Transportation Safety Board of Canada



Bureau de la sécurité des transports du Canada

200 Promenade du Portage Place du Centre, 4th Floor Gatineau, Québec K1A 1K8

Our file Reference 825-A06F0121

28 August 2008

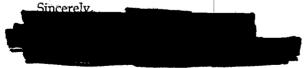
Mr. Thomas Haueter
Director, Office of Aviation Safety
National Transportation Safety Board (NTSB)
490 L'Enfant Plaza, SW
Washington, DC
20594

RE: Canada State Comments - NTSB Draft Report Regarding the Accident to DHC-6-100, N203E, 29 July 2006 (CHI06FA210)

Dear Mr. Haueter:

Thank you for giving the Transportation Safety Board of Canada (TSB) the opportunity to review and comment on the report of your investigation of the 29 July 2006 DHC-6-100 accident at Sullivan, Missouri. Our review of the draft review shows it to be very complete and correctly establishes the reasons for the occurrence. As was discussed previously, we believe that since the compressor turbine blades which failed were FAA PMA blades (part number T-023401) manufactured by Doncasters Inc., Turbo Products Division, this fact should be included. Viking Air, the holder of the Type Certificate for the DHC-6-100 has reviewed the report and has no comments on the report, but made some safety suggestions based on their review. Their comments are attached to this letter.

Please feel free to discuss any of the comments coming from Canada-with the Accredited Representative, Mr. David McNair. Thank you again for the opportunity to comment on the report.



Bryce Fisher

A/Director, Air Investigations

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Mr. Doug Hardy (Pratt & Whitney Canada)

Mr. George Gee (Viking Air)

Mr. Dan Poulin (Transport Canada)

Mr. Ed Malinowski (NTSB IIC)



Canada

Comments from Viking Air Limited

We have completed our internal review of the Draft report and as the OEM, we have no further comment or recommendations on the report. We believe it is an accurate representation of events and the recommendations and conclusions fit the facts.

However, it is obvious that changes in the Parachute industry and its relationship with the FAA would contribute to an increased level of safety. The following would further the safety of parachute operations:

- 1. Mandatory pilot proficiency checks including review of emergency procedures.
- 2. Mandatory compliance with OEM recommended TBO and service intervals unless TBO's increased through an operators historic reliability as with commercial operators.
- 3. Ultimately, prohibition of operation under Part 91 for skydive operations, requiring them to operate under commercial aircraft standards would greatly increase the level of safety and FAA oversight. However, I suspect that is unlikely to occur. Due to the loss of life that occurs each year with parachute operations (frequently involving multiple fatalities), there certainly needs to be a standard of operational requirements specific to the industry to address its current pitfalls. The continuance of operations as they are currently will continue to come at considerable cost to the Safety Boards, OEM's, and the victims' families.

Items 1 to 3 are not within the control of the OEM and therefore they are of opinion only.

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29 August 2008

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Reference:

NTSB Draft Accident Summary Report dated August 7, 2008

Skydive Quantum Leap Twin Otter Accident, 29 July 2006

TSB File A06F0121

Dear Mr. McNair,

Pratt & Whitney Canada Corp. (P&WC) thanks the Transportation Safety Board of Canada (CTSB) for the opportunity to review the above referenced Draft Accident Summary Report.

We have reviewed the subject report and have the following comments:

1. Investigation and Analysis (page 5, line 5)

Please add: "The compressor turbine blades were identified as PMA blades, P/N T-023401J".

2. Investigation and Analysis (page 6, line 3)

Please reference engine left hand engine S/N 20463 and right hand engine S/N 20529.

3. Investigation and Analysis (page 6, line 7)

Please add: "P&WC does not have any documentation indicating that the operator requested to P&WC or received from P&WC a recommendation to increase its operating TBO".

4. Conclusions (page 25, section 1)

P&WC request that a statement be made in the Conclusion to highlight again that CT blades were PMA.

Please add: "The compressor turbine blades were identified as PMA blades, P/N T-023401J"

NTSB Draft Accident Summary Report dated August 7, 2008

Yours truly,

PRATT & WHITNEY CANADA CORP.



Doug Hardy (05AQ1)
Group Leader, Service Investigation
Tel (450) 468 7850

cc: File: 06-084