Interview:	Jon A. Prater Principal Operations Inspector (POI)—Air Methods Federal Aviation Administration
Represented by:	Steve Dunn, FAA Counsel
Date:	January 5, 2012
Time:	1030 edt
Location:	Telephone Interview
Present:	Jim Silliman, Malcolm Brenner, Maryam Allahyar NTSB

Mr. Prater provided the following information:

His father purchased a helicopter when he was 8 years old so he was exposed to aviation at an early age. Following his high school graduation, Mr. Prater served for 21 ½ years in the U.S. military flying the Black Hawk and Huey helicopters. He next served for 10 years as a civilian fixed wing pilot for law enforcement, and one year as pilot for Mesaba Airlines. He began employment with the FAA in July 2001, and had worked as air safety inspector, certificate POI, team manager, and office assistant manager. He assumed his current position in June 2010.

His total pilot time is about 9,000 hours, of which about 5,000 hours are in fixed wing aircraft and the remaining hours in helicopter. He was not required to be type rated in the A350 helicopter but holds Airline Transport Pilot (ATP), Certified Flight Instructor, and Instrument Flight Instructor helicopter ratings.

He was not acquainted with the accident pilot.

Air Methods was at that time the world's largest FAR Part 135 EMS helicopter provider. It operated in 43 states. It had been very proactive with its SMS program, and it was very refreshing for him to see how the company had embraced SMS. He had been POI of smaller operators.

The company had expanded rapidly in size and scope, and kept doubling every 18 months. It was hard to oversee, with 350 bases and diversity of operations. All merger issues were grounds for additional oversight attention. The certificate oversight team was fortunate to have 27 dedicated staff persons, who travelled extensively and managed to visit every base at least once per year. Although there could always be a need for additional staff, the certificate oversight team had been able to increase staff as Air Methods expanded.

The St. Joseph MO base was very typical. No outstanding issues were raised at this base, and it had no history of fueling issues, need for additional inspection issues, or any abnormal issues.

Given the size and scope of the company, its accident rate compared to its peers was below national average. Air Methods assessed data from all accidents to redirect its safety efforts. For example, the Lamont Montana accident provided lessons on maintenance issues and the importance of cross-checks by independent inspectors to catch mistakes.

He strove hard to maintain a positive relationship between the company and the FAA. The FAA had to enforce penalties but worked to maintain a professional relationship. He interacted with the chief pilot, Director of Operations, and Director of Maintenance. Regarding complaints that he heard from pilots, there had been nothing out of normal. The pilots and company had been engaged in contract negotiations for the past two years and he stayed out of it. There had been no complaints about equipment.

Asked whom a pilot would contact regarding a difficult launch decision, Mr. Prater stated that the pilot had the ultimate decision. The flight release program required the pilot to complete a risk assessment form and evaluate weather as part of obtaining the flight release. If the pilot had concerns about the weather decision, he could contact the Communication Center or his chain of command.

The company spent approximately 2.4 million dollars to establish an Operational Control Center (OCC), based at Denver, which was state of art. It monitored weather models continuously, 24/7, and could also assist the pilot on weather issues. The OCC did share operational control and had direct access to the operational control persons listed on Operation specifications A006 required by FARS. The OCC did not have licensed dispatchers, but the OCC always had an employee with operational experience on duty.

Mr. Prater did not think that the Mosby accident reflected OCC issues. This pilot miscalculated his fuel not once but twice. The flight follower went above and beyond his responsibilities in trying to assist the pilot and did a phenomenal job. Concerning operational changes that might result from this accident, the company (working through him) could provide reminders to each pilot emphasizing the importance of confirming fuel numbers. They could also work on issues of flight follower awareness, perhaps using them as a backup to remind pilots to “double-check your fuel.”

The company’s Safety Office was phenomenal and provided internal evaluations, as well as LOSA and FOQUA programs. It maintained a dedicated safety staff. He participated in monthly SMS meetings. This Safety program was more robust than that of any other Part 135 company in his experience.

He was one of three principle FAA inspectors on the certificate. His daily contact was with the Chief Pilot (his counterpart) and often with the Director of Operations (DO). They exchanged text messages and talked every day, 7 days per week. Weekly, they

had either a one-hour telephone conversation or face-to-face meeting scheduled weekly. On a monthly basis, the three principles met with the DO, Director of Maintenance, and Chief Pilot at the SMS meeting.

Mr. Prater considered the CAMTS program to be phenomenal, since it was industry driven effort to surpass regulatory requirements and raise professional standards and team regulation. The industry itself decided to tighten up professional programs and the higher level of organization such as CAMPS had some clout. He considered it awesome to see companies such as Air Methods become CAMPTS certified and this effort had his complete support.

The SMS program was available for all operators, mandatory for FAR Part 121 operators but not yet for Part 135 operators. It was a risk-based proactive program within the company, a top-down program with buy-in at all levels. Air Methods did the research to establish SMS and came to the FAA with its proposal. They worked very hard. They had now progressed to a point that they were ready to exit level 3—ahead of major airlines which were more often at level 1 or 2. The Air Methods SMS program had established:

- internal evaluation
- root cause analysis
- internal audits

The FAA was an integral part of the SMS program. The FAA was a voting member, and principle inspectors had completed SMS training and attended monthly company meetings. Ultimately, the FAA principle inspectors recommended to the FAA whether the program should be accepted/certified.

The FAA members who participated in these monthly SMS meetings were the team supervisor and three principle inspectors; the company participants included the Chief Pilot, Director of Operations, Director of Maintenance, Director of Safety, and various Department heads throughout the company.

Air Methods routinely conducted root cause analysis for accidents and completed its own investigation. They shared the results with the FAA. These efforts were a major topic for all SMS meetings. The SMS program tried to fix problems as soon as they were identified, and the SMS systems include proactive approaches to safety. Any volume of incidents would also trigger an SMS course of action. There were countless examples of SMS actions.

The SMS meetings had discussed the Mosby accident in detail, including issues of simulator work, auto-rotation, and fuel alerting of dispatchers. The Chief Pilot targeted the check airmen and instructors of the A350 series helicopter to emphasize autorotation and differences in fuel gauges. Mr. Prater believed that Air Methods would develop a final package on the Mosby root cause. He did not know whether the company would provide a hard copy of this package to the FAA, since it was an internal

investigation, but indicated that the company would share their data and thinking directly with the FAA through the SMS program to provide sufficient information to the FAA to prevent a recurrence.

Asked whether there should be more coordination between OCC and the Omaha flight following office, Mr. Prater noted that there is no regulatory requirement for Air Methods to maintain a dispatch function. The flight follower performed well in the Mosby accident. The OCC also had an autolink function to track every helicopter so some data were provided back directly to OCC.

Mr. Prater indicated he was pleased about the upcoming company FOQUA program for which he expected a proposal within one month. The company had developed a LOSA program in which a line oriented observer rode in a helicopter to take written notes on all safety observations.

The Chief Pilot had recently developed a proposal for updated auto-rotation training as a result of the Mosby accident. Mr. Prater was very supportive and believed that the concept of a simulator for auto-rotation training seemed invaluable. The company recently committed to simulator training, despite its high cost, in which it would emphasize immediate aft cyclic input. This seemed spot on, an example of the company doing its homework. The company had talked with other operators and evaluated the A350 characteristics in autorotation. All helicopters emphasized back collective for entry into auto rotation, but with the A350 it was especially critical to get cyclic back immediately as well. The company would get material to Mr. Prater by January 17 for approval, and planned to begin the new training by March. Auto-rotation had always been a factor of consideration for pilots, and all accidents including Mosby increased focus and helped the industry to improve its understanding and procedures.