he flies his aeroplane. You can fly an aeroplane by feel and lots of pilots do. But there are lots of pilots who fly the aeroplane on numbers and they're looking at 70 knots and that's not even going to put that aeroplane down at 70 knots and if you're a numbers man like that and you've got it in your mind that the aeroplane stalls at 65 knots, so I'll always land at 70 knots. It is possible that you won't hear the stall warning come beep beep, just as you touch down if you're actually feeling your aeroplane and getting it to touch down very gently. So there are reasons why he never – he never heard it go off. He could have proven it quite easily by going to 3000 feet, pulling the throttle back and just letting the speed come back and listen and feel and see whether it worked as all pilots who appear to have been aware that Mr Stace was uncomfortable with the stall warning and equally it might have been set at minimum settings, even the stall warning may not have in the right place in the wing had that wing been repaired. We don't know what the reason was and I would have thought that even a young prudent pilot would have done something about finding out whether or not it was true that the stall warning didn't work, particularly before they started a manoeuvre in an aeroplane he hadn't flown before. Yeah, I – that is exactly why I disagree with Mr Tremain saying this is stall warning. I think those guys – well, Robert would have been confident in his mind, I feel sure, that the stall warning system would have worked had he wanted to rely on it, but I don't think he knew what was going to happen when he got there, or there, or there. Again that's only an opinion."

24. The deceased was a trained pilot, a competent pilot by all accounts. All of the pilots who gave evidence, and the experts, conceded that a pilot would know when a plane was about to stall without regard to the stall warning device.

25. There is no direct evidence that the stall-warning device was not functioning in BBI. Even if it wasn't functioning given the circumstances of the

accident it is difficult to come to the conclusion that it would have made a difference. The deceased for whatever reason attempted an aerobatic manoeuvre for which he was not trained and for which the aircraft was not designed. Its instrumentation was designed for "normal" flight, not unusual flight. Whether the stall warning device would have sounded during the manoeuvre and whether the deceased would have had time to react to it or not is problematic.

26. Air Frontier Pty Ltd and their operations were questioned by counsel for the family and both Mr Hunt senior and Mr Hunt junior gave evidence. It is clear that it was at the time of the accident a small charter operation, operating in East Arnhem Land and other places in the Northern Territory. Young pilots are employed not within the general aviation award, but on a verbal contract paying them hourly for their flying time. They are expected to live in remote communities in what can only be described as substandard conditions. I do accept that the accommodation at Lake Evella was all that was available, however, that does not make it appropriate.

27. At the time of this accident the pilots at Lake Evella were young and relatively inexperienced. They had chosen aviation as their respective careers and were flying as much as they could to get up their hours to move on. They were doing their apprenticeship.

28. Evidence was given at the inquest about a culture of cowboy flying by the "Mooney pilots", as the Air Frontier pilots were known. There was a habit of low flying and the doing of tricks, in fact both Mr Robertson and Mr Stace indicated that they had undertaken aerobatic procedures for which they were not trained. The deceased himself had a reputation for low flying and had told Mr Robertson when he arrived only two weeks before the accident as the newest Air Frontier pilot that "what happens in East Arnhem Land stays in East Arnhem Land". Given that the deceased was the Senior Base pilot at Lake Evella, and to an extent at least responsible for Mr

Robertson's training and supervision that evidence is disturbing and corroborative of the cowboy culture.

29. Mr Robertson gave evidence he had been warned by Air Frontier not to do antics, not to fly low, not to undertake aerobatics and that if Mr Hunt senior, the then chief pilot knew what they were doing he said "they would all have been sacked". Mr Stace also gave evidence about being informed by his employer not to engage in " horseplay…..as in low level flying…" Transcript p70.

30. Air Frontier through its Chief Pilot and Director purported not to know what was going on at Lake Evella and believed that Mr Baxter was performing well. They based this conclusion apparently upon the fact that the accommodation at Lake Evella was neat and tidy whenever the Chief pilot, Mr Hunt visited. All Mr Hunt's visits were scheduled visits, he made no surprise visits so the pilots knew when he was arriving so it is not unusual to expect that they would tidy up their accommodation in anticipation of his visit. No contact was made by Air Frontier with members of the community or anybody else who came in contact with their pilots to check about their conduct and activities. It is difficult to accept that the operators of a charter company in these circumstances would not be aware that young men might, if left to their own devices as these young men were, have some fun and try and extend themselves. Further, given the circumstances in which they were expected to live and work, it is almost beyond belief that they did not know what these pilots were doing. It is clear from the evidence that the pilots knew that what they were doing was wrong, inherently dangerous and not within the charter of their employment or in accordance with their training and knowledge of extant air safety regulations. However, having had the opportunity of seeing Mr Hunt Snr and Jnr give evidence I am inclined to accept that they did not know what their pilots were doing. I note that Mr Hunt Snr is now retired and no longer employed as a Chief Pilot.

31. As to how Air Frontier was operating at the time given the circumstances of the Air Operators Certificate and the relationship of Air Frontier Pty Ltd with Mooney Investments/ Mooney Holdings is curious. I will refer the evidence in relation to the status of the company to CASA and invite them to make comment. The issue of the safety of general aviation in the Northern Territory is also a matter that prompts me to forward the transcript of these proceedings to CASA for their information and appropriate action and investigation if necessary. It is beyond the scope of this inquest for me to comment further than I have about the activities of CASA or ATSB or make any findings in relation to them.

32. In conclusion I find that this accident occurred because the deceased lost control of VHBBI while at too low an altitude to effect recovery. The deceased lost control while attempting an aerobatic manoeuvre for which he was not trained and for which the aircraft VHBBI was not certified to conduct.

Dated this 21st day of March 2003.

_____

LYN McDADE
DEPUTY CORONER