

NATIONAL TRANSPORTATION SAFETY BOARD
Office of Aviation Safety
Washington, D.C. 20594

October 17, 2005

Group Chairman's Factual Report

ORGANIZATIONAL FACTORS

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A. ACCIDENT

Operator: Med-Trans Corporation
Location: Newberry, South Carolina
Date: July 13, 2004
Time: 0532 eastern daylight time
Aircraft: Bell 407, N503MT

B. GROUP

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C. SUMMARY

On July 13, 2004, at 0532 eastern daylight time, a Bell 407 helicopter, N503MT, operated by Med-Trans Corporation (MTC), was on an emergency medical service (EMS) mission when it collided with trees shortly after takeoff from interstate highway I-26 near Newberry, South Carolina. The pilot, flight nurse, flight paramedic, and patient received fatal injuries. The helicopter was destroyed by impact and post-crash fire. The 14 CFR Part 135 EMS flight was en route to the Spartanburg Regional Medical Center where it had departed at 0502. Night visual meteorological conditions with mist and light fog prevailed in the area of the accident site. The flight was on a company flight plan and was receiving flight following from Regional One Communications provided by Spartanburg 911.

D. DETAILS OF INVESTIGATION

The Organizational Factors group was formed after the conclusion of the on scene investigation. The group examined company history, accident/incident history, Federal Aviation Administration (FAA) oversight, company operational oversight, and the company's pilot training program. Between November 18 and November 23, 2004, the group interviewed eight persons. The group chairman prepared a summary of each interview, and these summaries are attached to this report as Attachments 1 through 8.

The interviewees were:

1. Mr. Dennis Rohlfs, CEO/Owner, MTC
2. Mr. Russ Braddock, Director of Maintenance, MTC
3. Mr. Tom Rohlfs, Senior VP of Business Development, MTC
4. Mr. Bert Levesque, Director Of Operations, MTC
5. Mr. Don Savage, Chief Pilot, MTC
6. Mr. Craig Roberts, Principal Maintenance Inspector, FAA
7. Mr. Charles Prince, Principal Operations Inspector, FAA
8. Mr. Dave Baron, Principal Avionics Inspector, FAA

Additionally, the group reviewed records, manuals and other pertinent data obtained from MTC and the FAA.

1.0 COMPANY HISTORY

MTC is the sister company of Executive Air Taxi Corporation. Executive Air was founded in 1973, and it is a fixed base operation in Bismarck, North Dakota, providing fixed wing charter service, aircraft fuel sales, aircraft maintenance, flight training, and other aviation services. In 1995, the CEO of Executive Air formed MTC as a separate company to conduct helicopter EMS operations. MTC has its business office in Bismarck and its main base of operations in Tucson, Arizona. The CEO of MTC is located in Bismarck, the MTC Director of Maintenance is located in Bismarck, the MTC Director of Operations is located in Tucson, and the MTC Chief Pilot is located in Johnson City, Tennessee.

During its first 8 years of operation, from 1995 through 2002, MTC expanded from 1 air ambulance program in Minot, North Dakota to a total of 7 programs. The programs were added as follows: Johnson City, Tennessee and Tucson, Arizona in 1995; Greenville, South Carolina and Madera, California in 2000; California City, California in 2001; and Morristown, Tennessee in 2002. During the next 18 months, from January 2003 through June 2004, MTC added an additional 8 programs: Aberdeen, South Dakota in April 2003; Spartanburg, South Carolina in May 2003; Odessa, Texas in June 2003; Morehead, Kentucky in October 2003; Lexington, Kentucky in December 2003; London, Kentucky and Silsbee, Texas in March 2004, and McCook, Nebraska in June 2004.

At the time of the accident, MTC had 14 air ambulance operations in the states of Tennessee, Kentucky, South Carolina, Texas, Arizona, California, South Dakota, North Dakota, and Nebraska. The programs in Kentucky and Nebraska have since been closed, and programs have been added in Douglas, Arizona and Colorado Springs, Colorado.

2.0 ACCIDENT/INCIDENT HISTORY

A review of NTSB records from 1995 to the present found documentation of three previous occurrences involving MTC aircraft.

1. On December 20, 2003, the tail rotor of a Bell 407 struck an object during a night landing in a field near Morehead, Kentucky. The purpose of the flight was to pick up a patient for transport to a hospital. The helicopter sustained substantial damage, and the pilot, the flight paramedic and the flight nurse were not injured. The Safety Board determined that the probable cause of the accident was ground personnel's failure to identify the hazardous condition. Factors were blowing snow and night conditions.
2. On February 19, 2004, a Bell 407 made an autorotative emergency landing following failure of a tail rotor drive shaft hangar bearing near Madera, California. The purpose of the flight was pilot training. The helicopter sustained minor damage, and the two pilots were not injured. The Safety Board determined that the probable cause of the incident was the failure of the number 6 hangar bearing due to overheating. A factor in the accident was the operator's likely inadequate compliance with service bulletins and airworthiness directives on this issue, along with an inadequate maintenance inspection program for the bearings.
3. On March 21, 2004, a Bell 407 impacted terrain while maneuvering in reduced visibility conditions near Pyote, Texas. The purpose of the flight was to transport a patient from one hospital to another. The helicopter was destroyed. The pilot, a flight paramedic, an infant patient, and a passenger sustained fatal injuries, and a flight nurse sustained serious injuries. This accident is still under investigation.

3.0 FEDERAL AVIATION ADMINISTRATION OVERSIGHT

MTC holds an operating certificate issued by the FAA on December 21, 1995, to conduct on-demand air taxi operations under the provisions of 14 CFR Part 135. The FAA Flight Standards District Office (FSDO) in Scottsdale, Arizona manages this operating certificate.

The FAA's Program Tracking and Reporting Subsystem showed that FAA inspectors conducted a total of 20 surveillance activities on MTC in fiscal year 2002. Inspectors from the Scottsdale FSDO conducted all 20 activities. The system also showed a total of 20 surveillance activities on MTC in fiscal year 2003. Of these activities, inspectors from the Scottsdale FSDO conducted 8 and geographic inspectors conducted 12. The system reported a total of 5 surveillance activities from October 1, 2003, to July 12, 2004. Scottsdale FSDO inspectors conducted all 5 activities.

Following the accident, the management of the Scottsdale FSDO made a decision to conduct an office in-depth inspection of MTC. The inspection took place on July 19 and 20, 2004, at MTC's Tucson facility. The inspection resulted in 13 operations findings and 20 maintenance findings. These findings were classified into three categories, category A being non-compliance with the Code of Federal Regulations, category B being contrary to guidance developed by the certificate holder and approved or accepted by the FAA, and category C being systemic deficiency that could cause non-compliance with regulatory requirements. The 13 operations findings and their categories were as follows:

1. Operator could not produce OST form 4507 to show compliance with the registration requirements of the Office of the Secretary of Transportation. Category A
2. Review of operations specifications lists some DBA's but not all. Category A
3. HAZMAT material is out of date and it is unclear whether operator's program is a will-not-carry or will-carry program. Category C
4. The Director of Operations is the only check airman and the Chief Pilot is the only instructor with 14 satellite bases, 16 aircraft and over 56 pilots. A sufficient number of check airmen and instructors should be trained and appointed. Category C
5. Review of the training program curriculum revealed a lack of written descriptions and/or pictorial displays of normal and emergency maneuvers or procedures. Category C
6. Training program for emergency training for crewmembers did not address duties of medical personnel as flight crewmembers. Flight following training program for individuals performing flight following duties and a list of current personnel who are authorized to perform flight following duties could not be located. Category C
7. Review of the check airman's qualification shows that the individual does not hold a helicopter instrument rating. The check airman on a 135.293 check is required to evaluate instrument procedures such as unusual attitudes, partial panel and an instrument approach. As this is not a requirement in the 8400.10 or the FAR's for the check airman in this type of operation to hold an instrument rating, it would be recommended that the check airman hold such a rating so he/she could evaluate instrument maneuvers. Category C
8. This finding lists 7 separate discrepancies found in reviewing the General Operations Manual (GOM). Category B
9. Passenger briefing card depicted in GOM lacks required information such as procedures for emergency exits or emergency equipment. Category A
10. Crew duties during in-flight emergencies could not be located in GOM. Category C
11. Passenger briefing card lacks required information such as procedures for emergency exits or emergency equipment. Category A
12. Individual pilot records have missing information on pilot ratings. Front of pilot certificate is copied but not the back. Category C
13. Individual pilot records have missing information on initial training, which must be kept indefinitely. Category B

On July 21, 2004, the POI wrote a letter to the Director of Operations (DO) of MTC stating, in part:

Due to recent accident history of Med-Trans Corp. this office is recommending that each of your line pilots be given additional training. This training should include, but not be limited to:

- Instrument Approaches
- Unusual Attitudes
- Climbs, descents, and turns
- Maneuvering by partial panel
- Review of inadvertent IMC
- Review of hazards associated with night vision

The above maneuvers should be done solely by reference to instruments.

The letter also recommended that MTC develop a program for pilots "on exercising good judgment in a crisis situation" and review dispatcher, flight following and in-flight medical crew "as to their particular procedures and for in flight coordination." The letter concluded by asking that the DO advise the Scottsdale FSDO "in writing at least 10 days prior to any of the above training."

The POI informed the DO of the findings of the in-depth inspection in a letter dated July 27, 2004. The DO responded to the POI in a letter dated August 13, 2004, with the following list of 9 corrective actions:

1. OST form 4507 has been updated with the Office of the Secretary of Transportation and I will send you a copy of the stamped form when I receive it.
2. A revision to the Ops Specs will be submitted that will list each DBA and its location of operation.
3. I have submitted a new HAZMAT manual for Non-Acceptance and Non-Transport of Dangerous goods.
4. We are in the process of completely revising the General Operations Manual and Training Manual. These revisions will in essence completely revamp both manuals.
5. Along with the manual changes we will now have 2 Company Flight Instructors and I will request 3 Check Airmen.
6. The new Training Manual will incorporate a maneuver guide, Training for medical crews, Training for Dispatch personnel and Crew Resource Management.
7. Inadvertent IMC procedures will be included in the GOM and covered in the Training Manual. Instrument maneuvers will be evaluated during check rides.
8. New Passenger Briefing Cards will be developed and placed in each aircraft.
9. All Pilot records have been reviewed and corrected to include missing information.

In addition to conducting the in-depth inspection, the Scottsdale FSDO made a request for geographic surveillance of the 13 MTC bases located outside of Arizona to the FSDOs having geographic responsibility for these bases. The request asked that each base be visited and the following items checked:

1. How do flight crews obtain weather information?
2. Is there a current hazard map posted at the various locations?
3. Check with the on duty pilot as to what his/her inadvertent IMC recovery procedures are.
4. Obtain the current inadvertent IMC recovery procedures for each location.

5. Check procedures for flight following at each hospital.

Results of the geographic surveillance at 5 bases were provided to Safety Board investigators. Four of the 5 base inspections found no problems. The inspector who visited the Spartanburg, South Carolina base reported on his findings to the POI in an e-mail dated October 22, 2004, stating, in part:

No training records available for flight followers. No list of trained dispatchers was available. No other procedure to ensure dispatchers have Med Trans training or meet Med Trans dispatcher training requirements.

The POI assigned to MTC joined the FAA in 1988 and has been the POI of MTC since the company received its operating certificate in 1995. In addition to MTC, he is also POI of 7 other helicopter operators and 1 airplane operator. Three of his helicopter operators are involved in EMS work. He spends about 90% of his time on helicopter operations and about 40 to 50% of his time on EMS operations. When questioned regarding his workload, he stated that he is "kept pretty busy." He does not have an assistant POI, but would like to have one.

In response to a question concerning his general experience with MTC, the POI stated that MTC was a "good operator" and that they "always had good people" doing their flight training. He expressed the opinion that he does not think the company's two fatal accidents "had anything to do with lack of training." He said that he had been concerned that the DO was MTC's only designated check airman, but that the DO had "showed him that he could handle it." The POI further stated that the DO was traveling a lot, but that the DO "liked it that way because he could see who he was hiring and what they were like." He said that he was aware the DO did not have an instrument rating. He further stated that the DO could, when acting as a check airman, evaluate a pilot on unusual attitudes and basic instrument flying without having an instrument rating. Following the accident, the POI rescinded the DO's check airman authorization. He stated that the main reasons he rescinded the authorization were the accident and that he wanted the DO to spend more time at the Tucson base so he could have more contact with him. In November 2004, the POI certified two new check airmen for MTC.

Regarding MTC's bases outside Arizona, the POI commented that this was "a logistics problem" for him. His information comes from the DO and other FSDOs when geographic inspectors perform base inspections. The POI stated that prior to the accident, geographic inspections were not being done "very often." He said that he would like to visit other MTC bases and had tried to do this for the past 3 years. He was scheduled to visit the bases in Tennessee, Kentucky and South Carolina earlier this year; however, when the accident happened, the trip was cancelled. The year prior, his trip was cancelled due to lack of funds. Two years prior, he had an assistant who went to one of MTC's Texas bases and gave some check rides.

Regarding the discrepancies found with MTC's Operations Manual and Training Manual during the in-depth inspection, the POI commented that MTC was in the process of rewriting both manuals before the accident. He stated that he had told them to update the manuals, as it had been 8 years since they started operations and "things change."

Regarding the issue raised by the geographic inspector concerning the flight follower training records for the Spartanburg base, the POI said the flight follower records were maintained at MTC's Tucson office. According to the POI, a list of trained flight followers for Spartanburg was provided by the DO to the geographic inspector. No other geographic inspector responded to the POI with a problem concerning flight follower records.

4.0 COMPANY OPERATIONAL OVERSIGHT

As defined in FAR Part 1, operational control, with respect to a flight, means the exercise of authority over initiating, conducting or terminating a flight. Section I of the MTC Operations Manual in use at the time of the accident was entitled "General." In Section I, under the heading "Operations Personnel," the manual indicated that the Director of Operations and the Chief Pilot were authorized to exercise operational control. In Section I, under the heading "Pilot-In-Command," the manual stated "the Pilot-In-Command reports directly to the Chief Pilot and is responsible for the safe and efficient conduct of the flight assignment and is authorized by Med-Trans Corporation to exercise operational control for each flight he is assigned to."

Section V of the MTC Operations Manual in use at the time of the accident was entitled "Air Ambulance Service Operational Procedures, Air Ambulance – Helicopter." In Section V, under the heading "Operational Control," the manual again indicated that the Director of Operations and the Chief Pilot were authorized to exercise operational control and stated, "in addition, a Base Manager will be assigned at each Med-Trans base of operation listed in the Operation Specifications." In Section V, under the heading "HEMS Pilot – Duties and Responsibilities," the manual indicated the pilot will report to the Director of Operations or Chief Pilot through the Base Manager and stated the pilot is responsible for "total operation of Med-Trans aircraft assigned to this hospital, insuring the safe and efficient conduct of each flight."

The DO was initially hired in 1995 as a consultant to assist MTC in obtaining an operating certificate from the FAA. After the certificate was issued, he served as Chief Pilot until he was promoted to DO in 1998 or 1999. Prior to joining MTC, he worked as Chief Pilot and then as DO for another Part 135 helicopter operator. Before joining this operator fulltime in 1993, he had worked for them part time as a pilot and flight instructor for several years. In addition, he was employed by the City of Tucson Police Department fulltime from 1973 to 1993. During his time with the Police Department, his duties included flying both airplanes and helicopters. During his last 5 years with the Department, he was a training pilot for the Bell 206B. The DO holds a commercial pilot certificate, with a rotorcraft helicopter rating, and private privileges in single engine land airplanes. In addition, he holds a flight instructor certificate with a rotorcraft helicopter rating. He reported that he has approximately 7,000 hours total flight time, of which about 6,900 hours are in helicopters, and has given approximately 2,000 hours of helicopter flight instruction.

The Chief Pilot was hired by MTC in 1995 as a line pilot at the base in Johnson City, Tennessee. He progressed to lead pilot, was designated an instructor, and then promoted to Chief Pilot in 2000. He continued to serve as a line pilot until January 2004, when he stopped flying the line because he became "too busy" with his duties as Chief Pilot. Prior to joining MTC, he

served in the U.S. Army as a helicopter pilot where he spent his last 8 years as an instructor pilot on a flight standardization team. The Chief Pilot holds a commercial pilot certificate with rotorcraft helicopter and instrument ratings. He reported that he has approximately 7,000 hours total flight time, all in helicopters, and has given approximately 3,500 hours of flight instruction.

The CEO of MTC stated that operational control “works through delegation.” He, the DO and the Chief Pilot set the parameters for flight launch decisions. The parameters are then communicated through initial training to the pilots. It is expected that the pilots will make the individual launch decisions. There is no requirement for a line pilot to check with anyone, such as the base manager, before making a launch decision. When asked if the rapid expansion of MTC in 2003-2004 had contributed to the recent accidents, the CEO stated that he did not think there was a relationship between the accidents and the expansion. He commented that MTC “did not rush through training” in order to open the new bases; the training was done the same way it had been done in the company’s early years.

The DO stated that the “biggest problem” associated with the rapid expansion of MTC in 2003-2004 was “to have the infrastructure keep up with the growth.” He wanted to have more instructors and check airmen, but he did not have time to make that happen. Therefore, he (acting as check airman) and the Chief Pilot (acting as flight instructor) compensated for the lack of infrastructure by “running all over the country to try and maintain the same standard of safety with 12 programs that we had with 6.” The DO stated that if he and the Chief Pilot had not made this extra effort, he would say that the expansion did contribute to the accidents. He further stated that before the two fatal accidents, he had a conversation with the Chief Pilot in which he talked about his fear that “everyone would get caught up in growth and things going well and people would start not paying attention.” In response to this conversation, the Chief Pilot wrote an e-mail memorandum “telling everyone to keep their eye on the ball.”

The e-mail memorandum, dated November 16, 2003, sent by the Chief Pilot to the Base Managers, stated, in part:

Team,

Some of you are aware that Med-Trans is in another growing spurt. And unlike the days when there were only 12 company pilots, we now number 52! Without [the DO] and I becoming “mother hen’s”, it’s easy to get a little nervous about all the decisions made in our cockpits. Let’s face it, the more pilots, the more exposure.

The e-mail continued with a discussion of “the company philosophy when it comes to flying in less than optimum weather” and included the following statement:

Finally, know that when you abort a mission for weather, make an unscheduled landing because of weather, or decline a mission due to weather, you will enjoy full company support in your decision.

The Chief Pilot stated that the rapid expansion was a “very big concern” and that it was a topic of discussion between himself and the DO on many occasions. They had concerns that as MTC grew, they would lose control of standards. They handled this by continuing to do all the training and checking. The Chief Pilot said that he could see why an outsider would perceive the company’s rapid growth as diluting safety and standards, “but actually the opposite happened.”

He also said "no matter how many pilots needed training," he and the DO "did it the way we always did it."

5.0 TRAINING PROGRAM

MTC provided training for its pilots in accordance with its FAA approved Helicopter Operations Training Manual. When a new base was opened, initial training was conducted for the newly hired pilots at the base, utilizing the helicopter assigned to the base. The training took place over a one-week period, and as detailed in the Training Manual in use at the time of the accident, consisted of 16 hours of basic ground training, 9 hours 15 minutes of aircraft ground training, and 4 hours 40 minutes of flight training. The Training Manual specified that recurrent training consisting of 4 hours ground training and 2 hours flight training was required every 12 months.

The Training Manual indicated that the initial flight training was divided into six periods; the first five periods were instruction and the sixth period was an oral examination and flight test conducted by a company check airman or FAA inspector. The manual specified that during flight instruction period #3, one of the items to be accomplished was to have "the trainee demonstrate the ability to navigate and control the aircraft with reference to instruments only and recover from unusual attitudes by reference to instruments only." There were no other requirements for instrument flight specified in the five instructional training periods described in the Training Manual.

According to the Training Manual, it was permissible to complete recurrent flight training "during the Recurrent Flight Test," and all recurrent flight training was to be completed as described in the recurrent flight test requirements. The recurrent flight test requirements listed two instrument maneuvers, "partial panel (hooded)" and "recovery from unusual flight attitudes."

The CEO stated, "Training is critical." He explained that MTC pilots receive flight training every 120 days. He was concerned upon entering the helicopter business about maintaining pilot proficiency in conducting autorotations. Initially, the pilots were receiving proficiency training every 180 days with the result that their autorotational proficiency was "okay." The training interval was shortened to 90 days with the result that the pilots' autorotational proficiency was "great." However, this was costly, so a compromise of 120 days was selected. The CEO mentioned two occurrences (December 30, 2003 accident in Morehead, Kentucky and February 19, 2004 incident in Madera, California) where an MTC pilot had executed an autorotation due to a tail rotor problem and landed with no further damage to the helicopter.

The DO stated that he believed in training pilots in the area where they would be flying, in the aircraft that they would be flying. When a new base was opened, the Chief Pilot would provide the ground and flight training over about a one-week period, and then he would go to the base and give the pilots their check rides. Regarding his lack of an instrument rating, he explained that his concern during initial training was to determine that a pilot had the ability to

recover from an inadvertent IMC encounter. To give this type of training, the instructor is not required to hold an instrument rating. According to the DO, MTC had been in the process of rewriting both their Operations and Training Manuals for a year before the two fatal accidents. Since the accident there have been changes made to the training program, including the addition of Crew Resource Management (CRM) training, increased documentation of training and checking, and addition of an instrument approach to the 120-day recurrent training.

The Chief Pilot stated that he had been training all MTC's newly hired pilots since January 1997. Additionally, he was providing recurrent training to all the pilots at each base every 120 days. The Chief Pilot commented that "this was easy at first with four bases," but became more difficult as the number of bases increased. He said that he was able to keep up with the recurrent training program until the first fatal accident in March 2004. Following that accident, he was able to provide training at each base "at least once" in 2004. During past recurrent training, he covered most of the maneuvers on the FAR 135 competency check, including autorotations, engine failure at altitude, and hydraulic failure procedures; specific instrument flight maneuvers covered included basic instrument flight, inadvertent IMC recovery, and unusual attitudes. In the future, recurrent training will focus on more instrument training and conducting instrument training at night, including simulating inadvertent IMC encounters at night. The Chief Pilot stated that there have been some changes to the initial training program. The amounts of ground and flight training have not changed, but a required minimum amount of instrument flight training of ½ hour is now specified. Also, a special ground training segment has been added covering CRM, hazardous materials, hot refueling, and oxygen refilling. Additionally, the Chief Pilot and another company instructor have written a maneuver guide that is now part of the training manual.

Review of the accident pilot's MTC training records revealed that he completed initial new hire ground and flight training between April 15 and April 20, 2003. During initial flight training, he received 6.6 hours of flight training in a Bell 407 from the Chief Pilot of which 1.6 hours were at night and 0.2 hours were simulated instrument flight. He completed recurrent training in a Bell 407 given by the Chief Pilot on August 28, 2003, receiving 1.3 hours of flight instruction of which 0.2 hours were simulated instrument flight. He next completed recurrent training in a Bell 407 given by a company instructor on April 19, 2004, receiving 1.2 hours flight instruction of which 0.3 hours were simulated instrument flight. On April 27, 2004, he satisfactorily completed the required 12-month FAR 135.293 competency check and the FAR 135.299 line check. These checks were given by the DO during a flight in a Bell 407 lasting 0.9 hours.

The DO commented that at the time he administered the competency check to the pilot in April 2004, he told the pilot "that the most likely thing to cause him to be involved in an accident was making a bad decision." He further commented "if you had talked to [the pilot] before takeoff and told him "You have a highway to takeoff over or you can takeoff over the trees, what are you going to do?" [the pilot] would have chosen the highway." The DO expressed the opinion that taking off over the highway was clearly the better choice, and the fact that the pilot did not choose the highway during the accident flight indicated to the DO that the pilot "was not

thinking" when he made his decision. The DO also stated that the pilot was known for turning down flights due to poor weather conditions.

The Chief Pilot reported that the pilot's initial new hire training was "normal." He commented that following the new hire training, the pilot completed recurrent training twice, then took a check ride, and that he "does not know what more they could have done in training." He further commented that the pilot was "very conservative" and that "maybe his downfall was that he did not fly in a lot of crappy weather, so when it came he was not prepared for it."

E. LIST OF ATTACHMENTS

Attachment 1 – Interview of Mr. Dennis Rohlfs, CEO/Owner, MTC

Attachment 2 – Interview of Mr. Russ Braddock, Director of Maintenance, MTC

Attachment 3 – Interview of Mr. Tom Rohlfs, Senior VP of Business Development, MTC

Attachment 4 – Interview of Bert Levesque, Director of Operations, MTC

Attachment 5 – Interview of Mr. Don Savage, Chief Pilot, MTC

Attachment 6 – Interview of Mr. Craig Roberts, Principal Maintenance Inspector, FAA

Attachment 7 – Interview of Mr. Charles Prince, Principal Operations Inspector, FAA

Attachment 8 – Interview of Mr. Dave Baron, Principal Avionics Inspector, FAA

Attachment 9 – MTC Air Ambulance Programs

Attachment 10 – Excerpts from MTC Operations Manual

Attachment 11 – Excerpts from MTC Training Manual

Attachment 12 – E-mail from MTC Chief Pilot to Base Managers, 11/16/03

Attachment 13 – Excerpts from Pilot's MTC Training Records