Attachment 1

to Operational Factors Group Chairman's Factual Report

ERA12MA122

INTERVIEW SUMMARIES

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Interview: Steve Stout, Helicopter Pilot – SK Jets
Date: January 3, 2012
Location: SK Jets Headquarters, St Augustine, FL
Time: 1625 EST

Present: David Helson – National Transportation Safety Board (NTSB); Leigh McIntosh – SK Jets; Steve Moore – Federal Aviation Administration (FAA).

Mr. Stout was represented by Mr. Michael B. Ely – Hassell, Moorhead & Carroll.

Mr. Stout stated the following information:

He was employed by the Florida Fish and Wildlife Conservation Commission (FWCC) as a full time helicopter pilot. He also worked part time as a helicopter pilot for SK Jets. He said he worked for SK Jets since they moved to St Augustine about 10-12 years ago and he had worked for the FWCC since June of 1984. He learned to fly in the Navy Flying Club and then was employed as a crop duster flying fixed wing aircraft for about 1 year and helicopters for about 2 years. He then worked as a flight instructor in helicopters and airplanes for about 8-9 years. He said he was hired by the Florida Marine Patrol which later merged with the FWCC. He started in Miami flying Hughes 500 helicopters and a Cessna 172 then flew Bell Jet Rangers, a Lakes 250, and a 560 Aero Commander. He said the crop dusting was done in a Bell 47 and he flew a Cessna 182 and OH-58 (Jet Ranger) for the state of Florida. He said he had "a lot of Hughes 500 and Bell 206 time" and estimated he had logged about 14,000 hours total time with about 11,000 of that in helicopters. He said he had worked as a helicopter instructor at a flight school based at St Augustine Airport (SGJ) flying Robinson R22's and R44's and occasionally ferried a helicopter across the country. He said it was about 20 hours of flying from California to Florida. He had also conducted some checking events and some biennial flight reviews for the FWCC but had not worked as an instructor or check pilot at SK Jets.

He said that he had worked for SK Jets on a contract for fire control with a 2 week on and 2 week off schedule. More recently he had conducted medical flights for SK Jets between SGJ, Mayo Clinic heliport and Shands Heliport. He said he conducted the medical flights on an "on call" basis and that he was used as a relief pilot for when the other pilots were not available. He said the on call schedule was typically to cover a 12 hour period over night until one of the other pilots was available again. He said the schedule was variable and he may or may not get called out for a flight. He said he was usually given a 2 hour callout when there was a flight but sometimes he would be given more notice. He said they would also call him ahead of time to advise him of when they were working on a possible flight. He said sometimes it took so long to set up the flight that the next pilot was on duty by the time the flight actually occurred. He said if they gave him more than a 5 or 6 hour notice he would just go to bed and wait for them to call back with a planned flight schedule. He said they would typically give him a notification 2 hours prior to a flight.

Mr. Stout said that when notified of a flight he would check weather from home before driving in to the airport. He said he used "Weather Tap" to obtain weather because he had access provided

by his job at the FWCC, and it was paid for by the state. He said he was normally notified of a flight by a dispatcher. There was a dispatcher available 24 hours a day and he would start prepping for the flights when she called. He said the dispatchers did not assist with obtaining weather data or flight planning; the pilots were responsible for doing that. He said the dispatchers called to advise of the flight, destinations, and number of passengers. He said after checking the weather, if he had any question about the safety of the flight he would also call the Flight Service and talk to a weather briefer.

He said Shands Hospital had a heliport but he did not know if they had a weather observer on location. He said some heliports did have a weather observer when collocated with an airport. He said Tallahassee was one example as they had a medical helipad at the airport. For other heliports, he said they would use the weather observations from the nearest airport. For Shands heliport, he said they typically used Gainesville Airport (GNV) weather as Shands was only about 3 miles away and was inside the GNV airspace. He stated that the GNV weather was usually a pretty accurate indicator of the weather at Shands. He said when available, he would also call to get the ASOS (Automated Service Observations System) weather for an airport.

Mr. Stout said that for the Mayo Clinic Heliport, they usually used weather reports for Craig (CRG) airport which was about 6 miles from the heliport. He said the CRG weather was an accurate depiction of weather at the Mayo Clinic Heliport "most of the time". He said the clinic was near the St. Johns River which could affect the weather.

Mr. Stout said the training he received at SK Jets for the Jet Ranger covered everything for a commercial checkride including, landing on slopes, operating into confined areas, auto-rotations, and abnormal and emergency scenarios. He said they also covered company policy and procedures as well as FAR (Federal Aviation Regulation) Part 135 rules. He said this was all included in initial training and in the annual recurrent training.

He said he had not flown any flights for SK Jets in about 5 ½ months and recalled that his last flight for the company was August 2, 2011. He said the company had two full time helicopter pilots and only one helicopter so they did not need him to cover any flights. Mr. Stout clarified that the accident helicopter had just been acquired by the company 1-2 weeks prior to the accident and with only the one other helicopter in use; they had not needed a relief pilot.

Mr. Stout stated that he had known Hoke Smith for about 12 years. He thought that he may have met him earlier when he was working up at Craig airport years ago but he was not sure. He said the last time he talked with Mr. Smith was about 4-5 days prior to the accident. He said he stopped by SK Jets fairly regularly, 1-2 times per week, because his full time work had business on the airfield. He said when he talked to Mr. Smith last; there was nothing remarkable about the conversation or anything that Mr. Smith mentioned. They had talked briefly about business and whether or not there was any possible flying that SK Jets might have for him to do; but there was not. He said he did not talk to Mr. Smith about his personal life so could not address it.

When asked if he ever flew with Mr. Smith, he said that he had done training and checkrides with him and had also flown with him in the Agusta when the trip required two pilots. He said Mr. Smith was an instructor and check pilot and had conducted all of his checkrides at SK Jets.

He said the last time they flew together was for a checkride about one year ago in the Jet Ranger. He recalled that they flew to Pensacola or Clewiston together in a fixed wing so Mr. Smith could give him and another person a checkride in the helicopter.

He said he would characterize Mr. Smith as an excellent pilot but that when they were together Mr. Stout flew most of the time. He said Mr. Smith's greatest strength as a pilot was his knowledge of systems. He said he had a "photographic memory". He could not think of any weakness Mr. Smith had as a pilot. He said he had never encountered any abnormal or emergency situations while flying with him.

Mr. Stout said he was not aware of any safety reporting program at the company but the Director of Safety did send out a safety newsletter every month. He said he always felt there was an understanding that the pilots would report any safety issues to the director of safety or the chief pilot. He said he dealt with the chief pilot more so he probably was more likely to report something to him. He said he felt comfortable talking to them and would not hesitate to bring up any safety issues. He did not recall ever needing to bring up any safety issues.

Mr. Stout was asked if he ever had occasion to turn down a flight while working for SK Jets. He said the only times he could recall were due to weather or availability. He said the decision to turn down a flight was made by the pilot and there were never any repercussions if that occurred. He said when they are assigned a flight, it must also be "released" by the chief pilot, the director of operations, or the head of dispatch. When the pilot showed up to the aircraft the paperwork included a remark that indicated who released the flight. He said the paperwork was basically a trip sheet that included who was flying, where they were going, and at what time. He said the flight planning, weight and balance, and fuel load were all done by the pilot.

He said they did not use night vision equipment on the helicopters as it was not authorized on the company Operations Specifications and when asked about TAWS (Terrain Awareness and Warning System) he said the Jet Ranger and the Agusta both had a radar altimeter. He said he was not aware of what equipment was available on the accident helicopter.

Mr. Stout said when they conducted the medical flights they were always conducted under VFR (visual flight rules). He said FAR Part 135 rules required a minimum altitude of 300 feet. He said the company weather minimums contained in the operations specifications were 1,000 foot ceiling and 3 miles visibility for night flights.

Mr. Stout was asked if he had ever conducted the medical flights between Mayo Clinic Heliport and Shands Heliport and he said he had flown that route "a hundred times, same as Hoke". He said they typically navigated by GPS (global positioning system) from Mayo Clinic direct to Shands. He said the route of flight went just east of Greencove Springs and took you right over Camp Blanding. He said much of the route was not well lit at night.

He said when he had turned down flights for weather; they did not go by helicopter to complete the mission. He thought they may have completed the mission using a ground vehicle or by use of a fixed wing jet.

Mr. Stout said all of his Ground school training had been conducted ate SK Jets in a briefing room by the chief pilot and on the computer. He said he also took a written test at the completion of training. He said there was differences training for the new (accident) helicopter. He described the differences as very minor and that there were only a few he could think of. He said there were a few switches in different locations and that this helicopter did not have a cabin heater. He said the accident helicopter had a Garmin 430 GPS (global positioning system) with localizer and glideslope indications. He said it also was equipped with altimeter, rate of climb indicator, attitude indicator, turn and bank indicator and other basic flight instruments. He said there were not many differences between Jet Rangers, mainly just layout of switches and radio configuration.

He said they flew VFR but navigated GPS direct. When conducting the flight between Mayo and Shands, they typically used the heliport identifiers to go direct; they did not enter additional enroute waypoints in the GPS or any user defined landmarks or waypoints.

When asked if he felt that he was always afforded the opportunity for adequate rest, we said "absolutely". When asked about a company fatigue risk management program, he said a pilot could turn down a flight for fatigue, weather or anything else without any issues.

Mr. Stout said he did not take part in any post accident debrief or investigation for the company. He said he flew the Clay County investigator and Clay County accident photographer to the accident site as part of his flying duties at his FWCC job.

The interview ended at 1720.

Interview: Timothy Daniel Murphy, Helicopter Pilot – SK Jets
Date: January 3, 2012
Location: SK Jets Headquarters, St Augustine, FL
Time: 1800 EST

Present: David Helson – National Transportation Safety Board (NTSB); Bill Bramble – National Transportation Safety Board (NTSB); Leigh McIntosh – SK Jets; Steve Moore – Federal Aviation Administration.

Mr. Murphy was represented by Mr. Michael B. Ely – Hassell, Moorhead & Carroll.

Mr. Murphy stated the following information:

He was employed as a helicopter pilot for SK Jets. He had been employed with SK Jets for one year. He said he was previously employed by Escambia Country Sherriff's Office in Pensacola, Florida as a pilot. He said his total flight experience was 2,450 hours and about 2,440 hours of that was in helicopters. He said he had 2,250 hours in a Bell 206. He said he held a commercial instrument helicopter license. He said he was not a check pilot and reports to the Chief Pilot, Mr. Gary Fernandes. He said his job was to handle the helicopter for charter, medical or fire contract flights. He said he was currently working on the fire contract at Eglin Air Force Base.

When asked about the company procedures for a medical flight, Mr. Murphy said that he would get a call from dispatch. He said dispatch would ask if he was able to take a flight. He said if he could, he would come in, do the preflight, verify the maintenance logs were taken care of and go where needed. Mr. Murphy said the pilot decided if a flight would be accepted and said that he could turn down a flight due to weather, fatigue, or anything that might cause the flight to be unsafe. He said that he used FltPlan.com for flight planning. He said we would check local and en route weather at home, go to the airport, do a preflight, verify the maintenance, verify the fuel load and verify the flight had been released. When asked if he spoke with the releaser, he said no, dispatch would tell him if the flight had been released or not. He said he exclusively used FltPlan.com for weather. Mr. Murphy was asked what weather he used for medical flights to the hospitals and he stated that most of the pads do not have weather reporting but are located close enough to an airport to use that airport's weather data. He said he had flown from Mayo to Shands and uses Craig (CRG) and Cecil (VQQ) weather for Mayo and Gainesville (GNV) for Shands. He said that the weather for the airports was pretty accurate as far as the conditions at the hospitals. When asked if there was any other source of information for those locations, Mr. Murphy replied not generally and said he just used the Aviation Routine Weather Reports (METARs) and Terminal Area Forecasts (TAFs) on the website. He said that he usually went on a Global Positioning System (GPS) direct course to the hospitals and said that they do not operate under Instrument Flight Rules (IFR) and all flying is under Visual Flight Rules (VFR). He said he never files IFR flight plans nor does he do any Special VFR. He said that dispatch did not help with flight planning and said that the pilot did it all. He said the pilot was ultimately responsible for accepting or declining a flight. Mr. Murphy was asked if he had ever declined a flight and he said he had because of weather and that there were no repercussions. He said that the General Operating Manual (GOM) had procedures that defined how to flight plan and check

the weather. When asked what those procedures were, he said they used FltPlan.com to check local, en route, and destination weather, times on the aircraft and verify maintenance was up to date. He said he thought there were other approved sources for checking the weather but that he did not use them. He said the company weather minimums were three miles visibility and 2,000 foot ceilings at night for the entire route. He said they have to stay within VFR limits during the entire flight regime. He said the day weather minimums were 1,000 feet and three miles visibility. Mr. Murphy said the minimum altitude requirements en route required that a flight be conducted at a height that can be safely operated without danger to persons or property on the ground. He added that they do not normally operate any lower than 500 feet above ground level.

When asked about the training he had received through the company, Mr. Murphy said he did ground training going through the GOM, company procedures and did a check ride with Mr. Smith prior to being signed off to fly the aircraft. He said that prior to being released to do the medical flights; Mr. Smith accompanied him to train on the location and communication procedures of the hospital pads. He said he completed the flight training in the aircraft at St. Augustine (SGJ). When asked to describe the quality of the training he said he felt it was pretty good. He said it was certainly sufficient for the operations we conducted. He said he was trained on the company procedure for flight planning and what websites to use and so forth.

Mr. Murphy said he had used night vision goggles (NVG) previously but not while flying for SK Jets. When asked if the helicopter had a terrain avoidance warning system (TAWS) he said no. He said the training he received on terrain avoidance was to stay above the minimum altitude.

When asked how he conducted flights from Mayo to Shands, Mr. Murphy said GPS direct. He said there was a restricted area and training range between the two when flying direct but they were normally cold. He said they would contact Jacksonville Approach to find out the status of the airspace. As far as other communications, he said they would normally just talk to Jacksonville Approach and GNV tower. Mr. Murphy was asked what he put in the GPS for Shands and he said the identifier for the heliport.

When asked about the schedule, Mr. Murphy said he was generally on call and that the company rotated the pilots and let them know when they were first up. He said he usually covered the nights and Mr. Aaron Dyess would work the days. When asked if he was on call for 24 hours for weeks straight, he said no, they had enough people to divide it up. He said that they abided by the 10 hour rest period after a flight before they were subject to another call. He was asked how he felt about the schedule and he answered he never had a problem with it because he was on it for several years at his previous job. When asked about the amount of rest he was able to get, Mr. Murphy said “plenty, it is adequate.” He said the company fatigue risk management policy was if you felt too tired you could turn down the flight.

When asked about the company safety reporting system, Mr. Murphy said you could go directly to the Chief Pilot or there was an anonymous box in the pilot room were you could leave a card. When asked about his interpretation of how those suggestions were received, he said he had never had to bring a safety issue to someone’s attention. He added that he thought there would be no repercussions if he had and that it was encouraged. He said he was not aware of any safety issues that the pilot group was concerned with.

When asked about his flights with Mr. Smith, Mr. Murphy said he had last flown with him on November 18, 2011 for a Part 135 check ride. He said most of the flights they had flown together were for training. He said Mr. Smith flew some of the Mayo trips with him when he started as well as about 5-6 hours in the Agusta for familiarization training. When asked about Mr. Smith's skills and abilities, Mr. Murphy said he never had an issue with it. He said Mr. Smith always seemed like a competent pilot, made good decisions and was knowledgeable about what he was doing. When asked about Mr. Smith's strength as pilot, he answered decision making and aircraft handling. He said nothing stood out as a weakness. Mr. Murphy said Mr. Smith was open to suggestions and opinions as President of the company. When asked about checklist usage, he said that they used checklists for startup and shutdown and had an emergency checklist available in the aircraft if they needed it. He said he never had an abnormal or emergency situation in the aircraft with Mr. Smith.

Mr. Murphy was asked about the last time he met with Mr. Smith and he said they met on December 20 or 21, 2011 about the Eglin contract and how to handle the days off now that Mr. Dyess was leaving. He said the plan was to have Steve Stout cover in January because they were required to have two days off every 12 days per the contract. He said that was less than normal because with Mr. Dyess working they would work 12 days on then have 12 days off. He said the reason for adjusting it was because you had to have an Office of Agricultural Services (OAS) card to work on the contract. He said while working on the contract you were on call during the day and had nights off. When asked about the amount of hours he flew, Mr. Murphy said before the Forestry contract he would typically fly 3-5 trips a month for about 10 hours total. He said that was typical for him and Mr. Dyess and Mr. Smith would fill in as necessary when they were not available.

Mr. Murphy was asked how long he had been a pilot with the Escambia Sheriff's Office and he answered almost five years. He said before that he was an officer. He said that he paid for his own initial pilot training and the Sheriff's office paid for the job specific training. He said that they did not require an instrument rating and that he did not have one until last summer. He said he paid for his own instrument rating for job opportunities. Mr. Murphy said he was hired at SK Jets with 2,100 total flight hours. When asked to compare his job with the Sheriff's office versus SK Jets, Mr. Murphy said they were public use rules versus Part 135 rules. He said the charter flying was far easier than the flying for the Sheriff's office. He added that the flying for the contract in Eglin was closer to the type of flying he did before. He said it was mostly all single pilot flying in the helicopters at SK Jets unless a charter client requested two.

When asked of example weather conditions that he had declined flights for, Mr. Murphy said the one that stuck out was when Navy Jacksonville (KNIP) and Palatka (K28J) were calling for 300 foot ceilings in fog. He said that was obviously something he could not fly through as a VFR pilot. When asked about his personal comfort weather minimums, he said 1,000 feet and 1 mile at night. He was asked if a different helicopter would change those minimums and he said no, not as far as the Bell 206s because that was what he was flying before.

Mr. Murphy was asked about the obstructions on the direct route from Mayo to Shands and he responded "not that I can think of." When asked how the Agusta compared to the 206, he said

they only used it for VFR, so as far as utility as a pilot, it was the same as the 206. He said the Agusta had the capability of doing IFR flights but that it was only utilized for VFR flights. When asked if one or other was preferred for night flights, he said no, the Agusta maybe because it was faster. He said as far as equipment it was the same either way. He was asked to compare the autoflight and stabilization on the two helicopters and he said the 206 did not have any. He said the Agusta had a stability augmentation system (SAS), a 3-axis autopilot and Garmin 430. He said the helicopter in question, N5016M, also had a Garmin 430 and the other Bell 206 at Eglin had a Garmin 396.

When asked about the lighting and weather conditions of his previous flights with Mr. Smith, Mr. Murphy said it was a year ago, but thought it was normally clear nights. He said there were a couple of dark patches going across the training ranges but other than that they were mainly over populated areas. He said the dark areas between Mayo and Shands are restricted areas 293A, C, and D ranges and 2904A. He said those were the only spots that would be dark. Mr. Murphy said he had flown over the area where the accident had occurred. When asked to recall the visual picture of that area, he said nothing specifically; the majority of the flight was normal residential lighting except for the training areas.

When asked about his familiarity with Mr. Smith, Mr. Murphy said he knew him as an acquaintance and his boss. When asked about Mr. Smith's general attitude towards flying, he said he loved it as far as he could tell. He described Mr. Smith's personality as agreeable. He said he was the boss. He said he would not describe Mr. Smith as a dominant person. On a day to day level, he said Mr. Smith was agreeable, approachable, friendly, easy to get along with, calm in the aircraft and very conscientious. He said Mr. Smith did not display any of the five hazardous attitudes described in FAA literature. Mr. Murphy said Mr. Smith's cockpit style was very well managed. He said if they were flying the Agusta, Mr. Smith would make sure Mr. Murphy understood what he wanted. If they were in a very congested area like Orlando, Mr. Smith would ask Mr. Murphy to share responsibility and handle the radios. Mr. Murphy said they had good crew resource management (CRM) when they flew together.

Mr. Murphy said he had no knowledge of Mr. Smith's general health, use of prescription medication, alcohol or tobacco use, recent illnesses, significant changes in health, finances or personal life, daily sleep need or any sleeping difficulties. He said he was unaware of Mr. Smith's 72-hour sleep and activities as their last communication was on either the 20th or 21st. Mr. Murphy's most recent flight prior to the accident was on December 22, 2011 for a local Mayo flight. He said he had flown with Mr. Smith 5-6 times at night and he said he did not recall anything unusual. He said Mr. Smith did wear glasses while flying. He said they never encountered an abnormal or emergency situation while flying together nor had he ever had to take the controls.

When asked if SK Jets was growing or declining, Mr. Murphy said it had declined some since he had been there and he said he did not know why but the charter side declined and the fire contracts remained steady. When asked about the helicopter pilot pay at SK Jets, he said that it was better than his previous job. He said it was salary plus flight hour bonus. On fire contracts, Mr. Murphy said the flight pay was about 25% of his paycheck whereas while not on the contracts he said the flight pay accounted for only 10%. He said the pilot morale was pretty

decent from what he had observed. He said the company policy on flight time was a maximum of eight hours per day for single pilot operations. He said that the pilots and dispatch tracked the flight times. He said the individual pilots were responsible for their own time and duty but dispatch helped. He said that he did not receive overtime pay but said the company did provide sick leave. He said he did not know how many days they provided per year. When asked about the size of the workforce, Mr. Murphy said they had three full time helicopter pilots, including Mr. Smith, and had Steve Stout as part time and that was adequate for the operations. Regarding recent helicopter pilot turnover, he said Mr. Dyess had put in his two week notice and that was the only difference. He said he did not know about overall pilot turnover. When asked about the turnover of managers, he said they had been consistent.

Mr. Murphy stated that he received no simulator training. He said that they had a decision making CRM section in the ground training. He said he did not receive any in the aircraft because the helicopter pilots who started at SK Jets had previous experience and Mr. Smith had been comfortable with their decision making as the flight instructor and check airman. Mr. Murphy stated that he received spatial disorientation training in the Bell 206 during the check rides with Mr. Smith by putting on foggles and recovering from an usual attitude. When asked if that was challenging, Mr. Murphy responded, "pretty easy for me." When asked how difficult it was to transition to instruments if you suddenly lost visual references, he said it was not difficult at all and said he never had any issues with that. Mr. Murphy was asked if he had any fixed-wing IFR time and he said just 10 hours instrument familiarization with a rated pilot in simulated instrument conditions. When asked what speed below which control becomes more challenging in the Bell 206, he said if flying solely by reference to instruments it may get more difficult below 30-40 knots but he said not as far as he had experienced.

Mr. Murphy was asked about the quality of the equipment at SK Jets and he replied it was in good condition and said he had confidence in the maintenance. When asked about the financial condition of the company, he said he could not speak to that. He said he felt supported when he turned down flights for safety-related reasons and said he never felt pressure to fly in questionable weather conditions. Mr. Murphy said he was not aware of Mr. Smith taking flights in questionable weather conditions. When asked about subcontracting practices, he said they never had to his knowledge since he had been there. He said if there was a procedure for it he did not know what it was. When asked about his relationship with Mayo, Mr. Murphy said they only went through dispatch. He said the pilots never had any interaction with Mayo nor did they have any role in preflight decision making. Mr. Murphy said it was common to have Mayo staff, including a surgeon, on board the helicopter for medical flights. He said the typical wait during organ recovery was 2-3 hours, two hours for a heart. He said the flight from Mayo to Shands took 30-45 minutes in the Bell 206.

When asked how closely pilots follow checklists and adhere to company standard operating procedures (SOPs), Mr. Murphy stated he had never personally seen any pilot violate a company SOP. When asked about a formal preflight risk management process, he said in the Agusta they used a flight risk analysis tool (FRAT) but not usually for the Bell 206. He said he did not know if Mr. Smith used one on the day of the accident. Mr. Murphy said he did not usually complete the form for the 206 because he scored so high on the list that he said he did not have to worry about turning down the flight because he would not have met the requirements and he said he

would always turn down for weather if there were issues. In other words, he said he went through the flight in his head without actually completing the form. When asked if the FRAT form was an insurance requirement he said he did not know but that it was a company requirement.

Mr. Murphy stated that he last flew the accident aircraft on December 22, 2011. He said everything functioned normally and that was the only time he flew it. He said there was nothing inoperative and no maintenance write-ups. He said it flew about the same as the 206 he normally flew. When asked how a crew would normally set up the Garmin 430, he said hit direct to, pull up the identifier for Shands and follow the line on the map. He said he was not aware of any particular hazards associated with flying in the accident area. He also said that there were not any navigational aids used for back up.

Mr. Murphy said he did not know if the trips went that he turned down due to weather. He said he did not typically file a FAA flight plan but said he did speak to approach control. He said Jacksonville approach covered the entire flight from Mayo to Shands. When asked if they spoke with approach control when he flew with Mr. Smith, Mr. Murphy said that he worked the radios and they used it. Mr. Murphy said the minimum SK Jets weather requirements were published in the GOM. Mr. Murphy said that Mr. Smith did the company helicopter flight training and checking. He said he did a little of the differences training with Steve Stout but the company flight training was all done by Mr. Smith. When asked for some of reasons why you would be off the GPS direct to line, Mr. Murphy said the only reasons would be aircraft avoidance or unexpected weather.

When asked how you get an OAS card, Mr. Murphy said there is a man that came from an office near Washington, DC that performed a check ride. He said the check consisted of the man standing on the ground outside the aircraft to see if the pilot could do long-line and aerial suppression with the bucket. He was not aware if Mr. Smith had an OAS card. Mr. Murphy was asked if the helicopter required two hands to fly en route and if that was why the pilots did not use en route checklists and Mr. Murphy said yes. Mr. Murphy was asked if he would turn down a trip from Mayo to Shands if the ceiling was 500 feet overcast and he said yes. He said in that case, the Mayo team would drive to SGJ and take the jet to GNV or drive directly from Mayo to Shands.

When asked about low visibility training for VFR, Mr. Murphy said they do inadvertent instrument meteorological conditions training with foggles. He said the procedure for that, as he was taught, was to recover and perform a 180-degree turn to get out. Mr. Murphy was asked about the requirements for checking the weather once you had departed and he said he was always talking to approach so if they were aware of any weather they would give him a heads up. He said they would also check Aeronautical Terminal Information Services (ATISs) at the local airports if they thought there was going to be an issue. When asked if there was a procedure in the manual that defined continuation to an airport where weather may have changed, Mr. Murphy said not for VFR helicopters. He said that he usually got flight following services with Jacksonville approach.

When asked if there was anything he could tell the investigators there was any more information that he wanted to add he said no.

The interview ended at 1937

Follow up Interview: Timothy Daniel Murphy, Helicopter Pilot – SK Jets
Date: January 5, 2012
Location: via telephone from SK Jets Headquarters, St Augustine, FL
Time: 0915 EST

Present: Bill Bramble, David Helson – National Transportation Safety Board (NTSB); Steve Moore – Federal Aviation Administration (FAA).

Mr. Murphy was represented by Mr. Michael B. Ely – Hassell, Moorhead & Carroll.

Mr. Murphy stated the following information:

The VFR (visual flight rules) minimums were actually 1,000 foot ceiling and 3 miles visibility. He said after his previous interview he realized he made a mistake and wanted to provide the correct information. He said there was also a clause in the GOM (General Operating Manual) that allowed the director of operations or the chief pilot to waive the limits down to FAR (Federal Aviation Regulation) minimums.

He said that he had flown the accident helicopter one time and had also completed differences training.

Mr. Murphy said typically he would use the Garmin 430 for terrain awareness information but on that one particular flight from St. Augustine to the Mayo Clinic Helipad it was a clear night and he was up over 1,000 feet the whole time so he did not use it. He said he could not recall if the terrain feature was set up on that helicopter.

When asked how he would normally use the terrain function, he said you could turn it on or off and if you flew below about 500 or 300 feet, he could not recall which, the screen popped up yellow on the Garmin 430. If you flew lower, at some point the screen turned red. He said there was no aural alert, only a visual indication.

Mr. Murphy said the radar altimeter provided an audio alert depending on how you set it. He said he normally set it about 100 feet and there would be an audio alert if you went below the set altitude. Aside from that, he said there was a visual indication of your height above ground.

Mr. Murphy said he could not say how Mr. Smith set up that equipment because Mr. Murphy had set it up when they flew together. He said Mr. Smith did not tell him to set it differently but he did not have any experience observing how Mr. Smith set it up.

Mr. Murphy was provided a copy of weather reports and forecast for the time of the accident flight, recovered from Mr. Smith's computer and was asked to provide his impression of the conditions. Mr. Murphy stated that he would also check NAS Jacksonville and Palatka for enroute weather but it would be hard to say based on what he was looking at. He said he could not make a decision based solely on the information provided. He said the METARs (aviation routine weather reports) were showing clear but the TAFs (terminal area forecast) were showing some pretty low weather for Craig and Gainesville. He said in his experience the forecast weather was not always accurate. He had seen a forecast for bad weather when the weather was clear, and a forecast for clear when it was real bad. He said with the METAR indicating good weather, he would want to keep monitoring until takeoff to see if the conditions changed at all. In this case, he said he might tell scheduling that he would accept the flight with the condition that they be ready with a backup plan.

Mr. Murphy said he experienced one situation like that where the forecast weather was not very good and he told scheduling to make alternate arrangements and let the client decide ahead of time. He said they decided to take the jet in that case.

He said if he took a flight with that presented to him, he said he would continually monitor the weather enroute using JAX Approach and the ASOS (automated service observation system) at Palatka and Gainesville.

Mr. Murphy was asked if he knew anything about an accident Mr. Smith may have had in 2007 or 2008. He said he had not heard anything about it as he was just hired in 2011.

The interview ended at 0932.

Interview: Joshua Kenneth Deitrick, Learjet Captain – SK Jets
Date: January 4, 2012
Location: SK Jets Headquarters, St Augustine, FL
Time: 0910 EST

Present: David Helson – National Transportation Safety Board (NTSB); Bill Bramble – National Transportation Safety Board (NTSB); Leigh McIntosh – SK Jets; Steve Moore – Federal Aviation Administration.

Mr. Deitrick was represented by Mr. Michael B. Ely – Hassell, Moorhead & Carroll.

Mr. Deitrick stated the following information:

He was employed as a Captain, fixed wing, for SK Jets. He said he resigned Monday, January 2, 2012 and was starting a new job at Craig Air Center pending drug test results. He said he was hired by SK Jets in June 2007. Prior, he said he worked for an owner-operator in Flagler Beach (KXFL) flying a Citation under Part 91 regulations. He said he worked there until he had 1,800 hours when he started at SK Jets. He stated that he started out with a Bachelor of Science degree from Kansas State where he completed his private through multi-engine instructor training. When asked about this certificates and ratings, he said that he had a multi-engine airline transport pilot (ATP) certificate and instructor rating. He said his type ratings included Citation 500 and the Learjet series. He said he had approximately 3,900 hours of total flight time, 2,000 hours with SK Jets.

When asked why he left SK Jets, Mr. Deitrick said he was concerned about job security in the wake of the accident. He said he an no flight time in helicopters. He stated that he flew charter and organ procurement (medical) flights as a line captain and before that as a first officer (FO). He said he had no office duties other than navigational chart updates. Mr. Deitrick was asked how the medical flights were assigned and he said the company had a rotation. He said that when you were first in the rotation you were waiting for a phone call. He said once you get the phone call you typically had an hour callout. He said SK Jets tried to give you two hours notice so the pilot had an hour to get to the airport and an hour to get the airplane ready. He said after that it was just a normal flight. He said the Captain was responsible for flight planning. As Captain, he said that once he got the call, he would first check the weather to verify the trip could go. If the weather was ok, he said he would go to the airport, file the flight plan using FltPlan.com, get the Notices to Airmen (NOTAMs), and check the aircraft can (logbooks, maintenance write ups) to verify he was legal to depart. Mr. Deitrick said he used FltPlan.com to check the weather. When asked about weather minimums, he said that it must be "above minimums." He said if the ceiling was below 1,000 feet or visibility below three miles, you had to have an alternate. He said he always filed a legal alternate anyway. Mr. Deitrick said that the medical flights normally took place in the southeast United States.

When asked if the company had dispatchers or flight followers, he said yes, they would call and say there was a medical flight leaving to a destination at a particular time. They would also say which FO and which aircraft. They did not help with weather. When asked how a flight got

released, Mr. Deitrick said they had to have a release from Katie, Jen, Gary or Leigh. He said he did not usually have any interaction with the helicopter crews.

When asked to describe his initial training at SK Jets, Mr. Deitrick said he did indoctrination (indoc) training eight hours a day for a week where he went over PowerPoint presentations and completed a written test after each section. He said he completed his initial flight training at Simuflite in Dallas, Texas. He said indoc training was thorough on weather and flight planning and went through each step on what you were supposed to do and how to check the weather and what services you could use. He said the training he received on risk analysis and risk management talked about the difference between good risk and bad risk, what was acceptable risk and how to manage it.

When asked about the schedule he normally had, Mr. Deitrick said a rotation. When you returned from a flight you went to the bottom of the rotation. As flights went out, you would move up through the rotation. He said you always had 10 hours off when returning from a flight and SK Jets would not call you inside that 10 hour rest period. He added that they were really good about not interrupting those 10 hours.

When asked about the safety reporting program at the company, Mr. Deitrick said there was a form and a box that where you could leave it anonymously or you could speak directly with the Director of Safety. He stated that he had never used the box but may have discussed safety related issues with other pilots and Leigh [Director of Safety] in an informal matter. He said he never brought up any particular safety issues and there were no specific safety concerns among the pilots.

When asked about how he felt the maintenance at SK Jets was handled, Mr. Deitrick said they did a good job. He said they kept the airplanes running and everything working although sometimes it took them a while to get it completed. He said that he had never had any concerns about the level of maintenance.

Mr. Deitrick was asked how he knew Mr. Hoke Smith and he said their relationship was exclusively professional. He said he never met Mr. Smith outside of work. He said Mr. Smith was his employer and the owner of the company. Mr. Deitrick stated he had flown with Mr. Smith in the Learjets maybe three or four times over his time at SK Jets. When asked when the last time was, Mr. Deitrick thought maybe six months to a year ago. He said that one of those flights was a charter trip a couple years ago and he said he thought he also went on at least one medical trip with Mr. Smith. He said that all those trips were as FO as he had not upgraded yet. The only thing specifically Mr. Deitrick said he could remember was one time when they were coming to intercept the localizer during an instrument approach with a ceiling of maybe 800 feet overcast. He said they (Mr. Deitrick and Mr. Smith) thought the autopilot was set to capture the localizer but the aircraft flew through it and so Mr. Smith disengaged the autopilot and hand flew to re-intercept the localizer. Mr. Deitrick said he thought Mr. Smith did a good job of recognizing what was happened and hand flew the rest of the approach. Mr. Deitrick said if passengers were onboard the aircraft Mr. Smith would fly and if the aircraft was empty Mr. Smith would let the FO fly. When asked his impressions of Mr. Smith's flying skills, Mr. Deitrick responded that he never had eventful flight with him. He said what he had personally

witnessed was the Mr. Smith was an adequate pilot. He said he had never seen him do anything dangerous or questionable. When asked about Mr. Smith's aeronautical decision making, Mr. Deitrick said the previously mentioned approach was the lowest approach he had ever flown with him and everything else was pretty normal. He also said that Mr. Smith was easy to fly with and said he would not have had a problem telling him something did not look right and he had the impression that he would respond well to that. Mr. Deitrick stated he thought Mr. Smith's greatest strength as a pilot was his experience. He also stated that he thought Mr. Smith's weakness was that he did not fly every day like the line pilots. When asked if he heard of anybody brining up issues or concerns about flying with Mr. Smith, Mr. Deitrick said heard he could be rusty in the jets but said he never noticed that when they flew together. He said the last time he spoke with Mr. Smith was two weeks ago when he saw him in the office after a medical flight. He said it was a short conversation, mainly pleasantries, while Mr. Smith was getting coffee.

Mr. Deitrick was asked about the risk management process at SK Jets and he said they have a sheet they complete prior to each flight. He said if the number was over a certain amount they were supposed to get a third party involved, which was Gary [Chief Pilot]. He said that never happened while he was the Captain. He said he tried to complete the form but not always. Mr. Deitrick said that the form could help gage a little bit of the risk you were taking but he would not make his go/no-go decision based solely on the form. He said he might also make a no-go decision based on his own judgment. He also said that he always flew under instrument flight rules (IFR).

When asked about Mr. Smith's general attitude toward flying, Mr. Deitrick said he did not talk to him very much about things like that. His impression was that Mr. Smith had a get it done attitude but he did not have any facts to back that up. He said he had that impression because if the phone rang and everything was legal and a flight was safe, Mr. Smith definitely wanted it to go. Mr. Deitrick stated he never felt any pressure from Mr. Smith to do anything unsafe. When asked about Mr. Smith's general personality, Mr. Deitrick could not comment because his interaction was never direct. He said he always went through the Chief Pilot. He said Mr. Smith was outgoing, calm in flight and organized. When asked about the five hazardous attitudes found in aviation literature, Mr. Deitrick said his experience with Mr. Smith was limited so therefore it was hard to comment. When asked about Mr. Smith's style of interaction, comments and coaching, Mr. Deitrick stated that by the time he flew with Mr. Smith he had been with the company for two and a half years so there was not a lot of coaching but that he was a nice guy in the cockpit. Mr. Deitrick said it was not like Mr. Smith yelled at you, he was always jovial. During layovers, Mr. Deitrick said Mr. Smith would usually be on his phone or sitting in the pilot lounge. Mr. Deitrick said Mr. Smith wore corrective lenses when flying. He never saw him use tobacco or alcohol. Mr. Deitrick was asked if he ever had an emergency situation or ever had to take the controls unexpectedly when flying with Mr. Smith and he said no.

Mr. Deitrick said he flew approximately 12 days a month for a total of about 30 hours. He said the typical duty time on a flight was 8-10 hours. He stated that the company policy was a maximum of 14 hours of duty and 10 hours of flight a day. He added that maybe once he got to 10 hours of flight time in a 24 hour period but usually that was not an issue. He said that a typical layover on a medical flight was three hours. Mr. Deitrick said more than half of the

medical flights were conducted at night. When asked about the typical amount of sleep he obtained prior to one of those flights, Mr. Deitrick said if they called me at 2:00 am he would probably would have had four hours of sleep because he would go to bed at 10:00 pm. He stated that duty time started when he would arrive at the office. He said that he had 10 hours of rest following a flight or required training.

When asked if the company was growing or declining, Mr. Deitrick said it was declining. He said he could not speculate why other than the economy. He said that he made more money at SK Jets than he was going to be making at his new job. When asked about pilot morale, he said that he did not think pilots came here for a career, but that was what it was; it was a middle of the road job. Mr. Deitrick was asked about tracking of flight and duty times and he said they had a duty log where they entered their times themselves after every trip. He said it was on a spreadsheet and calculated how many hours you had flown and how many days off you would need by the end of the quarter. He said that could be completed remotely. When asked about pay structure, Mr. Deitrick said 2/3 of his income was salary and a third was flight hour pay and said there was no overtime. He said he was not aware of sick leave because he had been pretty healthy but said he thought if you were sick you would tell dispatch. When asked if you would still earn a salary if sick for a week, he said “as far as I know.” Mr. Deitrick said the workforce was adequate for the work load as he had flown 30-40 hours a month since he started with the company. He said the size of the pilot pool and number of aircraft had decreased since the economy turned in 2008. He also said that the company had a low turnover rate of pilots. Mr. Deitrick said there were three crews for the fixed wing aircraft plus the Director of Operations and Chief Pilot. He said there were two new first officers hired this year and two that left. When asked how long people typically stayed, Mr. Deitrick said he had been at SK Jets since 2007 and the pilot hired right after him was employed just as long. When asked about the turnover rate of managers, he said there was a change of Director of Operations (DO) a couple years ago and recently the Director of Maintenance (DOM) changed. He said the Chief Pilot and Director of Charter had been there since he started. He said Mr. Smith took over as DO in 2009, maybe the end of 2008, when Brian Bowie left. When asked about the quality of the new hires, Mr. Deitrick said he had 1800 hours and thought Angela had maybe 1500 hours. When asked about the flight training, he said that as an FO he went to Bombardier in Dallas once a year and as a Captain you had to do a check ride every six months and recurrent once a year.

When asked if he had ever turned down a flight for a safety-related reason, Mr. Deitrick stated that he had not as a Captain but had as an FO. He said he had delayed flights for weather as a Captain. Mr. Deitrick said an example of this was a Mayo team to Orlando. After the team harvested the organ the weather had deteriorated considerably in St. Augustine (SGJ) and Jacksonville (JAX) so the team went back to SGJ with the organ in a limousine. He said he was the FO at the time so the Captain made the call but he had input. Mr. Deitrick said that he felt supported in the decision and actually got a gift card (approximately $25) from the DO, Brian Bowie. When asked if people felt equally supported after Mr. Smith became the DO, he said he thought so and said he never experienced any pushback for delaying a flight.

Mr. Deitrick was asked about the subcontracting practices at SK Jets and said he thought they would subcontract if they did not have an aircraft or crew available for a medical flight. When asked if he dealt directly with Mayo, Mr. Deitrick said yes, the medical team would call the

crew's cell phone to say if they were delayed or on their way back to the airport. He said that he never felt any pressure to continue or take a flight from the Mayo team, adding if it was not safe they did not want us to go.

When asked how closely pilots at SK Jets follow checklists and adhere to company standard operating procedures (SOPs), he said everybody did checklists and that the use of SOPs were not on the level of the airlines but pretty good. He said 95% was standardized. When asked about the go/no-go criteria he said it had to be legal, that was number one. Number two was did he think he would be able to get in to the destination airport. Mr. Deitrick said he rode in a company Bell 206, N95SK, once for a very brief ride with Gary Fernandes. When asked about any particular hazards associated with flying in the accident area, Mr. Deitrick said he did not know because he would fly at 5000 feet and 250 knots.

Mr. Deitrick was asked if he ever heard anyone say they were not comfortable with a trip and Mr. Smith went ahead and did it. Mr. Deitrick said Mr. Smith never did that with him and nothing specific came to mind. Mr. Deitrick said if you were legal to go and the airplane was fine Mr. Smith did not want to hear any excuses for not answering the phone. He said one time he was called out for a Mayo flight and did not get a lot of notice so the team arrived to the airport about 15 minutes after he did. Mr. Deitrick said it was during the day and the Captain arrived earlier and got everything ready. He said Mr. Smith complained to the Chief Pilot about how long it took it him to get to the airport. He said Mr. Smith did not talk directly to him. He said the Chief Pilot explained to Mr. Smith that Mr. Deitrick was notified later than normal and Mr. Smith understood.

When asked if you were able to turn down a flight due to fatigue, Mr. Deitrick said he never did but said if he ever felt fatigued and not safe to fly then he would have. He was asked who was able to see the time and duty records and Mr. Deitrick said the pilots and maybe scheduling. When asked if he was familiar with the new hire minimums in the General Operating Manual he said he knew they were published but could not remember what they were. He was asked about the check rides at Bombardier and he clarified that the six month check is the same check ride completed after recurrent training covering normal and emergency procedures.

When asked about fog in Florida using his previous experience, Mr. Deitrick said "it can get low in a hurry." When asked if a Terminal Area Forecast (TAF) was temporarily calling for fog would he cancel the flight, Mr. Deitrick answered no. He said it means you watch the weather more closely.

Mr. Deitrick was asked about the company fatigue policy and said it was included in the training.

When asked how common and how reliable temporary fog conditions were, he said it was common and it would put him on alert to be checking the weather observations and said he may call the control tower on the phone to ask the trend. He said he would also verify that he had an alternate and enough fuel in case he could not get in to the destination airport. When asked if he would fly under Visual Flight Rules (VFR) in those conditions he said no because 400 feet overcast is below VFR weather minimums.

When asked if he was aware of an incident involving Mr. Smith and damage to a helicopter, Mr. Deitrick said he knew it happened but did not know any facts, just hearsay. He said he did not know if there was an NTSB report. When asked what the hearsay was, he said he heard that Mr. Smith hit some bushes by the fuel farm that caused damage to the tail of the aircraft. Mr. Deitrick said he did not think anyone was on board nor that anyone was injured.

When asked if he had anything to add, Mr. Deitrick said no.

The interview ended at 1025.

Interview: Daniel Robert Casteran – SK Jets
Date: January 4, 2012
Location: SK Jets Headquarters, St Augustine, FL
Time: 1103 EST

Present: David Helson – National Transportation Safety Board (NTSB); Bill Bramble – National Transportation Safety Board (NTSB); Leigh McIntosh – SK Jets; Steve Moore – Federal Aviation Administration.

Mr. Casteran was represented by Mr. Michael B. Ely – Hassell, Moorhead & Carroll.

Mr. Casteran stated the following information:

He was a Learjet Captain at SK Logistics. He said he was hired in September 2007. He said he learned to fly at Embry-Riddle Aeronautical University, instructed for a few years in Orlando, Florida and flew freight and cargo Part 135 in Orlando. He said his total flight experience was approximately 6,000 hours with about 3,000 hours at SK Jets. He had no helicopter time. He said that he had been a Captain at SK Jets for about three months and had previously worked as a First Officer (FO). He said the FO's primary duty was customer service and the captain's primary duty was decision making, safety, verifying airworthiness of the airplane and readiness of the crew. He was not a company instructor nor a check airman.

Mr. Casteran stated at least 50% of the Learjet operations are lifeguard (medical) flights with Mayo or Jackson Memorial and the other half are charter flights. When asked how the flights are assigned, he said dispatch would get a call from the hospital, arrange everything then call him. Dispatch would tell him the departure time and then he would plan the flight accordingly. As a captain, he said he would flight plan regarding weather and flight times. He said he then would have to get a release from dispatch to verify the flight was legal to go. He said that the go/no-go decision was ultimately up to him but the release was from someone who had looked over the information. Mr. Casteran was asked if when you got the release, someone double checked the flight and he answered yes. He said they mainly checked the maintenance, crew and weather. When asked what weather sources he used, he said FltPlan.com and aviationweather.gov (NOAA). He said he always flew under instrument flight rules (IFR). When asked what type of shared decision process existed regarding flight release, Mr. Casteran said someone at SK Jets for the paperwork and the pilots had to complete the Flight Risk Analysis Tool (FRAT) prior to each leg. He said that if the numbers were high on the FRAT form, you had to call the Chief Pilot (CP) and decide if it was safe to go or terminate, but ultimately it came down to the Captain. He said he had not had to cancel a flight as Captain. As an FO, he said he remembered delaying to wait for fog to burn off but did not remember canceling. He said a lot times you would have to talk to the hospital and have them push back a flight. When asked if the company procedures clearly define the weather limits for takeoff or landing he said yes. Mr. Casteran said it mainly had to do with the company Operations Specifications and that the minimums were listed on the Jeppesen approach charts. He said the lowest they could take off was 500 feet runway visual range (RVR) or a ¼ mile visibility. When asked if he ever wanted to cancel a

flight or been talked out of it, he said that as a Captain, he had never received a phone call from anybody asking why he made a certain decision. He said he had never felt pressure.

When asked about his initial training at SK Jets, Mr. Casteran said at the time they were sent to Simuflite in Dallas, Texas and trained on the Learjet 35. He said that all the aircraft specific ground school was completed at Simuflite for the initial type rating. He said all the indoctrination and initial company training was completed at SK Jets along with aircraft differences training. When asked about the training he received for risk management, Mr. Casteran said essentially Leigh McIntosh and Gary Fernandes did the training and they would talk about it during the orals. He said it was a form that they complete every day. He said if it added up to a certain number, 30 he thought, they would have to discuss it with Gary. When asked about the quality of training, he said he thought it was thorough and that he felt well-prepared.

Mr. Casteran was asked about the safety reporting program at SK Jets and he said that there was an anonymous form in the pilot room. He said they could report anything they felt was unsafe. He said he may have turned in one that had to do with the brakes on a tug and the issue was addressed in a timely and effective manner. He said he was never consulted about it because the form was submitted anonymously. Mr. Casteran said he was not aware of any concerns about safety issues among the pilot group.

When asked about the pilot schedules, Mr. Casteran said there was a rotation that was published online. He said there was a column for Captains and another for FOs. He said it was published there because when they were third in the rotation, in theory they could call you, but said it was unlikely. Essentially, he said, they were on call because of the medical flights. When asked if he had seen the schedulers bypass the first pilot in the rotation, he said once or twice because the pilot turned down the flight. He said that he could not recall why the pilots turned down the flights. He said a lot of times they would not know and moved on to the next person. Mr. Casteran was asked how the rotation worked as far as duty periods and rest periods and he said that they had to stick to the 10 hours rest and 14 hour duty day and 13 days off in a quarter. He said that when you went off duty, you would have 10 hours off then you would be available to go back in to the rotation. He said the rotation was continuous. He said as far as the 13 days off, they would try to work in three days a month minimum and four in the third month, if required. When asked if he felt the schedule provided ample rest he said yes and added that it was rare to get called right at your ten hours. He said some weeks you would fly twice a week and other times you would fly five days a week. Usually, he said, they did not come close to the 10 hours of flight time in a 24 hour period. He said generally they got plenty of rest by the time they got called again. When asked about the company fatigue management policy, he said the big part was that they were able to turn down flights if they did not feel it was safe. He also said that part of the training is how to manage fatigue by taking naps, resting and eating well.

Mr. Casteran was asked to define his relationship with Mr. Smith. He said Mr. Smith was his boss and that they had flown together a few times over the past few years, ten times at most. He said the last time he flew with Mr. Smith was at least six months ago as an FO. He said that when they flew together Mr. Smith usually flew because he liked to fly. Mr. Casteran said that he probably only flew four or five legs with Mr. Smith because Mr. Smith was usually the flying

pilot. When asked to describe Mr. Smith's flying abilities, Mr. Casteran said he was absolutely proficient. He said that Mr. Smith never did anything to affect safety. Mr. Casteran added that he was not as smooth as come Captains, but nothing that ever made him think twice about his ability. When asked about Mr. Smith's decision making, Mr. Casteran said nothing stood out that made him question his decision making at all. Mr. Casteran stated that Mr. Smith's greatest strength as a pilot was that he always hit his aiming point on the runway. He said he had good stick and rudder skills. When asked about Mr. Smith's weakness, Mr. Casteran said that when there were customers on board, he was a little shaky and was not quite as smooth as some people, but he said he was sure it was nothing the passengers noticed. Mr. Casteran described Mr. Smith's personality when flying as outgoing, loved his job and very friendly with customers. He said he never felt intimidated to question Mr. Smith in the airplane. When asked if he ever told him anything in the cockpit, Mr. Casteran said one time climbing out under 10,000 feet he pointed out that they were little fast and Mr. Smith corrected it. Mr. Casteran said he had never attended training or checking events with Mr. Smith nor had he ever encountered any abnormal or emergency situations with him. When asked if he had ever cancelled a flight, Mr. Casteran said maybe once for a maintenance issue; a nose wheel strut or something. Mr. Casteran was asked how he felt about the maintenance at SK Jets and he said it was fine. He said they walk right into the maintenance office and tell them about issues and they take care of it. When asked if he had ever had any concerns about any repercussions should he cancel a flight, Mr. Casteran said he never felt that pressure. He said that he had not heard of anybody having any issues with that.

When asked about his interaction with the helicopter pilots, he said only when the Mayo crew gets out of the jet and into the helicopter. He said he had flown between St. Augustine (SGJ) and Gainesville (GNV) a couple of times. When asked to characterize the weather in that area, he said it was generally nice with occasional fog right before sunrise and some thunderstorms in the summer. When asked about the fog particularly at the airport, Mr. Casteran said he lived by Interstate 95 and it was typically foggy there. When asked if fog tended to be in certain areas he said he did not know. He said patchy fog was pretty common. When planning those flights to GNV, he said that the weather reports for the area were pretty accurate. He said GNV had its own Terminal Area Forecast (TAF). When asked if he would also get the area forecast for GNV, Mr. Casteran said he would look at it and the departure point as well. Mr. Casteran was asked what he recalled about his flight planning training at SK Jets. He said the first thing he did was go to FltPlan.com and pull up flight times and required fuel then take a look at the current weather information including METARs for trend, area forecasts, NOAA for charts and wind aloft charts. Then, he said, they would refer to the Operations Specifications for the legal takeoff minimums. When asked if that procedure is how he was taught, he said yes, he thought the training hit all those points. When asked about checking weather en route when going to GNV from SGJ, he said that on longer flights you could call Flight Service (FSS) to get an update. However, he said, that particular flight is only 10 minutes in a jet so would they take off and Jacksonville approach would tell them what to expect.

Mr. Casteran was asked how much of his total flight time was multi-engine and turbine and he stated he had about 3,500 hours multi-engine and 3,000 hours turbine time. He was asked who released most of the night flights and he said it would have had to be either Gary Fernandes, Leigh McIntosh, Katie Godwin, or Jennifer McKeen but at night it was more often one of the

schedulers. When asked what the releaser double checks regarding crew release, Mr. Casteran said recency of experience, six approaches, holds and tracking and crew pairing requirements. When asked if they double checked the weather, he said he was not sure but said he believed they were supposed to. Mr. Casteran stated that Mr. Smith had released flights and was authorized to do so. When asked how the release worked, he said the pilots got their paperwork emailed with details on the leg, passengers and the initials of the person who released the flight. Mr. Casteran was asked if he ever spoke with the releaser and he said if the FRAT form came out to a high score he may have to talk to them about it. If the FRAT did come to a high score, he said he could initially discuss it with Katie or Jen but had to consult the Chief Pilot.

When asked if Mayo had oversight in terms of risk management, Mr. Casteran said that they did not have operational control and they relied on SK Jets to determine whether a particular flight was safe or not. When asked how closely pilots follow checklists and adhere to company standard operating procedures (SOPs), he said 9 out of 10 on a scale of 1 to 10. When asked about Mr. Smith specifically, he said not quite as much, maybe 7 out of 10. For example, he said after takeoff Mr. Smith may forget to turn off the landing lights. He said it was part of a flow and the line pilots flew more than Mr. Smith did. He said he was more flexible in flows because he was not as current as the line pilots and they would catch the mistake on the crosscheck with the checklist. Mr. Casteran was asked about Mr. Smith's drive to complete missions. He stated that the drive was there to take care of the customer and especially dealing with organs you wanted to try and make that flight happen. When asked if Mr. Smith was more committed than the other pilots to accept risk in the process, Mr. Casteran said no, he did not think so. He said that most of the flying he did with Mr. Smith was charter flights and that he could not recall a lot of medical flights.

Mr. Casteran was asked if he was aware of an incident with the helicopter when Mr. Smith was flying. He answered that he heard about the one on the ramp but he stated that he was not there at the time and did not know the details. He said he heard that the helicopter was taxiing and the tail rotor caught some bushes.

While looking at the GNV TAF recovered from Mr. Smith's computer (temporarily calling for 4 miles visibility, mist and overcast at 400 feet), Mr. Casteran was asked about his confidence in its accuracy. He stated it was a possibility for that to happen during the time frame. He said he would pay close attention to the temperature and dewpoint. He said he would file an alternate but added that he could get in with a 200 foot ceiling and a half mile visibility with the instrument landing system (ILS) approach at GNV in the jet.

Mr. Casteran said he last spoke with Mr. Smith at the company Christmas party held at the office on December 20, 2011. He said it was mostly small talk and eating turkey. He said he could not recall if they talked about work. He said Mr. Smith was in a pretty chipper mood. Mr. Casteran did not know about any recent changes in health, personal life or finances for Mr. Smith. He said he never saw Mr. Smith consume alcohol or smoke anything.

Mr. Casteran was asked if he had ever been released and then found a maintenance issue with the airplane or that the copilot was not qualified. He said no but one time the paperwork had the wrong date on it and he had them send him a new release with the proper date and times. When

asked if it was common for the number of passengers to be different than planned, he said it was not common but did happen. He said if it did happen he would just look at the unexpected passenger's identification and call the company with the information so they could update the paperwork.

Mr. Casteran was asked what the FRAT form says to do in regards to the values and he replied that you were to terminate a flight for anything over 30 and call the CP for anything over 20. When asked who normally completed the checklists when he flew with Mr. Smith he said that he did as the pilot not flying. Mr. Casteran was asked if the previously stated values on the FRAT form were the same for the helicopter he said he did not know because it was a separate form. He said that he had never had to consult with the CP because of a high score. He stated the highest value he ever got was maybe a 9. He said you have to have ice, snow, low IFR, brand new copilot, etc. He said he never got close to that. When asked about a Do-verify or call/response checklist system, Mr. Casteran said more of a flow and response and the person who had the checklist in their hand verified for the third time. He said generally the person that was doing the checklist would call out the flow and the other person would respond verbally then they would look at the checklist and verify a third time.

When asked if he had been involved in any safety improvements post-accident, Mr. Casteran said no.

When asked, Mr. Casteran said he had nothing to add.

The interview ended at 1200.

Interview: Daniel Paul Firebaugh, Learjet Pilot – SK Jets
Date: January 4, 2012
Location: SK Jets Headquarters, St Augustine, FL
Time: 1345 EST

Present: Bill Bramble, David Helson – National Transportation Safety Board (NTSB); Leigh McIntosh – SK Jets; Steve Moore – Federal Aviation Administration (FAA).

Mr. Firebaugh was represented by Mr. Michael B. Ely – Hassell, Moorhead & Carroll.

During the interview Mr. Firebaugh stated the following information.

He was employed as a first officer for SK Logistics dba SK Jets, on fixed wing airplanes. He had been a captain until very recently when he was assigned as a first officer. His date of hire was January 2007. His professional background before SK Jets was working 11 years for a Part 91 company in Macon, Georgia. The Part 91 company in Macon Georgia had a Lear 35, a Lear 31, and a turbo commander. He said he flew the airplanes with the company owner. Also, he said he had additional duties as manager of the IT department at the company in Macon, Georgia, where he only flew a couple hundred hours a year. When asked about his flight experience, he said he had logged a little over 8,600 hours total flight time and approximately 2,500 hours flight time at SK Jets. He had no helicopter flight time. He had never ridden in a helicopter until he came to SK Jets. He said he had never been an instructor or check airman at SK Jets.

When asked why he had been changed from a captain to a first officer, he said that he was hired as a captain and was a captain until October 2011. In November 2011 he was due for Part 135. 297 check ride and there was a potential for some sort of deal with a Lear 60 that used to be at SK Jets. It was going to be put under contract for charter, but the deal fell through. They were waiting to send him for recurrent on the Lear 60, so he did not do the Part 135.297 check in the Lear 31. SK Jets was going to let him lapse to second in command status in December for one month. SK Jets had already promoted a person to captain in the Lear Jet and had spent the money to upgrade that person when the deal on the Lear 60 fell through, so SK Jets did not need him as a captain.

When asked about his roles and responsibilities as a pilot for SK Jets he responded that as a captain it was a little different than first officer. As a first officer, when he got a call for a flight, he prepared the airplane, made sure it was fueled, got the airplane out, put the necessary stock onboard that was needed, made sure the aircraft was clean while the captain completed the paperwork. When flying the airplane, he and the captain swapped legs.

When asked what type of flights he made, he stated it was a mixture of charters and organ transport flights. Sometimes they flew a medical team to procure the organ and then took the organ back and other times they just picked up the organ in a box and took it somewhere else.

When asked how he was called out for a flight, he responded that they had a rotation. There was a company web site that they went on to see where they were in the rotation or they could call

and ask the scheduler. Based on that, they knew whether they might get a call for a medical flight. Sometimes they were assigned a flight for the next day. It came through via a cell phone that they carried all the time. Calls came from the schedulers.

When asked when he got the call, how he was released or dispatched, Mr. Firebaugh stated that the scheduler created paperwork that told who released the flight and only certain individuals at the company had approval to release flights. That person then initialed for the Part 135 or Part 91 flights. Captains usually complete the paperwork.

When asked, as a captain what did he do to prepare for the flight or plan the flight, he said they went online to check the weather, the airport they were going to, the NOTAMS, fuel requirements, and if there were any requirements for an alternate; the typical planning for a flight. Knowing who the passengers were and computing the weight and balance.

When asked how he obtained the information for weather for the flight, he said he always used FltPlan.com.

When asked if there were company policies on required weathers minimum to launch, he said, "Yes", based on departure minimums, destination minimums, and alternate minimums. When asked where he would find that information, he responded in the company's general operating manual.

He was asked, who made the decision on whether a flight can go or not and he responded, "the captain".

When asked as a captain, have you ever had occasion to cancel or refuse a flight based on weather conditions, he said he thought of maybe a couple of times where he actually canceled a flight due to weather and a few times he delayed a flight because of weather. He was asked when he canceled a flight, what was the process; how you decide, who do you have to talk to, he responded that usually the first person he told would be the scheduler. He was not sure if the chief pilot got involved. He said that once there was a passenger flight that he refused to fly because of the weather. He thought he told scheduling and it was in conjunction with another company that had their own airplane and SK Jets was helping them because they had a lot of passengers. They were opting to send the airplane to another location where the weather was good and then they were going to ferry them Part 91, but they ultimately canceled the flight.

When asked when he cancelled or delayed a flight, how was that received by the company? Was there any pressure to go anyway? Did anyone try to talk you into pressing on anyway? He said "no". He could remember a time or two where he was questioning the weather or conditions of the flight and the chief pilot always told him it was ultimately his decision to go or not to go on the trip. He said he never felt pressured to do anything he did not feel comfortable with. When asked if there were any repercussions after the fact, he said no, when he delayed medical flights, the medical team was always very grateful. They said "no problem", if the weather was not good they did not want to go and they were grateful that the pilots were being careful.

When asked if he was aware of a safety reporting program at the company, he said they had procedures for maintenance problems. He was further asked if there was a program where flight crews could report safety issues to management, to which he responded that they had a suggestion box they could put notes in to be anonymous. In addition he said he always felt free to go to the maintenance department if he thought there was some sort of issue that needed attention that went beyond some issue that we needed to report on the minimum equipment list (MEL). In addition, he said he felt comfortable going to the flight operations management with any safety related issues, but could not recall doing so.

When asked if he was aware of any safety issues the pilot group was concerned about or talked about on a regular basis, he said that nothing came to mind. He further stated that sometimes in the Lear 55, it required more runway length, so they talked about just how much runway they needed as a minimum length for the Lear 55 and if it did not meet the requirements the pilots would take the Lear 31 instead. But he added that SK Jets had procedures to determine runway lengths and they would never exceed those lengths.

When asked about his relationship with Mr. Smith, he said he was the company owner and ultimately his boss. He usually interfaced more with the chief pilot than with Mr. Smith. Only one time did he actually remember sitting down with Mr. Smith to talk about company business. He said he flew with him a few times, but was not a close personal friend. They did not socialize.

He was asked what was discussed the one time he did sit down with Mr. Smith, to which he responded, it was about training. Mr. Smith implemented training contracts and he had not been under a contract. Mr. Smith implemented contracts for all pilots. He said he sat down with Mr. Smith to find out his motivation for requiring them to sign the contract obligating them to go to training or find another job. Mr. Firebaugh said he was not planning on leaving anyhow, so he signed the contract, he just let him know that it did not help his morale. He felt he should have been trusted as a three year employee. They had sent him to Lear 60 training and did not ask him to sign a contract. Then they required him to sign one for Lear 31 recurrent and he talked to Mr. Smith because he was offended. Mr. Firebaugh was asked if all pilots were asked to sign contracts, to which he said “I was told yes”. He was asked when the contract signing started; he responded that it was in his third year of employment with SK Jets. However, he went on to say that he believed the contract requirement had been discontinued because the last time he went for recurrent training he was not asked to sign a contract.

Mr. Firebaugh was asked if he had flown with Mr. Smith, he said that he had a few times, but it had been quite a while ago, maybe nine months to one year and that when they flew together Mr. Smith was always the captain. They usually traded off flying different legs, however the last time they flew, Mr. Smith flew the whole trip and he just stayed in the right seat.

When asked what he thought about Mr. Smith’s flying abilities, he responded that he did not see any problems. He never felt like he was in danger. The only complaint he had about his flying was he was not as smooth as he would like him to be. He said the he liked to give passengers the smoothest possible flight and that Mr. Smith was just a little jerky. He said that he had never had an abnormal or emergency situation occur when flying with Mr. Smith. He said he was never in a situation with Mr. Smith where he thought there was any need for critical decision making,

such as emergencies or weather at minimums. Every flight he had with him was typical with no problems. He never had a flight with him that required them to decide about shooting an approach in minimum weather conditions.

When asked what Mr. Smith greatest strengths were, he responded Mr. Smith's experience.

When asked about any weakness he found in Mr. Smith, he replied "just the smoothness". He said Mr. Smith was the boss and he was not going to tell him how to fly. He said he never saw him do anything dangerous.

When asked if Mr. Smith was open to safety-related input, he said that Mr. Smith's piloting technique was one thing, but if he had to tell him something that was potentially dangerous, Mr. Smith would accept that. He said Mr. Smith was not like some captains who did not want to hear from the first officer. He was a nice guy.

When asked if he had ever heard anybody say they had any problems with Mr. Smith, he said he could not think of any problems. He said he heard stories about all kinds of little incidents and other things that go way back. He remembered some of the former pilots who had been at SK Jets a long time telling hangar flying stories, but nothing dangerous or reckless. Mr. Firebaugh further said that when you fly long enough you are always going to have a malfunction or something like that.

When he was asked if he was familiar with an incident where Mr. Smith was flying a helicopter that was damaged, he said he heard about that. He said the helicopter was sitting out there the next day. He said that he saw the helicopter and knew it was damaged. He said it was ultimately replaced.

When asked if he heard what happened, he said he heard that Mr. Smith taxied over to the fuel farm so they would not have to tow it over there and he swung it around and the tail rotor hit the bushes. He said it was third party information.

He said the last time he saw Mr. Smith was on December 23rd or 24th. And it was just a greeting and some small talk.

When he was asked if he ever felt like he got any undue pressure to complete flight in adverse weather and what was Mr. Smith's attitude toward flying and completing the mission, he said as the owner, he did not want to lose business. He never felt Mr. Smith would force him to make a trip he did not feel was safe. He never asked him to do something like that. On the other hand if you thought the trip could be made, if the pilot thought it was legal, he was expecting the trip to be made. He said there were trips where he said the weather was too bad and never felt he was in danger of losing his job because of it.

When asked if he had any reason to believe that something else might have happened to the helicopter in the 2007 accident, he said he was not there and did not observe what had happened. He just heard what they told him. There was a copilot who told him about it who was on the ramp at the time. He did not think the copilot saw it, but he thought he told he had ducked behind

the tug because there were parts and pieces of the tail rotor flying over his head. He said the copilot told him he hit the ground. He said this was all hearsay.

Mr. Firebaugh was asked about the training contract. He said that you had to work for the company for another year in return for sending you to training, or you would have to reimburse a pro-rated share of the training cost. If you were insubordinate and got terminated, you still had to pay it back. He said if you just quit, you had to pay it but if you were laid off you did not have to pay.

When asked what would qualify as being insubordinate, he responded, “Lots of things I guess”. He said he did not know if that term was actually in the contract and the last time he signed one was probably two years ago. He said he was using that word as something generic. It was probably a little more specific but he could not recall exactly what the words were. He said for example if the pilot refused a doable trip; but the contract did not use those exact words. He said it would not be for personal reasons like going on a date or riding motorcycles.

When asked if Mr. Smith displayed any hazardous attitudes, he responded, no. He said there were none that he would say would apply to Mr. Smith or anyone else at SK Jets. He said he had known some pilots like that, but not at SK Jets. He said that he did not know of health issues with Mr. Smith. He thought Mr. Smith may have had a knee replacement or something like that, but other than that, he did not know about his personal health. He said that Mr. Smith was down for a while for some sort of operation to his knee or hip. He also got hit by a car one time that put him out of business for a while. He thought this happen about a year ago, but assumed he had a valid first class medical. He did not know if Mr. Smith was taken prescription medications and never saw him use tobacco. He said Mr. Smith did not totally abstain from alcohol. He went two times on overnight trips with him. One time to San Diego for 2 or 3 days and he had a beer or two while they were eating. That was all he could recall. Mr. Smith and he never socialized. He did not know if Mr. Smith had any recent illnesses or significant recent changes in health, finances, or personal life. He was unaware of any sleeping difficulties Mr. Smith may have had.

When asked about Mr. Smith sleep and activities in the 72 hours before the accident, he responded that he was not exactly sure, he had seen him, but just walking through the office, there was no specific conversation. On December 20th SK Jets had a company Christmas party and he had chatted with Mr. Smith, but did not think the conversation was company related. He said they both live in the same community and they talked about the community and new school there.

When asked what percentage of his flying at SK Jets was at night, he responded, one third to a half. In addition, when asked how many trips per month over the last year or so he made, he responded, that it has been slower lately, but a good average of 15 trips a month or roughly 40 hours a month.

When asked about the approximate duty times for a medical flight, he said that it could be as short as two to three hours or as long as a 14 hour duty day. This would include layover times for a heart transplant trip, which were typically on the ground for 2 hours, not much longer, the flight time each way and then add a little duty time for getting airplane ready and putting it away.

He said that sometimes they ended up being there 4 or 5 hours with a heart team or they may have a heart team, lung team, and liver team and have to wait for all of them. He said that sometimes they would get there and have to wait for one of the other teams; he stated that was just part of the organ transplant business.

When asked about the typical amount of sleep obtained before a night flight, he said if he knew he was up for a flight, he would usually go to bed early or take a nap in the afternoon. A lot of times he took a nap anyway. He said if he did not take a nap, he would watch television at 7:30 or 8:00pm and wake up at 11pm.

He said he believes the company was slower the last year or two. He said that five years ago it was going gangbusters, and that he flew all the time. It was that way for the first two years of his employment with SK Jets. After that it was sometimes slow and sometimes busy. He said the pay was in line with or maybe a little better than other commercial operators.

When asked about the company morale, he said that recently because things had been slower than they had been in the past, it had not been as good because the pilots were all on a base salary plus money for flight pay and when they were not flying as much as in the past they were not getting paid as much. Usually pilots need the paycheck to be a little bit bigger than it had been recently.

When asked about the medical transplant flights with the Mayo Clinic and if there was special emphasis on accepting, or guaranteeing them service, he said he did not know of any arrangement guaranteeing them service. He said he had canceled a few trips, but could not remember if they were medical trips. I remembered some trips that were delayed as a result of weather and there was no pressure. As a pilot he always felt once he got to wherever they were harvesting the organ, there was an organ that only had a certain amount of time. He said it never occurred when he was flying that the weather was below minimums, but he always feared that because he would have felt bad if he could not get back in time. He said it was his own personal pressure but he was not going to jeopardize the lives of the team and crew to save an organ. He said you feel the pressure because you want the person to get the organ if possible.

He felt the size of the pilot workforce was adequate in the last year. He said there were always pilots coming and going at SK Jets. However, he said there were fewer airplanes and pilots than five years ago, but the ratio of pilots to airplanes had always been about the same, if anything maybe a little more right now. He believed that SK Jets had two airplanes and three crews. In the past they had a crew per airplane, plus the pilots who were not in the normal rotation, like the chief pilot and Mr. Smith. He said that was beyond the scope of his job. He said that he just flew the airplanes.

He said that when he first came to SK Jets there was more turnover in personnel than there has been the last two to three years because the whole industry was more active back then and there were more jobs out there. He said in the past pilots came to SK Jets to build flight hours and then go off to another jobs.

He told us the newly hired pilots usually do not have experience in the Lear jet, so they start out as first officers. He said when a fairly new recruit was put on line, there was always care to make sure they were paired with an experienced captain. He said he was usually the more experienced captain so they were always sent to him.

When asked if the pilot received special training on spatial disorientation (SD), controlled flight into terrain (CFIT) or Upset Recovery, he responded that the pilots received that training at the Bombardier Training Center in both the classroom and simulator.

When asked if he agreed with how SK Jets handled the Lear 60 deal and training, he said it made sense, but thought in the back of his mind it might be a problem. He said Mr. Smith told him if it fell through they would just send him back to training. Before it happened he talked to Gary Fernandes. He understood it could happen because they had just promoted Dan Casteran to captain so he was fresh and there would be no reason to send him back, just let him continue to be a first officer. So Gary talked to Mr. Smith and that was what they decided they would do. He said he could understand them wanting to save some money and that he was not bitter about it. He said they were still paying him his captain pay. The only thing they really saved was a trip to Dallas and the checkride.

He said it was not unusual for a small company to require a training contract. When asked if he knew if the two pilots that left this year were subject to the terms of the contract, he said he did not know. The personal conversation he had with Mr. Smith was about why he would send him to get a type rating and make me sign contract for recurrent.

He was asked if he knew the name of the pilot that was on the ramp at the time of the helicopter incident in 2007. He said it was Darrin Felton. Mr. Felton had not been employed by SK Jets in a long time, but he believed he went to Flex Jet. He thought Mr. Felton left not too long after that helicopter ramp accident.

When asked, Mr. Firebaugh said he had nothing to add.

The interview ended at 1455.

Interview: Aaron Wayne Dyess, Helicopter Pilot – SK Jets
Date: January 4, 2012
Location: SK Jets Headquarters, St Augustine, FL
Time: 1540 EST

Present: Bill Bramble, David Helson – National Transportation Safety Board (NTSB); Leigh McIntosh – SK Jets; Steve Moore – Federal Aviation Administration (FAA).

Mr. Dyess was represented by Mr. Michael B. Ely – Hassell, Moorhead & Carroll.

Mr. Dyess stated the following information:

He had worked for SK Jets but was unemployed as of December 31, 2011. He said his departure from the company was being worked out prior to the accident. He was hired by SK Jets on February 1, 2008 as a helicopter pilot. Prior to working at SK Jets, he had worked in law enforcement aviation for the Escambia County Sheriff's office and then the Nashville Police Department. He said he had logged about 3,000 hours total time and the majority of that time, about 2,400 hours, was in Bell Jet Rangers but he had also logged time in an MD-500E and had logged about 120 hours in fixed wing aircraft. He held a commercial helicopter certificate with an instrument rating and a private pilot certificate for airplane single engine land. He had about 1,700 hours when he was hired at SK Jets.

Mr. Dyess described his job at SK Jets as a helicopter pilot with an OAS (Office of Agriculture Services) card to fly fire suppression and vertical reference and that he also flew on-demand charters and FAR (Federal Aviation Regulations) Part 135 flights. He said he did all types of flying for the company including medical flights and passenger charters.

Mr. Dyess described the process for setting up a medical flight at SK Jets. He said they had dispatchers on duty 24 hours a day. They would take the calls requesting a flight and then would call to notify him of the flight. Once notified, he said he would check the weather for the proposed flight time and call the dispatcher back to let them know if the weather was acceptable for the flight so they could start making their arrangements. He said he used FligthPlan.com and DUATS (Direct User Access Terminal Service) initially to check weather but he also used the HEMS (Helicopter Emergency Medical Services) tool as a supplemental source of weather. He said the HEMS tool was a good source of weather for low level enroute conditions and it had been created to aid in identifying weather conditions between airports or weather reporting stations by interpolating the data between those stations. He said he did not check the HEMS if the first two sources already indicated he could not go. He said you could not base the decision to fly on the HEMS data but it was a supplemental source of weather he used if the approved sources indicated the weather was acceptable to go on the flight. He said they always conducted their flights under VFR (visual flight rules).

Mr. Dyess said the decision to take a flight based on weather conditions was always made by the pilot. He said the company had some things in place to assist the pilot but ultimately, the pilot made the decision. He said they used a FRAT (Flight Risk Analysis Tool) form on every flight.

He said the pilot went through the form to check various conditions of the flight, and it helped you evaluate the level of risk.

Mr. Dyess was asked if the flights had to be approved by someone else. He said they had specific people at the company with releasing authority who released a flight based on maintenance, flight crew qualification, and flight time and duty but the final authority was with the pilot. He said the releasing authority was double checking but the safety of the flight fell on him. He was asked if there were any occasions when he and the releasing authority disagreed about whether or not a flight could be conducted. He said he could say with 100 percent certainty that he had never been second guessed when he turned down a flight.

Mr. Dyess said there were clearly defined weather limits in the GOM (General Operating Manual). He said section V of the GOM stated weather limits of 3 miles visibility and 1,000 foot ceiling for night flights. He said it was hard to say what percentage of flights were at night but there were "quite a few". He was asked if he ever cancelled flights due to weather. He responded "absolutely" and that he would cancel for any weather below the 1,000 and 3 limitation. He said there stipulations in the GOM that allowed the DO (Director of Operations) or the chief pilot to waive those limits. He said they could waive down to FAR 135 limits but not below 300 feet and 1 mile at night. He said the company minimums had never been waived on one of his flights, that it had never been offered and that he had never asked to have it waived. He said on the night flights he usually just talked to a dispatcher and had never experienced any problems when he made a call regarding a flight. He said he was not aware of any times when the company weather minimums had been waived and since he was the primary pilot, it would have been him most of the time.

He said information from the HEMS tool was available on line via computer but it was not available in flight and they could not base the decision to fly on HEMS; it could just be used to augment approved weather.

Mr. Dyess said he had made the flights from St Augustine (SGJ) to Mayo Clinic Heliport and Shands Heliport before and was asked what weather he used to plan the flights. He said he would look at weather for SGJ, Craig, and Cecil Airport for the flight to Mayo Clinic. He added that Cecil was notorious for having inaccurate weather. He said he might also use NAS (Naval Air Station) Jacksonville. He said he would use Gainesville Airport (GNV) weather for Shands. He said Shands was about 4 miles from GNV on the edge of class d airspace and GNV was the closest reporting station to Shands. He said the GNV weather was "very accurate" for Shands Heliport.

Regarding the use of HEMS for flights between Mayo Clinic and Shands he said in his experience, the weather was fairly accurate, as accurate as the stations were. He said Florida weather was fairly unpredictable. He said every region of the country had its challenges. He said all kinds of weather, fog, thunderstorms, depending on the season could sneak up on you here.

Mr. Dyess was asked how he treated temporary conditions in a weather forecast. He said it meant to him there was a possibility for that weather phenomenon to exist. He said there were

no guidelines in the GOM on how to apply temporary conditions. He was asked if he would consider a temporary condition in a forecast calling for a ceiling below 1,000 feet or visibility below 3 miles to be a limiting factor. He responded "yes".

Mr. Dyess said when he was hired by SK Jets he completed FAR 135 training. He said the ground school was about 2 weeks and was conducted at the company headquarters. He said all ground and flight training was conducted at that company by company personnel and he attended recurrent training annually. He could not recall exactly what training he received for weather analysis but it included discussion of approved sources of weather. He said the methods he used to prepare for a flight were his own. He said the training covered how to read weather reports but he went one step beyond by using the HEMS tool.

He said he received training on risk management and aeronautical decision making but could not recall specifics.

He said he had used night vision equipment before but they did not receive training on or use night vision equipment at SK Jets as it was not authorized.

Mr. Dyess was asked about TAWS (Terrain Awareness Warning System) equipment on the helicopters at SK Jets. He said they did not have TAWS but they had a radar altimeter in the Jet Ranger and the Agusta. He said in the Agusta it was linked to the Garmin 430 and provided a visual warning. He said the display screen turned red and got real annoying. He said the radar altimeter in the Jet ranger could provide an audible alert consisting of a rapid beeping. He said you could set the radar altimeter altitude for where you wanted to receive the alert. He said at night he might set it for 150 feet and it would let him know when he needed to flare if he lost an engine or if he was flying too close to the ground. He said you could turn it off by pulling the circuit breaker but you could not otherwise adjust the volume. He clarified that he was talking about the Jet Ranger 95SK, he did not know if the accident helicopter had the same system.

Mr. Dyess said there was no standard procedure for how to set the radar altimeter; it was up to the pilot. He said for a flight from Mayo to Shands, he would set it at 150 feet.

He said he had never flown the accident helicopter and had not received differences training for that tail number. He was scheduled for differences training but had not had an opportunity to take it as he had been out of town working on another contract.

Mr. Dyess said the company safety reporting system consisted of a safety officer and also a safety reporting form that could be completed anonymously and placed in a box in the crew room. He said he had never had occasion to report any safety issues or concerns. He was not aware of any safety issues or concerns among the helicopter pilot group. He was not sure about the jet pilots; he said the schedule had them away a lot.

Mr. Dyess said his schedule on the contract he was working on was a 12 days on and 12 days off rotation mandated by the government and it required the pilot to have an OAS card. He said the OAS had an SMS (Safety Management System) in place and required them to have 2 days off every 12. He said the other work at SK Jets had a more relaxed schedule. He described it as

"semi on-call" but not required to answer the phone. He said if he needed a day off he had to find someone to cover for him. He said the company was pretty laid back about getting the days off. He was asked to clarify requirements to answer the phone. He said they would like you to but you do not have to. If you did not, they would just go to the next guy on the list. He said they could not fire you for not answering and he had not seen them fire anyone for that yet. He said he felt like he got adequate rest following this schedule and that generally they received about 6 to 8 hours notice for a flight.

Mr. Dyess was asked about a company fatigue management policy. He said if he was fatigued, it was his call. He said he had done that before and there were no repercussions.

Mr. Dyess was asked about his relationship with Mr. Hoke Smith. He said he spent a lot of time in the office talking about business. He said they had a professional business relationship. He said he flew with Mr. Smith twice a year and that Mr. Smith was the company check pilot who administered all of his checkrides. He said the last time he flew with Mr. Smith was for a checkride toward the end of November 2011. He said the last time they flew together when Mr. Smith was the flying pilot was about 3 years ago. He said Mr. Smith had good flying skills and he did not see any problems with his decision making. He had a hard time critiquing his flying skills as Mr. Smith had a lot more experience and gave him his checkrides. He deferred to the FAA since they gave Mr. Smith his checkrides. He stated that he never had any issues when he flew with him.

Mr. Dyess stated that most of his discussions with Mr. Smith were about business. Mr. Dyess handled the government contracts and that was what they talked about most of the time but they also talked about Mr. Smith's dog because Mr. Dyess had a background in the K-9 unit. He said the last time he talked to Mr. Smith was on Thursday December 22, 2011 when he went in to resign. He said they talked for about 45 minutes. Mr. Dyess was resigning to spend more time with his family and to help with the business his wife was operating. He said Mr. Smith accepted the resignation fine and offered to have him stay on to do part time work. He stated that his understanding was that even after he resigned, he was going to be part time.

Mr. Dyess stated that he never encountered any abnormal or emergency situations when flying with Mr. Smith and that usually Mr. Dyess had been the flying pilot when they flew together.

He said that when he saw Mr. Smith on that Thursday afternoon, he seemed to be in a good mood and that he did not mention anything about how business was going with the Mayo contract.

Mr. Dyess stated that he had done most of the medical flying; they brought Tim (Murphy) on in January 2011 for the contract at Eglin Air Force Base. He said Steve Stout had also done medical flights but had not flown for SK Jets in about 4 or 5 months. He said overall Steve had probably done more medical flight but over the last year, Mr. Dyess had done most of them.

He said once Tim was hired the level of work had decreased. He said he covered days and Tim covered nights when they were not on the contract. They were on contract at Eglin usually December through about June or July and during that time, Mr. Smith and Steve Stout covered

the medical flights if he and Tim were not available. He said he and Tim were the primary pilots.

Mr. Dyess estimated that he flew 14 or 15 days a month during a busy month but the helicopters were not as busy as the jets. He estimated that 1 or 2 of those were medical flights but it varied a lot. He said some months it might be 5 or 6 medical flights. He said when the helicopter was in St. Augustine, all it did was medical flights but when on contract it was focused on that. He said after the contract ended in June or July, there was not much going on. He said he was almost off for 4 months and did not mind.

He said when he flew with Mr. Smith it was almost always for a training or checking event. He recalled when he first started at SK Jets he might have flown with him on medical flights a bit more. He said it was 4 years ago and he did not feel qualified to measure Mr. Smith's proficiency. He stated that based on his experience, nothing raised any flags or caused him concern.

Mr. Dyess stated that the radar altimeter was user selected on the 95SK and the Agusta and was on the checklist but he had never looked in the accident helicopter.

He described the FRAT form as somewhat useful and something on paper that assisted them in making decisions. He stated that usually when it came back indicating an issue it was something you already knew about. You had a good idea before filling out the form. He said it was a useful backstop. He stated that he did not usually need to call the chief pilot about it because he had already turned down the flight at that point but it happened occasionally such as when there were thunderstorms, night time, and if a pilot had less than 200 hours. He recalled an occasion when he had only 150 hours that he had to consult with the chief pilot.

Mr. Dyess was shown weather reports and forecasts effective at the time of the accident that were retrieved from Mr. Smith's computer. He was asked to provide an assessment of the conditions. He stated that the conditions reported were not consistent with the forecast which lead him to believe the forecast was not accurate; which occurred regularly in Florida. He read through the weather reports and pointed out the Tempo on the TAF (Terminal Area Forecast) was 1,500 broken but the METAR (Aviation Routine Weather Report) for Craig was 7,000 broken. When asked about GNV weather he stated the TAF had a tempo for 400 overcast and 4 miles in mist but the METAR reported 1,600 foot ceiling and 6 miles. He said the top line was the 24 hour forecast period which did not mean much in Florida. He said he would consider it but the forecasted temporary condition was not consistent with the METAR. He said under these conditions, he would not turn down a flight but he would want updated weather closer to departure time. He said he would probably advise the dispatchers that the weather looks ok but they should work on a backup plan as well.

Mr. Dyess was asked how likely the temporary conditions were based on his experience. He stated that the forecast was like that 90 percent of the time. He said sometimes there was a forecast for fog and it was clear, and sometimes they forecast clear and there was fog. He stated that if he had a forecast that was consistent with the METARs he would base his decision on that

but there were other things to look at as well such as thunderstorms in area, front lines, and temperature dewpoint spread.

Mr. Dyess was shown a sectional and asked to comment on the environment in the vicinity of the accident location. He stated that the route of flight took you over areas where visual references were "few and far between". He said there were some towers west of Reynolds, and some to the south. There were also some towers along the main road that went through the area. He said the route varied a little depending on which areas were active, referring to 2903A, 2903C, 2903D, and 2904A. He said most of the time they were inactive but he would coordinate with JAX (Jacksonville) Approach. He stated that there were pretty good lights along the route until you got to the area south of Penney Farms. He stated there were some dark areas there but when you were near Penney Farms you should be able to see lights around Keystone in the distance. Mr. Dyess was asked about visual references if the ceiling was below 800 feet. He stated that he had never flown that low in that area and he would typically fly at 1,000 feet there. He was asked what the lowest altitude was that he would be comfortable flying at night on this route. He responded "not much below 800" feet. He said he might go as low as 500 during the day on that route with passengers on board and that the regulations stated 300 feet was the limit.

Mr. Dyess said that Mr. Smith loved flying, that he knew systems well. He never saw him do anything unsafe and that flying was his life. He stated that Mr. Smith did not exhibit any of the five hazardous attitudes listed in FAA pilot training literature. He was the owner of the company but never came in and took a flight after Mr. Dyess had cancelled it. He was not aware of any prescription medication Mr. Smith was using or of any recent changes in his health, financial condition, or personal life. He was not aware of his use of alcohol or tobacco but said Mr. Smith once said to him that if he knew Mr. Dyess smoked, he would not hire him. He was not aware of Mr. Smith's sleeping habits and did not know of any sleeping disorders he may have had. He did not have any contact with Mr. Smith after they talked on Thursday afternoon.

Mr. Dyess stated that he probably flew on some night flights with Mr. Smith years ago when the weather was bad. He said Mr. Smith flew with him early on to make sure he was familiar with the routes and the helipads. Some of them were pretty tight with light poles and wires and some had special procedures for noise abatement and for approach and departure paths. He said he probably flew with him for the first two months. He said his coaching style was not overbearing.

Mr. Dyess was asked about how he obtained the weather data off of Mr. Smith's laptop after the accident. He said he did not select the back button or look for any additional pages. He just wiggled the mouse and printed the page that showed up.

He stated that the morale at the company had been "fine" and the pay for helicopters was a little lower than elsewhere. The pay was based on salary plus amount of flight time. He said the flight and duty times were tracked by dispatch and the chief pilot reviewed them for legality. The pilots input their duty and flight time into the system after a trip.

He thought the pilot workforce was adequate for the workload and that the size of the workforce had increased as they hired Tim in 2011. He estimated that the turnover rate was about the same as at other companies and helicopter pilots were known to move around a lot as businesses and

jobs opened or closed. He thought the minimums for a new hire pilot were 1,500 hours but recalled that Tim had a lot more than that when he was hired.

Mr. Dyess said he never felt any pressure from Mayo Clinic personnel to complete a flight. Even though they had an important mission, they always said not to risk 3 or 4 lives to save one.

Mr. Dyess was asked to characterize the difficulty of flying at night in the 206. He said it did not make it any more difficult or easy. He stated that he had logged about 500 hours in the Agusta. He said a helicopter was not any more difficult to fly at night but it was then more reliant on visual ground references. He said at cruise it operated similar to an airplane but generally when you went below about 60 knots the body started to have trouble interpreting different motions. He stated that the Agusta had stability augmentation system, twin engines, and an auto pilot and that anyone would be more comfortable flying that at night. He stated that the 206 was acceptable for the operations it was used for. It was notoriously safe, had reliable engines, and had been in production for a long time but he would rather be flying a twin at night. He stated that there was no policy on the use of automation in the Agusta; it was up to the pilot. The Agusta was authorized to conduct instrument approaches but the company was not.

Mr. Dyess was asked how a pilot would normally set up the navigation. He stated that in the Agusta he would set up the grid coordinates for his destination helipad in the Garmin 430 and turn on terrain and obstacle alerts. He said it would alert when within 500 feet of an obstacle but the problem was that it could become a distraction when coming in to land. He said he did not know how Mr. Smith set up the terrain features and since he had not been on the accident helicopter, he was not familiar with any programmed default settings.

He was asked if he knew anything about an accident Mr. Smith had in 2007 or 2008. He said he had heard about it but had no firsthand knowledge of it since it occurred before he was hired. He said all he knew was that it was an inadvertent tail rotor strike on a bush. He said he was not present when it occurred.

Mr. Dyess said usually the shortest notice he got for a flight was 2 hours.

He said the company had acquired the accident helicopter because the other Jet ranger was going to be out of town on another contract for about two thirds of the year. He said he and Tim did the bulk of the flying and he was not sure how much flying Mr. Smith did.

Mr. Dyess said he would be very surprised to hear if a pilot at SK Jets was reprimanded for turning down a flight but there would probably be some talk about it around the office.

He stated that he was not aware of Mayo Clinic ever putting any pressure on management to complete flights and that they did not play any role in making a go / no go decision.

When asked he said he had nothing to add.

The interview ended at 1732.

Interview: Rita Gayle Adkins, Charter Scheduler – SK Jets
Date: January 5, 2012
Location: via telephone from SK Jets Headquarters, St Augustine, FL
Time: 0930 EST

Present: Bill Bramble, David Helson - National Transportation Safety Board (NTSB); Steve Moore – Federal Aviation Administration (FAA).

Ms. Adkins was represented by Mr. Michael B. Ely – Hassell, Moorhead & Carroll.

Ms. Adkins stated the following information:

She was employed by SK Jets as a charter scheduler. She was originally hired in September 2005 and had worked for them off and on over the years. She worked for SK Jets from 2005 until summer of 2007 then started again in March or April of 2008. In 2008 she worked for them for about 8 months before leaving and then started working for them again in October 2011. She said she previously left for family reasons and had moved to Virginia Beach. Starting in October 2011 she was teleworking but previously she had worked in the office at SK Jet Headquarters.

Ms. Adkins provided a description of her job duties and responsibilities. She said from the time a person requested a flight, she entered everything into the schedule including passenger names, number of passengers, flight times, FBO (fixed base operators) and fuel vendors to be used. She said they also arranged concierge services and checked the TSA (Transportation Security Administration) watch list for the passengers they were carrying and notified the pilots of the flight schedule. She summarized by saying she managed all the details of the flight as far as setting up and scheduling.

Regarding a medical flight for Mayo Clinic, she said she first documented the time of the call, who the coordinator from Mayo was, and the UNOS (United Network For Organ Sharing) number. The UNOS number was used for invoicing and tracking and was tied to the donor patient. They were told what type of team was travelling, whether it was for liver, heart, kidney for example or whether it was just picking up a box. She said they were provided the time they needed to arrive and then they determined the departure time and when the driver needed to pick up the team from Mayo. She confirmed the passenger names and confirmed which FBO they were using with the coordinator. She said there was a form in their dispatch folder that she used as a checklist. It listed all of the questions that needed to be asked of the coordinator.

Ms. Adkins stated that they generally tried to give the flight crew a 2 hour notice but if the call came at midnight, and did not need to go out until 4 am, she would wait until 2 am to call them so they could get more rest. If the call came during the day, she said she would call the crew right away. She said she mostly worked the night shift except on weekends. She said the flight crews had a way of checking the rotation so they knew who was next to be called. She said she then would get a flight release from someone who was authorized to release the flight. Once the flight was released, she called the crew back to provide the details of the flight; times, destination, FBO, and whether a it was box or a team.

Ms. Adkins stated that when obtaining a release, she let the authorized person know of any crew duty or flight time violations that popped up in the BART scheduling system. She also provided estimated flight and duty times to make sure the crew could stay within limits. She said she also confirmed the aircraft times and cycles were within limits for the airplane considering how many take offs and landings and flight time was planned. She stated that whoever was on duty as the operational control person released the flight and she included their initials on the flight paperwork. She said this was all done verbally over the phone. She said the only people in the company who were authorized to release a flight were Katy Godwin, Jennifer McKeen, Leigh McIntosh, and Gary Fernandes. She said a person was not allowed to release their own flight. She said the BART system was the scheduling system they used to track crew legality, availability, and other details.

Ms. Adkins said she did not check weather as part of the release, which was the responsibility of the pilot. She did not recall an occasion when a pilot called her with a weather issue since she had been back and she could not think of any specific instances when she worked there previously either. She said if there was an issue, she would contact the customer to make them aware of any possible delays. She said the chief pilot or Director of Operations (DO) might get involved to help discuss an alternate plan but she did not know how that would worked as she said she did not know about the weather requirements.

Ms. Adkins said she was not an FAA licensed dispatcher and did not have any pilot experience. She was going to an aviation school, Embry Riddle, in Norfolk Virginia.

Regarding operational control, Ms. Adkins stated that it was emphasized to her that Mayo did not have any operational control over the flights; only SK Jets, as the operator, had control. She said the customer only selected destinations and times and sometimes which FBO they preferred. But she said the company can change any of those as needed based on their requirements. She said there had been times when they could not take a flight because there was not enough time for example. She said in that case, Mayo might help out by pushing back the scheduled time.

Ms. Adkins stated that she was on duty the night of the accident and had received a call from Mindy at the Mayo Clinic shortly after midnight on the morning of December 26. She was advised that they needed to take a liver team and a heart team to Shands Gainesville. The pickup time for the liver team was going to be 0400 and the pickup time for the heart team was going to be 0515 at Mayo Heliport. The liver team was going to go by ground transportation in the suburban. She said since they were using the 206 instead of the Agusta, she notified the coordinator they could only take two people instead of the normal 3 plus equipment. She said they discussed it and the coordinator called back to advise that the doctor was ok with only taking one technician with him. She said it would be Dr. Bonilla and Mr. Hines on the flight.

Ms. Adkins said that she notified the driver about 0200 to pick up the team and drive to Gainesville (GNV) and shortly after 0200; she called for the flight release. She said she initially had Tim scheduled on the flight but when she called him, he said he was still in Atlanta. She then called Jen (Jennifer McKeen) who told her to call Aaron (Dyess). She stated that she called Aaron two times without reaching him and then called Jen again. She said Jen advised her to

call Hoke Smith. She said she called Mr. Smith between 0300 and 0336 then called Jen back to get a release. She said Mr. Smith called her back about 0505 to advise that he was about to depart SK Jets for Mayo. About 0515, Mr. Hines called her to check on the flight and to advise they were waiting at the Mayo helipad. She talked to him again at 0528 and told him that Mr. Smith was on the way. She stated that she called Mr. Smith at 0536 and Mr. Hines at 0537 and got their respective voicemails so she knew they were in the air. At some point after that she called University Air Center at GNV since the helicopter would have to wait there after dropping the people off at Shands. She said that was the last call she made before she went off duty at 0700.

Ms. Adkins stated that the first call she had with Mr. Smith was pretty short. She had given him the departure time, the time they wanted to be picked up, the team members and that it was a heart team. She said she could tell she woke him up but other than that, he sounded fine. He confirmed all of the information and then ended the call. The next call from the hangar was also short. He had only called to advise he was about to depart. He did not discuss weather or flight planning on either call.

Ms. Adkins said the first two times she worked at SK Jets she worked the day shift, was in the office a lot, and saw Mr. Smith there regularly. She stated that he held everyone to a pretty high standard. For example, you would book a flight and think you had all the details perfect but he would still look it over to keep them on their toes. She said he pushed them, but not in a negative way, to make sure everything was handled efficiently with the customers and flights. She said she respected him, he had a good business sense and that he had a very good way with people. She said she would talk to Chuck Higgins in the office about the trucking Company Mr. Smith previously owned and she thought anyone who could start up a charter company, which was financially risky, must have good business sense.

When asked if there were times the company could not take a flight Mayo asked them to, Ms. Adkins said she was not aware of any except when an airplane or crew was not available. In those cases, they would broker a flight with another carrier. She said if there were times when they knew they would not have an airplane or crew, they would call ahead to the operators they used so they would be prepared if Mayo called.

Regarding interaction with the flight crews, she said she provided them the scheduling information when they needed it. Once they were in the air she used FltPlan.com to track the jets and the crews also called before takeoff and after landing so she could keep the hospitals updated. She said there was no tracking of the helicopters except the calls received from the pilots.

Ms. Adkins was asked why both teams did not use ground transportation this time. She said once an organ was cross-clamped it was only viable for a certain amount of time. She said it was an hour and a half drive from Shands and with a liver you had more time. She said with a heart or lungs you only had 2-3 hours and going by helicopter direct to the helipad saved time. She said sometimes they used an ambulance and jet. Regarding who made the decisions on the mode of transportation, she said Mayo would call to discuss it but if it was something that would not

work, the DO or Chief Pilot would help make alternate plans. She said the hospitals had a good idea when they called of how long it took using each mode.

Ms. Adkins said there were two main companies they brokered with if needed. One was Florida Jet and the other was Hop-a-Jet. Both were located in Ft Lauderdale.

Ms. Adkins was asked to clarify the timing of the communications with Mr. Hines. She said on the first call she had told him the helicopter would be there in10-15 minutes. The second call was at about 0528 and was after she verified the flight times and she told him that Mr. Smith was the one making the flight.

Ms. Adkins stated that she started her shift at 1000 on December 25 and ended at 0700 on December 26. She said the last call she made was at 0637 or 0638 to the University Air Center at GNV.

Ms. Adkins said the coordinators at Mayo work on a rotating shift and she could end up talking with Patty, Mindy, or Tommy.

She said she had not received any other calls during her shift. She stated that she did not talk with Dr. Bonilla and that she had not talked with him before.

Ms. Adkins stated that her last interaction with Mr. Smith was on Christmas Eve. She said he had agreed to cover the phones for a while to help her and Jennifer, because Katy (Godwin) was going to be out of town. She said he covered the phones from 0700 on December 24 until about 0930 on December 25. She recalled talking to him on Christmas Eve because he was planning to go to midnight mass. She said she offered to take the calls when he was at mass but he said he could cover it. She stated that Mr. Smith advised her Christmas morning that there had not been any calls while he was covering the phones. She thought there was also an email from him as they always sent a “pass down” email at the end of each shift. She checked her schedule and verified that she did not have any contact with him on December 23. She said she and Katy had covered the regular schedule from December 21-23 but Mr. Smith had also covered the phones for them on the night of December 19-20. She said the schedule did not show her name on December 24 but she had covered part of Katy’s shift that day. She said when Mr. Smith covered the phones on the night of December 19 from 1900-0700 the next day, he had received one call from Flexjet which he provided a quote for but it did not result in a flight. On the night of December 20 she said she did not have a pass down email so she was not sure what occurred on that shift. She said there was a medical flight at 0030 on December 21 that may have been done on his shift.

Ms. Adkins said the pilots were required to have 10 hours rest after they duty off from a trip and before they started another one. She stated that the company had always adhered to that rule. She said the maximum flight time was 10 hours in a 24 hour period and they could not exceed 14 hours of duty. These were all discussed as part of the release. She was asked to identify the initials “JM” on the release form she said that indicated Jennifer McKeen had released the flight. She was asked why the name Linda Boso was on the form. She said she did not know; Mindy was the coordinator she talked to that night.

Ms. Adkins said she had never heard pilots talk of any safety concerns. She had never heard of Mr. Smith pressuring anyone to take a flight or of Mr. Smith taking a flight after someone else turned it down due to weather.

She said they were the exclusive provider of flights for Mayo Clinic Jacksonville and if they could not do a flight, they would broker one for Mayo.

She said she had never flown with Mr. Smith.

Ms. Adkins said she did not know anything about his health other than what could be observed and she was not aware of any recent illness he may have had. She said he never mentioned anything about being tired when the flight was arranged. She said when she called she could tell that he just woke up, and he mumbled something about how he was covering for Aaron. She said it was unusual for a pilot to not answer his phone so she said it made sense to her that he was covering for Aaron. She said he did not sound like he was annoyed, but like he had made an arrangement with Aaron. She said she originally thought Tim was the one on call and she did not know what he was doing in Atlanta but did not think it was work related.

Ms. Adkins stated that her normal schedule was 2 – 3 nights in a row of 12 hour shifts. She said they had just recently switched to the 12 hour shifts and she worked 1900-0700 Wednesday, Thursday, Friday, or 1900-0700 Thursday, Friday and 1900 Saturday to 0700 Monday.

She said at the time of the accident, they only had the accident helicopter available for charter because the Agusta was down for maintenance. She said it was down prior to her return to work but in previous years, she said the Agusta was the preferred helicopter because they could fit all three team members and their supplies. She said Mayo preferred it as well because it was faster and more comfortable. She said the Mayo contract was handled by Mr. Smith and Chuck Higgins.

She said for the medical flights they usually called Aaron during the day and Tim at night.

Ms. Adkins stated that when they brokered medical flights to another carrier, it was only for jets; there was no provision for brokering helicopter flights.

She stated that she did not have wifi so she had to stay at home during her shift because she needed her computer to set up a flight when a call came in.

Ms. Adkins said that if a pilot decided not to take a flight, he would go to the director of maintenance and he would advise us if the airplane was down. She said if it was a weather issue he would go to the chief pilot and he would notify scheduling if there was a change. If the chief pilot was not available, he would notify the DO. This had never occurred on one of her flights but she recalled someone talking about it a long time ago when the former DO, Brian Bowie was there. She could not recall if there had ever been a flight that departed and then turned back due to weather.

Ms. Adkins was not aware of any audits or inspections of the company that may have been done by Mayo.

She was not sure where Brian Bowie went. She thought he left to take another flying job in Clearwater, Florida.

Ms. Adkins was asked if FAR part 91 flight time counted towards the flight time and duty limits. She said she thought there was a rule allowing an exception but the company did not operate that way.

When asked, Ms. Adkins said she had nothing to add.

The interview ended at 1130.

Interview: Jennifer Ann McKeen, Director of Charter – SK Jets
Date: January 5, 2012
Location: SK Jets Headquarters, St Augustine, FL
Time: 1148 EST

Present: Bill Bramble, David Helson – National Transportation Safety Board (NTSB); Leigh McIntosh – SK Jets; Steve Moore – Federal Aviation Administration (FAA).

Ms. McKeen was represented by Mr. Michael B. Ely – Hassell, Moorhead & Carroll.

During the interview Ms. McKeen stated the following information.

She had been with SK Jets approximately four and one half years, starting as a charter scheduler. She was currently the director of charter with the responsibility for supervision of the schedulers. She said she also performed the duties of a scheduler to include, quoting, client contact for scheduling the aircraft, etc. She was taking the director of charter position because Katie Godwin was leaving the company to give birth and care for a new baby. She moved into the new position in August of 2011. She reported to Derrick Smith, the current Vice President of SK Jets.

When asked how she went about scheduling a flight, she responded that they quoted the flight and if the client told them that they wanted to do the flight, the schedulers would make sure all of the paperwork was in order, including credit cards, etc. She said they make sure they had an aircraft available per the client request, then they got all the information including where and when they wanted to go, how many people they wanted to take. The scheduler then entered all of that into the schedule. They also made sure that this did not conflict with any other flights that were already scheduled. They made sure they had a crew available that could complete the trip. They would get it released and then notify the crew.

When asked if they got the flight released before contacting the crew, she said, “Usually yes”.

When asked how a flight received a release, she explained that they performed a release to maintain operational control of their aircraft at all times. She said no one else had operational control of their fleet. The person releasing it verified that the aircraft was within maintenance times and if the flight could be completed within those times. They checked to ensure the proper crew was assigned to the aircraft, also checking the pilot in command to make sure the right person was in the pilot in command slot. They checked any upcoming training that was due, in order to ensure that there was nothing that needed to be done. After all those items were complete, the flight was released.

She was asked if they verified the crew training and whether flight crew checks were up to date, and she responded yes.

When asked if they checked the flight time, duty time and rest issues, she responded yes they did. They made sure that the flight could be completed within a 14-hour duty day and would not

exceed 8 hours (single pilot) and 10 hours (dual pilot) in a 24-hour period. She said they made sure that the pilots had their 10 hours rest before any assignment.

When asked who was authorized to release a flight, she responded that they had to have received operational control training. She stated that Gary Fernandes, Leigh McIntosh and Katie Godwin, and she were authorized. When asked what type of training she received for being able to release flights, she said that she had received a PowerPoint presentation and a written test. Gary Fernandes had trained her. Mr. Fernandes and she sat down and talked about flight release entails and what was expected. At the completion of the training she took a written test.

When asked if she had any airman certificates and/or ratings, she said she had a commercial pilot certificate with airplane single and multiengine land as well as a flight instructor certificate for airplane single engine and airplane instrument. She further stated that she had not flown in four and one half years and was not current. In addition, she said she had approximately 420 flight hours. All of it in fixed wing aircraft. She never had aircraft dispatcher training or held an aircraft dispatcher certificate.

She was asked to walk through the procedure for releasing a medical flight, she said, that the scheduler would call her or another releaser. She said she would have the information in front of her that was needed. This information would already be plugged into the schedule. She said the computer program they used contained the route of the flight and the crew or pilot scheduled for the flight. The computer program was able to tell us anything that pops up for the crew. She would use a spreadsheet that told her the maintenance times on her computer. She said at night the scheduler could communicate that information to her, and she could verify that everything was the way it needed to be and then she would put her initials on the trip sheet.

She was asked how it was determined if it was a Part 91 or Part 135 flight, she responded that if the flight had passengers on it then it was Part 135. If the flight was empty, that would be a Part 91 flight, however, it took all the same information to release the flight whether it was a Part 91 or Part 135 flight.

She was asked reviewed the information to release a flight by memory or used a checklist, and she said that at this point she had done it a lot, so she remembered what she needed to complete the release. She stated that the training covered the items they had to look for to release a flight.

When asked if she looked at issues such as route of flight, fuel required, and weather conditions when deciding whether to release a flight, she responded no, the pilots looked at that. When they called the pilot, they told him or her the destination, but the pilots planned out the route.

She said the person that released the flight had no interaction with Mayo Clinic before a flight. She said she could not recall not being able to release a flight for any reason. She said that if a flight could not be released because of a maintenance issue, she would contact maintenance and if it could not be released because of a pilot crew issue, she would contact the chief pilot.

When asked what interaction she had with pilots when releasing the flight, she said, that if everything checked out and she released the flight, the scheduler would tell the crew that the flight had been released.

Ms. McKeen stated that on the night the accident occurred, Ms. Rita Adkins was on duty as scheduler and Ms. Adkins had called her for the release. When asked if there was a set schedule for the flight releasers, she said, no, the scheduler could decide who she called. She said Ms. Adkins usually called her.

The morning of the accident Ms. McKeen stated that Rita Adkins called her and said that she had a helicopter flight for release. Ms. Adkins mentioned that she tried to contact Tim Murphy to complete the flight, but he was out of town. Ms. McKeen said she believed Ms. Adkins may have tried to give Aaron Dyess a call but could not get in touch with him. She stated the she told Ms. Adkins the she believed Mr. Smith was on call for the helicopter flights that night. Once she knew that he was the one who was going to do the flight, both she and Ms Adkins reviewed each item required to release him for the flight. She said all items checked out okay and she released the flight. She did not recall the time of day. She released the flight over the phone. She said she had no further conversions with the company until she was notified of the accident. She said she had no conversation that night with the Mayo Clinic.

She was asked if there had ever been an occasion where a pilot returned after a release and said they could not fly the trip for some reason, she responded that the only thing she could think of was maybe if a maintenance issue arose, but she did not recall any specific occasions.

She was asked what system she and the schedulers use to look up the information they used to release a flight, and she responded that for maintenance information they had a sheet that was kept up to date with the latest times from flight logs and the latest maintenance reports for the aircraft. SK Jets scheduling program contained pilot training information. She said all they had to do was click on the legal button and it showed up if there was any training or checking event that was upcoming. She said it was a hosted system on someone else's server. She said it was SK Jets program exclusively and it was a very large program with all of their information in it. It was called BART. She stated that SK Jets had been using it since before she was employed by them.

When Ms. McKeen was asked about the contract with the Mayo Clinic, she responded by saying, that they called the schedulers and gave them a destination. She stated that they worked with them to ensure that it was safe and to make sure that they could provide the appropriate transportation. They asked the Mayo Clinic representative if they would be transporting boxes or medical teams. When asked if the Mayo Clinic had any oversight of the contract and if they were involved in any decision making after they call the SK Jets scheduler, she said, that they gave the scheduler all of the information and then SK Jets took it from there and assuming SK Jets could complete the requested trip safely and legally it would be scheduled and they would work with them. If they foresaw a problem, they would try to work around issues if at all possible. But they made sure it was as safe as possible. She said that the Mayo Clinic did not have any hand in operational control of their aircraft.

When asked if she felt there was ever any pressure from the Mayo Clinic to complete one of these flights, she said that these flights were lifesaving flights, so there was that angle, but at the same time they did not want to risk safety. She stated that she believed they had done very well at keeping it safe and legal while helping the customer. She was asked if they had encountered any flights where the Mayo Clinic had pressured SK Jets pilots, and she said that in her experience, if SK jets said that they could not do exactly what the Mayo Clinic was requesting safely, they would always say that they wanted to be safe and they would find a different way. She said that the Mayo Clinic had been very good about safety issues.

When asked if the Mayo Clinic ever came over and did any type of audit of SK Jets' operation, She responded that they did not. Mayo Clinic trusted ARGUS when they did their audits.

When she was asked if she had ever taken part in the ARGUS audits, she responded that she did not think so. She said she was aware they took place but she was not physically in the office.

When asked if she had helped the company prepare for the audits, she responded that she ensured that as far as her part of the scheduling department, all of her items were completely caught up and good to go and she consistently made sure that she always had the best information and the latest information. She said that scheduling had a meeting before the audit to discuss what they could expect. When asked if she recalled what ARGUS had told them to expect, she said she did not recall anything that they did not expect. Nothing stuck in her mind. Just they were going to come in and look at SK Jets safety practices to make sure they were not just sitting back and relaxing.

Ms. McKeen stated that for some time she was working as a scheduler on the weekend shift that was from Saturday morning to Monday morning. She worked from home. Her home computer could access her office computer and during the day she could monitor the emails. At night she could go to sleep. She would put the phone by the bed and if it rang she would wake up and complete her scheduling duties, otherwise she would sleep through the night.

When asked about her impressions of the safety culture at SK Jets, she responded, that she thought it was good. She told us they had a safety reporting system, but she never witnessed anything she needed to report. In addition, she said ARGUS rated SK jets as platinum. She said that ARGUS was impressed with their safety culture as well. She said that neither she nor anyone else that she was aware of in the company had any concerns with any safety issues. This included any maintenance issues.

She stated that she rode on a flight to Puerto Rico once in an SK Jets Lear 31. It was a long flight. She was not sure if the pilots were currently with the company. She did not remember who the pilots were. In addition, she said she once rode in an SK Jets Bell 206 Jet Ranger with Gary Fernandes serving as the pilot.

She did not recall receiving training on risk management or decision making.

She said the last time she talked to Mr. Smith was on December 25, although she said it might have been on December 24th. She said it was just a quick routine conversation. It was less than a two minute call on her SK Jets phone.

She said she probable spoke to Mr. Smith on Friday or Saturday December 23 or 24th at shift turnover. She said she normally talked to the person that was the next scheduler on duty. She said she believed that Mr. Smith took over the scheduler duties from her on Christmas Eve.

She was unsure how many medical flights per month SK Jet conducted over the last year. She said it varied depending on the donors.

She said she did not know the cost of a medical or charter flight; she did not get involved in that end of the business.

When asked how well she knew Mr. Smith, she said it was a business relationship and since she was out of the office a lot, she did not see him much until recently.

When asked what kind of a person Mr. Smith was to work with, she said that sometimes he was a stickler. She remember times when he would say that there were planes on the ground, his airplanes were in the hangar, and they had better be quoting, but he really was good and looked out for his employees. She said shortly after she had surgery, she was going to drive to Atlanta and he said he was not comfortable with her driving that far after her surgery. So, she ended up not going. She said she never noticed him treating an employee unfairly.

When asked about Mr. Smith's health prior to the accident she said she did not see any problems.

When asked about the status of the charter and medical business, she said with the economy she thought everyone was struggling, but as far as SK Jets, she said there has been a little less business. Other then the comment about the planes in the hanger and some layoffs, Mr. Smith never spoke of going out of business. When she was asked about the comment concerning layoffs, she said that it was sporadic, maybe one person or two throughout the last two years because of the economy. She said she thought the morale was good prior to the accident. She said everybody is happy to have a job.

She was asked again who could perform the duties of flight releaser, she said Gary, Leigh, Katie and herself could release. When asked if Mr. Smith could release she responded, yes.
When she was asked whether people ever released themselves, she responded no.

When asked if she would ever have a desire to fly for SK Jets, she said her love of flying had dropped off.

When asked who did the billing for the medical flights; she said Derrick Smith did it.

She explained that when not in the office, the scheduler pulled up all of the information on a trip on the computer from their home. The scheduler provided this information over the phone to the person that was performing the flight release duties that night. Based on that information, the

releaser would decide whether or not release a flight. The schedulers would call the pilot to informed them if the flight was released. When asked if the scheduler called the pilot before they called the releaser, she said sometimes they might give the pilot a heads up if it was a short notice on the flight. She said this was just to let pilots know what was going on. They wanted to give the pilot as much notice as possible. She said that it was sometimes possible that the crew would be contacted prior to release.

When asked if she ever missed a required item of information for the flight release, she responded, that she did not think that she ever had. She said because of the training and the written test she was prepared and did not think she had ever missed an item.

When asked if there was ever a time when a pilot called and reported that the weather was below his or her personal minimums, she said yes, and they had made other arrangements using a jet or a car. She said she did not remember any instances where a pilot had refused to fly and another pilot had taken that flight. She said once the first pilot turned down a flight due to a weather or maintenance issue, it did not go. If they said it was a maintenance issue, she would call maintenance to see if they could fix it. With a weather issue, she could not think of any real instances.

When asked she said she had nothing to ask.

The interview ended at 1257.

Interview: Mary Katherine "Katie" Godwin, Director of Charter ex-officio – SK Jets
Date: January 5, 2012
Location: SK Jets Headquarters, St Augustine, FL
Time: 1430 EST

Present: Bill Bramble, David Helson – National Transportation Safety Board (NTSB); Steve Moore – Federal Aviation Administration (FAA).

Ms. Godwin was represented by Mr. Michael B. Ely – Hassell, Moorhead & Carroll.

During the interview, Ms. Godwin stated the following information:

She said her position with SK Jets was that of director of charter, ex officio with SK Logistics. Jennifer McKeen was promoted to be her replacement in August 2011. Following Ms. McKeen's promotion, she could not think of what to change her own title to, so it had remained director of charter. She said that she was leaving the company to have a baby and stay at home. She was hired in March 2005 as a charter scheduler and shortly thereafter she was promoted to director of charter after the previous director of charter left the company. She stated that her aviation background prior to SK Jets was that of working at a fixed base operator (FBO) for a year and a half. She had no airman certificates or ratings. She said she had seven flight hours of fixed wing time. She said her duties and responsibilities at SK Jets consisted of overseeing the scheduling department. The scheduling department made sure there were trained employees available to answer phones and quote trips. She also said that the schedulers had to accommodate customer requests by determining what the client wanted to do and how they could best accommodate them. She said they assigned the flight crews. She said that as the director of charter she made sure the schedulers were trained and had the resources they needed.

When asked for the procedure for arranging a flight, she said that someone would call and request a quote. They would try to quote it as accurately as possible. If the customer had any questions, they made sure they could accomplish the flight as requested before they would give a quote. This included any limitations of the aircraft and duty time of the pilot. When the client booked the flight, she said that they got all the details as far as the FBO, the departure time, the passenger information, and any other preferences. She said they put that information into the schedule. Prior to the trip they would assign the crew and verify that the trip was released. When asked if there were any differences with medical flights, she responded that they did not have to quote them. When Mayo Clinic called, they just collected the information from them.

When asked how a flight was released, she explained that it was a two-tiered system that consisted of an operational release and a pilot release. For an operational release they would have to contact someone who was authorized to exercise operational control as listed in their general operating manual (GOM). She stated that they released the flight based on crew duty limitations, assignment of a qualified crew, and they ensured that the aircraft was within all forecast maintenance time limitations, and they designated a pilot in command. The second tier was completed by the pilot in command who released the flight after considering the weather and everything else.

When asked what role she played in the tier system, she said that she was involved in the first tier. Ms. Godwin said that the criteria she used when deciding whether to release a flight was based on those four qualifications. She said she did not participate in the second tier at all.

She was asked if there were ever occasions when pilots said that they could not take a flight and if so what were the reasons for their refusal. She responded that there were occasions when the forecast was below minimums and the flight would not be able to get in. When that occurred, she said they would look into other options such other airports that could be used as an alternate that was above minimums. She said another option was to perhaps delay a flight until the weather improved. She said they would look into other ways to complete the mission, and that sometimes they would have to be creative and flexible.

When asked which person the pilot would contact for options if the planned flight could not be completed, she said that the pilot would usually contact the scheduler or the person that released the flight. She also added that often the pilot would contact the scheduler because the scheduler was in contact with the customer and could present other options.

When asked, as director of charter, what role she played in that process, she said that usually it was the scheduler or the person who released the flight. If the itinerary or schedule changed they would have to do a new release.

She said that prior to the accident, the individuals authorized to release flights were Hoke Smith, Gary Fernandes, Leigh McIntosh, Jennifer McKeen and herself. She said that information was published in the GOM.

When asked if one of those authorized individuals could release themselves, she said not for tier one. She said that someone else had to complete the release. In addition she said that the Mayo Clinic played no role in the release process, she added that Mayo Clinic only requested the flights.

When asked what training she had received to authorize releases she responded that she received operational control training on how to ensure the flight met the four requirements as well as how the flight could be assigned, which pilot is the pilot in command, whether the airplane is within forecast maintenance time limitations, and how to know whether pilots are within the flight and duty time limitations.

She said that training was conducted one on one at the SK Jets facility by Mr. Gary Fernandes. In addition, she stated she felt the training was adequate.

When asked if she had known of any personnel from the Mayo Clinic auditing SK Jets, she said no.

She said she had taken part in the ARGUS and IS-BAO audits. She stated that her role was to answer questions that concerned how SK Jets scheduled trips. She further stated that in order to receive a platinum safety rating, the ARGUS auditors conducted a 2 to 3 day on-site audit. She

said they looked through everything, including the safety culture of the company. She added that the audits were very thorough.

When asked how SK Jets prepared for an audit, she said, that ideally they did not do much. She said in preparation for an audit, they reviewed the procedures that they had in place; they looked into what could be done better as well as gave the auditor opportunity for constructive criticism.

She said that because there were only four items that must be reviewed for the flight release, it was easy to commit them to memory and they did not typically use a checklist.

She was asked if there had ever been occasions when SK Jets could not complete a flight for the Mayo Clinic, she responded that there had been times when they could not make the flight and in those cases they would use a subcontractor or vender from the in-house list. Those vendors had to meet the same standard and have similar ARGUS ratings. She said that SK Jets had a longstanding relationship with those vendors.

She said the scheduler could call any flight releaser for a release. She said that it was not an official thing and as the scheduler if you tried to call one and they did not answer, you had other options.

She said she was not on duty the night of accident and that she did not receive any calls prior to the flight. The first call she received was when Jennifer McKeen called and asked her to take the phones so Ms. McKeen could drive to the office because SK Jets was activating the emergency response plan.

When asked what that plan entailed, she said it was hard to briefly describe. She said there were lots of checklists and procedures for different people because there was so much to be done simultaneously. One of the things SK Jets incorporated was not to have employees drive with the phones while they were doing an emergency response. They would arrange for someone else to take the phones while they drove to the office.

She said that SK Jets used BART as their software scheduling program. This program would alert the scheduler and flight releasers if there were potential duty issues or if flights would exceed a 14 hour day as well as if the crew was not qualified for that aircraft or past due on medical certificates, night takeoffs and landings or training. Ms. Godwin said maintenance tracking was separate and that they used an excel spreadsheet for that. She said it kept the latest information on aircraft hours and what inspections were coming due.

When asked about her feelings concerning the safety culture at SK Jets or if she ever had any issues, she said that she did not think so. She said they did not get platinum by sweeping things under the rug, they did it by having a solid safety culture. In scheduling they looked for things even like making sure the crew was not going to go hungry if they scheduled them for a pretty long day. They looked for things that could become issues before they did, like tight turns around mealtimes. She said she never heard anybody voice any concerns about safety issues.

When asked if the company had a safety reporting system, she responded that SK Jets had a hazard reporting system where you could anonymously report any safety related issue on a written form. She said that you could see the results of some of those reports around the hangar. For example, in the hangar where they parked the Suburban, there was a cone so that drivers knew how far to pull in when parking the Suburban. She said the safety issue was that either the driver would pull too far into the hanger leaving no room to walk around the aircraft or they would not pull in far enough which did not allow the door to be closed.

When asked who made decisions on what mode of transportation SK Jets used for Mayo trips, she responded that it depended on where they were going and what organ they were retrieving. She said the type of organ determined how critical the travel time was. She went on to say that ground transportation was only practical within a relatively small radius. The Mayo Clinic coordinators would usually ask for their preferred method of transportation, but if the SK Jets' schedulers thought there was a better option, they would often suggest it. It was usually determined more by location than anything else.

She said she had known Mr. Smith since she started at SK Jets and that he had been a good leader and it was a positive relationship. He was hard working and dedicated. She said she interacted with him on most days since they worked together in the office. She said the last time she talked to him before the accident was Friday, December 23rd. She said he was in the office and they discussed the issue concerning the fact that she did not have to go part time immediately after the holidays as had been planned. She said it was a very pleasant and positive conversation and that she wished him a happy anniversary because he was leaving the office to celebrate his 50th anniversary. She said Mr. Smith may have left the office around lunch time. He appeared to be healthy and in a good mood. She knew of no recent illnesses.

She said she knew of no management pressure to accept a flight in conditions that made the pilots uncomfortable and the pilots were not berated for refusing a flight. She was unsure how many medical flights per month SK Jets averaged. She said it varied. Ms. Godwin stated that cost also varied. The revenue fluctuated because the flights were irregular. After a flight, the hours were billed to the Mayo Clinic using the contract rate.

When asked how the FRAT form played into the release process, Ms. Godwin stated that if it reached a certain value, the pilot was supposed to contact either the Director of Operations or Chief Pilot and review it with them. That form applied to the second tier of operational control; the PIC tier of the release. She said that those were things that the scheduler and flight releasers were not responsible for. The pilot was required to fill them out. When asked if she knew if the pilots completed the FRAT forms, she said that she was not sure because the Director of Safety collected the forms.

She said that Mr. Smith very much enjoyed flying. He did not display any of the five hazardous attitudes described in FAA pilot training literature in terms of how he talked about flying. In addition, she said she did not know if Mr. Smith was taking any prescription medications, nor did she know if Mr. Smith used alcohol or tobacco. Ms. Godwin said that she had not noticed any recent significant changes in his health, finances, or personal life. She said he seemed to need less sleep than she did because he could stay up later and get up earlier.

When asked about flight and duty time requirements, she stated that pilots required 10 hours of rest prior to a flight and that the maximum flight and duty time was 14 hours duty and 10 hours of flight time (dual pilot) or 8 hours (single pilot).

When asked if one helicopter type was preferred over the other for medical flights, Ms. Godwin answered that the Agusta 109 was preferred, because it was bigger and faster. She said the Agusta 109 was always primary if it was available.

When asked if platinum was the highest ARGUS rating, she said yes. Ms. Godwin was asked if she took a test after completing the operational control and flight release training and she said yes and she had passed it.

Ms. Godwin was asked to elaborate on how pilots might try alternate routes if the original route would not work, especially for medical flights, she said they would explore the available options. If they could not get into a short runway, or get into an airport at that time, they would consider alternate airports or delaying the flight until conditions improved. They would looking for alternate solutions to accommodate the mission, and try to find a way that it could fit into safety parameters. When asked if it ever upset a client when they had to make changes like that, she said yes. They were pretty communicative but nobody would say they did not want to do it anyway. The scheduler would just present the alternatives.

When asked if it would surprise her if someone at SK Jets was reprimanded because they turned down a flight because of weather or a mechanical issue, she said yes because the pilots were required to make those decisions and in fact they were relied upon to make those decisions. She said punitive action for making those decisions seemed counterproductive.

She said that SK Jets had held the ARGUS platinum rating since 2006. She said prior to that they held a gold rating. She said it was her understanding that gold required that you input all your crew information into their system, but it did not require the audit. Platinum required that you have completed and passed an audit. She added that the difference between the platinum and gold ratings was the audit. When asked if she knew if SK Jets had not passed the audit, she said that on their 2008 audit they said ARGUS would be gold plus until they made a couple corrections because they had some suggested modifications. SK Jets sent documentation showing ARGUS that the modifications were made and they returned the company to platinum status. She did not recall what the modifications were.

She said she rode in the SK Jets helicopter on two occasions, once with Mr. Smith and once with Steve Stout. She said the flight with Mr. Smith was to Orlando Executive Airport (ORL). She said he was taking a Bell Jet Ranger to Orlando to leave it there and no other passengers were on board. She said she sat up front and it was one of the coolest things she had ever done.

When asked she said she had nothing to add.

The interview ended at 1550.

Interview: James Michael Holmes, Maintenance Test Pilot and Former SK Jets Employee
Date: January 5, 2012
Location: via telephone from Courtyard Marriott, St Augustine, FL
Time: 1633 EST

Present: Bill Bramble, David Helson – National Transportation Safety Board (NTSB); Steve Moore – Federal Aviation Administration (FAA).

Mr. Holmes stated the following information:

He had worked for SK Jets as a pilot for about one and half years before he left to fly in Iraq. He said that the owner of the company tried to pressure pilots to fly in bad weather and falsify flight time and duty records.

Mr. Holmes stated that in December (he recalled it may have been the 22nd) 2007 he was assigned a medical flight for the Mayo Clinic in Jacksonville. A Learjet was flying into St. Augustine (SGJ) with an organ and organ transplant team and after they arrived, he was supposed to fly them to the Mayo Clinic Helipad using an Agusta helicopter, but he refused to take the flight due to bad weather conditions. He stated that Mr. Hoke Smith yelled and screamed at him, called him an idiot, and then hopped in the Agusta and flew it VFR (visual flight rules) in IMC (instrument meteorological conditions). He said that Mr. Smith made it about 3 miles north before almost hitting a microwave tower and then returned to SGJ. He stated that during his approach back in to the SK Jets ramp at SGJ; Mr. Smith dragged the tail through the bushes next to the fuel tank. He stated that Mr. Smith put the helicopter in the hangar and did not report it to the FAA.

Mr. Holmes said that he and a Learjet pilot named Darrin both reported it to the FAA POI (principal operations inspector), Bill Edwards. Mr. Holmes stated that the POI and the Orlando FSDO (Flight Standards District Office) "swept it under the rug and covered it up". He said he looked at some of the weather on the day of this accident (December 26, 2011) and it looked like Mr. Smith might have done the same thing again; take off in weather he should not have been flying in.

Mr. Holmes said he thought the previous occurrence was on December 22, 2007 and that he had turned down the flight because the weather was bad. He said that Darrin was one of the Learjet pilots that had just brought the transplant team in and that he said he had to fly an ILS (Instrument Landing System) approach down to minimums. He said SGJ fell under JAX (Jacksonville) airspace and that Mr. Smith had not filed SVFR (special visual flight rules). He had taken off with the doctor and one of the technicians. He said the technician was David Hines.

He said there was a pool of doctors that flew on these flights and he could not recall which one it was but he said the doctor, Mr. Hines, and Mr. Smith were the ones on board the Agusta 109. He said later he found out they had reported it as a ground taxi incident but it had happened when they were coming in to land. He said that they only made it about 3 miles north of SGJ

and he almost hit a microwave tower on the east side of highway 1. That was what made him turn around and come back.

Mr. Holmes said the ground crew pushed the helicopter into the hangar and threw a tarp over it, and notified no one.

Mr. Holmes said that he, Darrin, and he thought one other Learjet pilot told the POI that Mr. Smith wanted them to falsify their duty time logs. He said he later heard from Mr. Smith that the POI had advised him that Mr. Holmes and Darrin were "ratting on him". Mr. Holmes said he went to Iraq and never heard anything else about it. He said that Darrin ended up leaving the company because of it also. He said they told the POI that they had witnessed the event but their statements never showed up in the NTSB report. He said he had given verbal reports to the POI; there was nothing in writing.

Break at 1655.
Resume at 1735.

Mr. Holmes said he lived in Melbourne, Florida and was employed as a maintenance test pilot for Wilson Construction. He flew MD-500E and MD-500F helicopters. He estimated that he had logged about 3,700 hours total time in rotary wing aircraft. He stated that he held a commercial helicopter / rotorcraft certificate, a private airplane single engine land, and an A&P (Airframe and Powerplant).

Mr. Holmes stated that he started his flying career in the US Army as a MH47 special operations flight engineer. He said he got his A&P in the Army then moved to Alaska where he became an A&P chief inspector and got his helicopter flying certificate. He worked for AGRotors in Gettysburg, Pennsylvania doing energized power line inspection and repair. He said that company went out of business so he went to work for SK Jets in February 2007. He stated that he was in the Army Reserve and was activated to go to Iraq in January 2008 and he was told by the SK Jets general manager, Mr. Derricke Smith, that they would not hold his job until he returned, so they "parted ways". He said he went to Iraq for about 15 months in an H60 unit during Operation Iraqi Freedom. He said he came home and went to work for Haverfield Aviation, who had purchased AGRotors, for about a year then he started working for Wilson Construction.

When asked to revisit the event that occurred on December 22, 2007 Mr. Holmes confirmed that he had been assigned a flight from SGJ to Mayo Clinic heliport in Jacksonville and he refused the flight due to poor weather conditions. He said Mr. Smith told him to get in the helicopter and do it, and Mr. Holmes refused. He said this occurred at about 10PM or 11PM after the SGJ tower had closed. He stated that they were at the SK Jets ramp outside the hangar. He said that the organ and transplant team were brought from the Learjet to the helicopter and Mr. Smith took off from the SK Jets ramp.

Mr. Holmes said that Mr. Smith was returning to the same ramp. He said north of the fence line there was a road and the trees were about 100 feet tall. He said Mr. Smith descended at a "pretty good rate". He said there were some trees by the fuel tank that were about 11 or 12 feet tall. He

stated that Mr. Smith almost hit the fuel tank but the tail rotor struck the trees and broke off the outer inch and a half of the rotor blades. He said the pieces of the rotor blade came off and went into the tail boom and took out longerons and the fitting for the bolts that attached the tail to the fuselage. He said it did so much damage that it "condemned the airframe". He said the tail number was 109SK.

Mr. Holmes said Darrin Felton was a witness to the event and so was the other Learjet pilot but he could not recall his name. He said Mr. Smith just pulled the PCL's (power control levers) to idle and ran inside to his office when the blades were still turning. He stated that Darrin went over to the helicopter and helped the passengers out. He said he thought Mr. Smith just "freaked out" when he realized what happened and he ran into his office.

He said Mr. Smith told the ground crew to put the helicopter in the hangar. Mr. Holmes said there was also a Lear 25 in the back of the hangar that landed hard after flaming out both engines and the gear ran up through the wing.

Mr. Holmes said there was an ongoing issue with Mr. Smith wanting them to fly in weather they should not fly in. As an example, Mr. Holmes said there was one time he flew a transplant team to Daytona Beach. He said he had to wait about 6 hours before the return flight to SGJ and while waiting, a line of thunderstorms moved in. He said he called dispatch to let them know to get an ambulance because he could not go and Mr. Smith called him back to yell at him. He said he told Mr. Smith they should not be flying VFR in IMC weather but Mr. Smith had a "my way or the highway" attitude. He said the event in Daytona Beach occurred before the event by the fuel tank.

Mr. Holmes said after the event with the tail rotor, he was sent out to Eglin AFB on a contract for 3 weeks. After he returned, he went to Iraq.

He said he had to fly with Mr. Smith for his training and checkrides at the company but Mr. Holmes was always the pilot flying on those flights. He said during training the weather was always good so there were no problems. Mr. Holmes said he and Mr. Smith had disagreements. He said FAR (Federal Aviation Regulations) 135 VFR night flying in helicopters required lighted visual reference to the horizon. He said if you were over a black hole you could not see the horizon and you were effectively in IMC. He said if you went down to 2, 3, or 400 feet over the Ocala National Forest you were in a big black hole. Mr. Holmes said legally you could not do it, and it was "downright stupid".

Mr. Holmes said he would not wish this on his enemy and it pained him to see this happen. He said he did not understand why when he had reported this to the FAA; he was still allowed to operate.

Mr. Holmes said he had previous discussions with Mr. Smith about the duty time issues. He said Mr. Smith hired dispatchers who did not know anything about aviation and they would book flights for 7 passengers on a Bell Jet Ranger; which just would not work.

Regarding the scheduling issues, he said they had no time off. He said they were on call 7 days a week, 365 days a year. He said Mr. Smith told him if they did not call him for a trip, that was his time off and that was what he was supposed to put in his duty and rest record.

Mr. Holmes said he would not have gone back to work at SK Jets even if they held his job for him. He said Mr. Smith was fine in the training environment; if the weather was good, he was good, but if the weather was bad, he was bad.

He said he also got pressure from the chief pilot, Mr. Fernandes. He said Mr. Fernandes was not a helicopter pilot so he just did whatever Mr. Smith told him to.

Mr. Holmes said at the time, he was the only other helicopter pilot and he reported to Mr. Smith.

Mr. Holmes estimated the weather conditions were about 400 feet overcast and 1 mile visibility, or maybe even less than a mile when the tail rotor event occurred. He said Mr. Smith had the helicopter started up before the Learjet pulled up to the ramp and he took off before the Learjet crew got out of their airplane. He said right after Mr. Smith took off one of the Learjet pilots came out and told Mr. Holmes that they had to fly the approach right down to minimums for landing and the weather had deteriorated a little since then.

Mr. Holmes said the weather he referred to was being reported at SGJ on the AWOS (automated weather observation system) and that the weather at Jacksonville was about the same; low clouds, fog, and poor visibility. He said they used to use the weather at NAS Jacksonville which was right across the river from the Mayo Clinic Heliport.

Mr. Holmes said Mr. Smith used to say he would fly down the intercoastal waterway and then hop over a tree line to get to the Heliport. Mr. Holmes said there was a set of antennas 700 or 800 feet tall on the east side of the hospital and if you went up US 1 there was a microwave tower off the highway; the one he almost hit. He said Mr. Smith's strategy was to stay low to the ground but the problem with that was at night it was like a black hole.

Mr. Holmes said that after the accident, the Mayo team was a little shaken but they pulled the SUV around and took them to Mayo with the heart. He recalled that they were still able to use it. He said they had used an ambulance before to get a heart from Gainesville. He said Mr. Smith was so insistent on using the helicopter solely because of the money they made. He said he did not know how much money they made for these flights. He said he never received any pressure from the Mayo clinic personnel about turning down a flight.

He said the flight from SGJ to the Mayo Clinic Heliport was about 10-15 minutes and it would take about 30 minutes in a car.

Mr. Holmes said he did not talk to any of the doctors or technicians after that because he went out to the contract at Eglin right after that.

Mr. Holmes was asked if he thought there was any disadvantage to taking the 206 on these flights. He said that with a twin, you had better reliability and also an autopilot. The 206 they

had was pretty barebones VFR. It had an attitude indicator a 386 GPS (global positioning system), and no VOR (very high frequency omni-range). He said he would not want to get stuck in the clouds flying it.

Mr. Holmes said FAR part 135 regulations required 2 pilots or an autopilot to fly IFR (instrument flight rules). He said Mr. Smith was IFR rated but you cannot do an instrument approach into the hospital helipad. He said part of the problem was that Mr. Smith would fly lower and lower to stay in VMC (visual meteorological conditions).

Mr. Holmes was asked about difficulties transitioning from VFR to IFR if you encountered a black hole area. He said the Agusta had force trim on cyclic and collective that you could lock into place but the Jet Ranger only had friction knobs. He said in Florida the trees were about 100 feet high and if you had 3-400 foot ceilings, it would not take long to lose that altitude.

He was asked if the damage to trees from the 2007 incident was still visible. He said probably not but it was right next to a 2,000 gallon white fuel tank and if someone had gone out at the time to look, it was noticeable and you could tell it was not from taxiing because it was high up and too far back from the ramp. He said the rotor had cut down about 8-10 inches into the branches of the trees.

Mr. Holmes said he found out later from one of the mechanics that Mr. Smith was not going to report it and that was when he decided to call the POI, Bill Edwards. He said he did not remember the names of the mechanics at the time.

He said he did not know why Bill Edwards did not pursue any action on their reports and he did not want to speculate. He just saw the news about this recent accident and thought it sounded similar to the 2007 event. He said nobody should have taken the flight; they could have driven.

Mr. Holmes was asked about his experience with weather forecasts and flying in Gainesville. He said that due to the swamps, Gainesville was “a fog magnet”. He described a time when he was flying a transplant team from Shands to Orlando. He said he landed on the roof at Shands and it was clear blue sky. He relocated to the ground helipad and waited for the team for about 45 minutes and by the time the team came out it was solid IFR. They ended up having to drive the team to Orlando. He said that was another instance when Mr. Smith had questioned him about not flying.

Mr. Holmes said the Lear 25 that was parked in the back of the hangar was damaged in a hard landing in August 2007. He was out of town doing the contract flying when that occurred but recalled that when he returned, a mechanic told him that one of the pilots pulled the power back on approach and flamed out the engines. He did not know the names of the pilots.

When asked he said he had nothing to add.

The interview ended at 1840.

Interview: Andrew D. MacQueen, Director of Maintenance – SK Jets
Date: January 6, 2012
Location: SK Jets Headquarters, St Augustine, FL
Time: 0835 EST

Present: Bill Bramble, David Helson – National Transportation Safety Board (NTSB); Steve Moore – Federal Aviation Administration (FAA); Leigh McIntosh – SK Jets.

Mr. MacQueen was represented by Mr. Michael B. Ely – Hassell, Moorhead & Carroll.

Mr. MacQueen stated the following information:

He was hired as the Director of Maintenance (DOM) by SK Jets about 4 months ago. Prior to coming to SK Jets, he worked as a contractor for the previous couple of years. He held an A & P (Airframe and Powerplant) certificate and an IA (Inspection Authorization) issued by the FAA with most of his experience in helicopters. He said he had the A & P since 1982. He said he had a helicopter Airline Transport Pilot Certificate (ATP) and a certified flight instructor rating, and a private pilot airplane single engine land certificate. He said he had logged over 10,000 hours total time in helicopters. He said he had been in the helicopter business for about 30 years as either a pilot or mechanic. He was civilian trained and then worked his way up through flying single engine piston, then turbine, then multi-engine helicopters. He said he still flew occasionally but he got out of flying because maintenance was more consistent work.

He stated that as the DOM he was responsible to maintain the airworthiness of the fleet, manage the mechanics on the floor, and schedule maintenance. He said they accomplished the day to day line maintenance and contracted out all the intermediate and heavy maintenance. He said they did not have the staff or equipment to do that in house.

Mr. MacQueen said they did the line maintenance on both helicopters and fixed wing.

Mr. MacQueen said the safety culture at SK Jets was “to the standard”, that they operated airworthy aircraft and that on the maintenance side of the house they did not cut corners and they made sure all of the aircraft were safe and airworthy. He said he had limited exposure to the flight operations side of the house but his impression was that they had the same safety culture He said safety was the motivating factor in the industry and they followed the industry and FAA safety standards.

He characterized the type of maintenance issues they regularly took care of as “simple line type” maintenance such as tires and brakes on the jets, servicing oxygen and inspecting fire extinguishers.

He said he reported to the president of the company, Mr. Hoke Smith.

Mr. MacQueen said he had not experienced any issue with accomplishing maintenance. He said if they needed to replace a part they got the part. He said in the four months that he had been there; he had not experienced any pressure to delay maintenance or cut any corners.

He described his relationship with Mr. Smith as professional. He said he thought Mr. Smith respected his opinion and judgment and that they had a mutual respect as professionals. He said he never encountered any resistance from him about the type of maintenance to perform.

Mr. MacQueen said he flew with Mr. Smith in a Bell 206 twice and that Mr. MacQueen was the pilot flying on both occasions. He said the flights were local in nature and for the purpose of conducting some operational checks. He said he had to adjust some radios and needed to have someone else to make sure they were adjusted properly.

He said he never had to fly with Mr. Smith and was not close to him when making any of his decisions on the pilot side. He said on the maintenance side, they made decisions together on a course of action and that worked out fine. He said he had no crew coordination experience with Mr. Smith.

Mr. MacQueen was asked if he had any impression of decision making by Mr. Smith outside of flying and he said he had no comment.

He said he had one mechanic working for him. He had two but the other one was let go. He said Human Resources handled that and he was not involved in that decision. He thought the current mechanic had been working there about one year and the one that was let go had not been there quite as long. He said he could not comment on the turnover rate as he had only been at the company about 4 months.

Mr. MacQueen said he did not play a role in flight operations except if a crew found a maintenance issue during preflight. He said he would have to look at records to determine how often that happened but he thought it was not very often. He said they tried to be more proactive by doing post flights when the aircraft came in so they could clear any squawks before the next flight. He said they had a lot of flights in the middle of the night and it was difficult to send out maintenance at that hour.

He said he had never heard of any flight crews being pressured to fly with a maintenance issue without checking with a mechanic first.

Mr. MacQueen said there had not been any squawks on the accident helicopter and the most recent maintenance he could recall was December 16, 2011 when they had a mode S transponder installed. He said there were no open squawks and no deferred items.

He said the accident helicopter was in good shape when they leased it. He described it as a “good, clean Jet Ranger”.

Mr. MacQueen stated that the accident helicopter had a Garmin GNS430 but he could not recall if it had a radar altimeter.

He said he never heard any pilots express concern about safety related issues at the company.

Mr. MacQueen said he was out of town, in Virginia, from Thursday before Christmas until Tuesday after the accident and had no interaction with Mr. Smith during that time other than receiving the standard pass down emails that were sent out. He said he thought there may have been a few emails from Mr. Smith during that time but he could not recall.

Mr. MacQueen Stated that he had met Mr. Smith about ten years earlier at Craig and had probably crossed paths occasionally but he had no personal relationship with him.

When asked if he had noticed anything unusual about Mr. Smith's decision making with respect to his vehicle, he said "yes, unusual to me". He said Mr. Smith had an 8 year old pickup truck with over 50, 000 miles on it that Mr. MacQueen and his staff used occasionally. He said Mr. Smith came in about 3 weeks prior to the accident and he noticed that the right front tire had experienced a blowout. He said Mr. Smith replaced only the one tire that blew out. He said he advised Mr. Smith he was not comfortable with him or the staff driving the truck when one tire had blown out and the other three were the same age. He said nothing transpired. He said the week before Christmas he noticed damage to the left rear fender and he saw another blown out tire in the bed of the truck that had damaged the left rear quarter panel. When he asked Mr. Smith about it, Mr. Smith advised him that a tire blew out when he was at high speed on the interstate. He asked Mr. Smith if he was going to buy new tires now and Mr. Smith said he was going to buy one more tire. He again told Mr. Smith he was not comfortable with him or the staff driving the vehicle at highway speeds knowing there were two similarly aged tires on the vehicle. Mr. MacQueen believed the rest of the tires were replaced just before Christmas by Mr. Smith.

Mr. MacQueen stated that he had not heard Mr. Smith mention any concerns about the financial condition of the company.

Mr. MacQueen was asked if he was aware of any previous accidents or incidents at the company. He said he thought there was an AS355 Twinstar that went down off the coast, there was an incident with the prior Agusta, a tail rotor strike, and there was a hard landing with a jet. He said none of those aircraft were here now. He said they still owned the Agusta but it was in a storage hangar somewhere. He did not know the tail number but stated that Mr. Smith advised him he had clipped a bush with the tail after refueling.

When asked, he said he had nothing to add.

Interview ended at 0918.

Interview: Gary Lynn Fernandes Sr., Chief Pilot – SK Jets
Date: January 6, 2012
Location: SK Jets Headquarters, St Augustine, FL
Time: 0941 EST

Present: William Bramble and David Helson - National Transportation Safety Board (NTSB); Leigh McIntosh – SK Jets; Steve Moore – Federal Aviation Administration.

Mr. Fernandes was represented by Mr. Michael B. Ely – Hassell, Moorhead & Carroll.

Mr. Fernandes stated the following information:

He was the chief pilot at SK Jets, Inc. He was not sure how long he had been the chief pilot, but he thought it might have been about four years. He was not sure about his date of hire with SK Jets. It was between 1999 and 2001. He had worked for them when they were called SK Logistics, before the SK Jets d.b.a. was added to the company's operating certificate.

Mr. Fernandes went to college at the University of Florida. He learned to fly and got most of his ratings there. He flew charters for a company called Gulf Atlantic for a few years. Then he became the chief pilot of Air Florida Charter in Orlando from 1997 to 1998 and he began to fly charter as a pilot for SK Logistics. He worked all three jobs for a while. Eventually, he quit his other two jobs and began to fly solely for SK Logistics as a line captain. SK Logistics offered him the positions of chief pilot or director of operations several times and he turned them down. But he agreed to be the chief pilot about three or four years before the accident.

Mr. Fernandes had about 8,000 hours total flight time. He held an airline transport pilot (ATP) certificate, he was a certificated flight instructor (CFI) with a certificated flight instructor – instrument rating, and a multi-engine instructor (MEI) certificate. He held type ratings in the Citation 500 series, Hawker, and Learjet series. He also held a commercial helicopter certificate. He had only about 100 hours in helicopters. He had obtained his private pilot helicopter certificate about four months before the accident, and his commercial helicopter certificate about three months before the accident. Steve Stout had been his helicopter instructor and he had taken his check rides with Scott Lunsford at the Flagler County Airport.

Mr. Fernandes was asked to describe his roles and responsibilities as chief pilot. He said he was in charge of the pilots. He ensured that their training was properly completed and that they were current and qualified for their respective duties. On occasion, he hired and fired pilots. That was generally the director of operations' job, but he had done it at Mr. Smith's discretion. He oversaw scheduling a little bit when it came to deciding which crews were assigned to certain flights, such as those into restricted airports like Aspen. He said he might look at the weather if the crew was junior to see if he really wanted them to take a flight at that time. He had other miscellaneous administrative duties. He distributed the new Jeppesen charts, for example.

Asked whether he had ever been an instructor pilot or a check pilot with the company, he said he was a ground instructor for various training modules. He served as a check airman for the

135.293a company orals and performed the 135.299 line checks in the Learjets, excluding the Lear 60. Mr. Smith did the checks in the Lear 60.

Mr. Fernandes was asked to describe his role in the flight release process. He said Mayo had a whole team of coordinators. When they found an organ that was viable that they wanted to harvest, they would call an SK Jets scheduler and tell the scheduler where they needed to go and when they needed to be there. The scheduler would look at SK Jets' BART computer database and assign the crew that was next up in the rotation. When they did that, BART looked at the flight and the crew and determined whether they would meet flight and duty requirements and whether any of their training was overdue. It would flag any training items that were set to expire the following month. If there were no flags, the scheduler would call the crew and give them the information about the trip so that the captain could do his part of the operational control. Next, the scheduler would call someone who was authorized to release the flight. After obtaining a release, the scheduler would type up everything in a trip sheet and print it for the crew.

Asked what role he played in the flight release process, Mr. Fernandes said he did not have any role, generally. The schedulers knew to call him if was a hazardous airport in the general operating manual (GOM), and in that case they would tell him who the crew was and ask if he had any concerns, but on a typical Mayo flight, they did not call him unless there were other problems with the flight. He was authorized to release flights, and so were Leigh McIntosh, Katie Godwin, Jennifer McKeen, and Mr. Smith, but the schedulers would usually call Ms. McKeen to release the flights. There was not a set rotation for the people who were authorized to release flights.

Asked what he looked for before releasing a flight, Mr. Fernandes said he wanted to know whether the crew had any flight or duty time problems, and whether the airplane met the hour, cycle and date limits. He already knew which pilots were authorized to fly which airplanes, so he did not have to ask about that. Asked whether he reviewed weather, flight planning, or fuel load, Mr. Fernandes said no, the company had a two-tier process described in the GOM. It was the pilot's responsibility to check the weather, aircraft performance, weight and balance, and passenger manifest, but if the captain had a weather concern, he might call Mr. Fernandes. That was the only input Mr. Fernandes might have on that side of the release. Asked how often he was contacted about a weather concern, Mr. Fernandes said roughly once a month, but it might happen three times in three days if bad weather was sitting over the region. It occurred more often with helicopter flights because they were operated visual flight rules (VFR).

Mr. Fernandes was asked to describe the process he went through when he received a call from a pilot about poor weather conditions for a flight. He said that a scheduler would usually call the pilot first. If the pilot looked at weather information and indicated that the weather was not good enough for the flight, the scheduler would call Mr. Fernandes and tell him that the pilot had said so. Mr. Fernandes would then call the pilot, they would explain that the weather was too bad, and he would say okay. He did not push them to take the flights. If they did not want to go, they did not have to. The company would make alternate arrangements to get the team where they wanted to go.

Asked to describe the company's helicopter VFR night weather minimums, Mr. Fernandes said they were 1,000 foot ceiling and 3 miles visibility. Their minimum altitudes were based on Part 135 regulations, 300 feet over congested areas and no minimum altitude over uncongested areas. The day limitations were to comply with the restrictions of the airspace they were in.

Mr. Fernandes was asked to describe the company's procedures for checking weather before a flight. He said they were approved to use four or five different sources of weather, according to the company's ops specs. The pilots were required to check one of those sources, but they could use other sources as a backup. A lot of them used a Helicopter Emergency Medical Evacuation Service (HEMES) weather tool, which was fine with Mr. Fernandes as long as they also used one of the approved sources and relied on it.

Mr. Fernandes did not fly any of the helicopter medical flights as a pilot.

Asked what weather stations the pilots should use for a trip from Mayo Clinic to Shands, he said they should use a weather reporting station that was close to those locations. It was up to the pilot to select them, and they usually checked several. The closest station to Shands was the Gainesville airport. Asked what training the company provided to pilots regarding weather analysis, Mr. Fernandes said that the training was specified in the general training manual and the specific training manual for each aircraft type. Most of those modules were provided as PowerPoint presentations.

Mr. Fernandes said some of the emergency training was done in the classroom and some was done in the airplane, for example removing the emergency exit.

Asked what type of risk analysis training was provided to pilots, Mr. Fernandes said the company had a special segment for that. The Flight Risk Analysis Tool (FRAT) form was included in the General Operating Manual (GOM). There was a form for helicopters and a form for jets. Use of the form was addressed during the PowerPoint training. Crews were required to fill out a form for every flight.

Asked whether pilots received any training on fatigue risk management, Mr. Fernandes said yes, there was a PowerPoint slideshow that was fairly intensive on that, provided by the National Business Aircraft Association (NBAA) and the Aviation Research Group of the United States (ARGUS). The pilots reviewed that PowerPoint slideshow during initial and recurrent training. They should all be familiar with causes of fatigue, countermeasures, and sleep patterns. The training was really detailed.

Asked about company flight and duty time limits, Mr. Fernandes said the company followed FAA rules. Pilots had to receive at least 10 hours of rest in the previous 24 hours before going on duty, and they could not fly more than 10 hours (2 pilots) or 8 hours (1 pilot) in any 24-hour period. Asked whether he ever waived those limits, Mr. Fernandes said he could not and he did not.

Mr. Fernandes was asked whether the company had a fatigue policy. He said that during training, pilots were advised of company procedures for scheduling and told that if they knew they were

close to the first slot and might be called for a medical flight, they should get adequate rest, at least 8 hours, and they should not do any strenuous activities just before a flight. If a crew was assigned to a flight and for unexpected reasons the trip extended beyond the original duration entered into BART and there was only an hour left in a crewmember's duty day, a scheduler would call Mr. Fernandes and he was required to call the crewmember, ask how much they had slept and flown before the trip, ask what their fatigue status was at the moment, and ask whether they felt they could continue the trip and return home. Depending on what the crew told him, Mr. Fernandes would release the crew to return home or tell the scheduler they were too tired.

Asked whether a flight crew had ever told him they were too tired to accept a flight, Mr. Fernandes said yes, he had had one or two of those. He had actually called a scheduler last night and told them he was too tired to be in the first slot for the rotation. If a crewmember said they were fatigued the company did not use them. No questions were asked. They went to the next crew. There was no disciplinary action. If they showed a pattern and did it every week, he might talk to them, they did not have a problem with a crewmember saying they were too tired to fly. Mr. Fernandes recalled a trip six months ago when one of their captains, Dan Firebaugh, was in Ft. Lauderdale and called and said he was getting sick, so the crew stayed in Ft. Lauderdale another day. The company was going to switch the crew, but Mr. Firebaugh called and said he was feeling much better and it worked out fine.

Mr. Fernandes was asked to describe the safety culture at the company. He said all the jet pilots went to training at Bombardier and the helicopter pilots were trained in St. Augustine. The company was ARGUS platinum rated and ISBAO Class II approved. They ranked among some of the highest as far as paying attention to safety and incorporating policies that encouraged safety.

Asked how the company determined what hazards might exist, Mr. Fernandes said there was a safety reporting form and there were several ways to bring safety issues to the attention of management. Pilots could always come and talk to him or the director of safety, or they could use a locked safety reporting box in the pilot ready room. The director of safety had control over that box. Any form that went in there she was required to review. She kept it anonymous who submitted the report.

Asked for examples of safety issues that had been brought to his attention, Mr. Fernandes said there were some little things like brake wear on a tug, and fuel on the hangar floor that might be slippery. More often, he was telling the pilots about various things, like SAFO bulletins from the FAA that he passed along to them. From time to time someone would come in and report something and they would fix it if it needed to be fixed. Asked to list the biggest safety concerns he had right now, Mr. Fernandes said he no particular concerns.

Mr. Fernandes was asked how he was first notified about the accident. He said Ms. McKeen called him to notify him of an overdue condition because the helicopter never arrived in Gainesville. He received that call around 0700 and 0730. He asked Ms. McKeen what she had done, and she told him. Mr. Fernandes called the director of safety who was on a trip but on the ground at the time. They we went over the procedures to initiate their emergency response plan

(ERP) and Mr. Fernandes carried those out to the best of his ability. The ERP was part of the company's SMS manual.

Asked whether he played a role in setting up the accident flight, Mr. Fernandes said he was not sure, but he thought a scheduler, Ms. Adkins, might have called him at 0230 or 0300. He was asleep and he vaguely recalled that she said there was a helicopter flight and she had called Aaron Dyess and he was not answering. He told her to call Mr. Smith and went back to sleep. It was common for a scheduler to call him if they could not reach the pilot on call, because they got a little nervous if they could not reach them. Mr. Fernandes knew Aaron had asked to be off duty and Mr. Smith was covering for him, so that was why he told Ms McKeen to call Mr. Smith. He had no further involvement in setting up or scheduling that flight.

Mr. Fernandes was not familiar with the details of the Mayo contract. He did not know how much SK Jets charged per hour or when the contract was signed. He had never read the contract from start to finish. Chuck and Mr. Smith and probably Katie Godwin took care of everything having to do with that. Asked whether the procedures for setting up Mayo flights differed from others, he said he thought it was the same as all their other medical flights. They flew for Jackson Memorial too.

He did not know whether Mayo conducted audits of their operation. ARGUS performed a biannual audit. Last year the company sought to combine the ARGUS and ISBAO audits because they were long and involved and time consuming. ARGUS did both audits simultaneously. He could not recall what company had performed the audit for ARGUS.

Asked what role he played in such audits, Mr. Fernandes said ARGUS audited each department when they came to visit. Maintenance would deal with a maintenance auditor. Mr. Fernandes and the director of safety would deal with an operations auditor. The director of charter would deal with the scheduling auditor. The audits were very detailed and precise. It was all about procedures. They wanted a procedure for everything, especially when it came to safety. They provided an outline in advance so the company could bring itself up to standard, and then they went over all the company's documents and procedures and made suggestions to bring them up to standard. The platinum rating was very hard to obtain. The audit normally took three days. Three auditors normally came out, one for each department. The last audit was performed about a year before the accident. As a result of the audit, the company maintained its platinum rating and received the ISBAO Class II certificate. ISBAO have given the company a class 1 rating to start and after the audit they awarded a class 2.

The auditors always found a couple of little things that the company had to correct, and if the company met all the requirements, they were issued a certificate. Asked what kind of things the auditors suggested, Mr. Fernandes said they might suggest a word change in a particular paragraph of a manual to make it comply with current business practices, or they might suggest a procedure for something, such as where to park the tug.

Asked whether the company had ever not passed one of the audits, he said he did not believe anyone passed the first time. Most people had no idea how detailed a platinum audit was. Mr. Fernandes said he thought the company did not pass the audit the first time about four years ago

when they first tried for the platinum rating. They corrected the auditors' findings, however, and got the rating within a month. It was pretty typical because the standards were extremely high. The company had passed its most recent dual audit on the first try.

Asked if he could recall anything the company had corrected that had been identified by the audits, Mr. Fernandes said they had corrected little minute things mostly, like where the pilots parked the tug in the hangar, things like that. There had been no major issues. The auditors suggested little things to further increase the safety of the company and avoid possible future problems.

Mr. Fernandes said that Mr. Smith always strived for the highest and the best. Most Part 135 operators had the ARGUS gold rating, the lowest rating, because to get platinum was a major effort. Mr. Smith always strived to get the highest rating, however, even if they did not need it because they could fly for many brokers with only a gold rating. Asked whether the contract with Mayo required a particular ARGUS rating, Mr. Fernandes said he did not know.

Mr. Fernandes flew with Mr. Smith occasionally, approximately once every two months. He and Mr. Smith did not fly that often because they were are a backup crew because they were usually doing paperwork. They had two or three crews that did a lot of the flying. Mr. Smith and he did not generally fly unless the company was really busy and the other pilots were unavailable. In the old days, he and Mr. Smith had been in the rotation, but as the company got bigger, they had to concentrate more on the operation, so Mr. Fernandes had flown with Mr. Smith less and less.

He thought Mr. Smith's flying abilities were fine. He went to Bombardier and passed the same checks as the other pilots. Mr. Fernandes never had any problems with Mr. Smith's flying. Mr. Smith was a procedure man, and he was very knowledgeable about aircraft systems. He would come back from Bombardier and quiz Mr. Fernandes about aircraft systems.

Mr. Fernandes had flown with Mr. Smith in the helicopter. He had ridden with Mr. Smith to the Mayo pad twice in the last two years. The Friday before the crash, Mr. Smith gave Mr. Fernandes a Part 135 check ride in the helicopter. It was local flying. They followed the 8410 check ride form. It went well. Mr. Fernandes passed. They performed the check in the accident helicopter.

The accident helicopter did not have a terrain awareness warning system (TAWS), but it was equipped with a Garmin 430 navigation system that provided information that could be used for terrain avoidance. The unit also showed the pilot the location of towers. Mr. Fernandes did not know if these features were operational in the accident helicopter or not. The company was not required to ensure that those features were available. He had not turned the GPS unit on during the check ride. Most of it was conducted at the airport, and some was performed at a nearby island. Mr. Fernandes did not know if the accident helicopter had a radar altimeter. He did not think so.

Mr. Fernandes was asked for his impression of Mr. Smith's decision making. He said it was as good as anybody's. Mr. Smith had never made a decision with which he disagreed when they were flying together.

Mr. Smith was open to suggestions when flying. He was accepting when Mr. Fernandes expressed his opinion on operational matters. They tried to ensure crew agreement on everything. Every leg, the copilot had to agree that the fuel quantity was adequate. The tried for safety reasons to have two people verify it, and they did not push anybody to do anything they did not want to do. Mr. Smith never pushed him to do anything. Coming back from Puerto Rico once, for example, Mr. Fernandes suggested they stop somewhere for fuel and Mr. Smith said okay.

Mr. Fernandes was asked if he was aware of an incident in 2007 or 2008, involving some type of damage to an Agusta 109 while Mr. Smith was flying. He said he knew of that incident. Brian Bowie, the director of operations, was in St. Augustine. Mr. Fernandes was in Gainesville, so he told Mr. Bowie, "'You handle this one because you are already there.'" Mr. Fernandes stated, "He did everything on that. I didn't have anything to do with that. He filed the reports. Whatever was required." The NTSB report finally came out a few years after because any report that came from the NTSB had an effect on the company's ARGUS rating and he did read the report just to see what the findings were but he did not remember what it said. But he did not have anything to do with it, he was not there, and he did not file any of the reports. Asked whether he was the chief pilot at the time, Mr. Fernandes said, it was possible. He did not recall. He was guessing he probably was. He was not sure. He was guessing he probably was.

Asked whether he took part in any type of investigation of the accident after it occurred, Mr. Fernandes said he talked to Wayne Bradbury (the director of maintenance) a couple times about things where he mentioned to Mr. Fernandes that the helicopter was going to be down for a while, and they were going to come get it on a flatbed. Mr. Fernandes walked into the hangar once and looked at it and there was not a whole lot to see from the outside. He was aware of what was going on, but he did not participate in any of it. Mr. Bradbury and Mr. Bowie took care of it all. Asked whether he had personally received any reports, either written or verbal, expressing concern about the events surrounding the accident, Mr. Fernandes said there was talk amongst the ranks, but he did not know. He did not think anyone specifically came to him. Mr. Fernandes was asked what kind of talk there was, and he said he did not know. He was not privy to it. When it first happened, there might be two pilots standing on the ramp talking and saying, "'Did you hear that, you know, that the helicopter was involved in an incident,'" and he just kept on walking, he did not get involved in that sort of stuff.

Mr. Fernandes was asked if he recalled a former pilot named Jim Holmes. He said he thought Mr. Holmes might have been a helicopter pilot, but he did not remember him specifically. He thought he might have worked for Delta. He said there had been so many people who came through the doors, that he had difficulty remembering. He thought Mr. Holmes might have worked for the company, but he did not recall Mr. Holmes ever coming to him and reporting any safety issues.

Mr. Fernandes was asked what happened to the damaged Agusta 109. He said it was trucked down to Lakeland, Florida and repaired. It was a different model when it came back. He remembered the change in the model designation because he had to revise the training manual. They may have changed some part of the fuselage or the tail boom. He thought it was originally

an A model and it came back as an A2. He had to drive to Orlando to get the new training manual approved by the FAA. Changes to the manual were minor – a hydraulic systems change and a couple of other things.

Asked whether the event in question had resulted in any damage to any trees or structures, Mr. Fernandes said yes, there was a notched-out area in a bush where the tail rotor had hit. He remembered seeing it through the window. He may have walked out on the ramp to take a look at it one time. Asked where this damage was, Mr. Fernandes said it was right on the edge of the ramp.

Mr. Fernandes said he did not know the extent of the damage to the helicopter, he did not get involved in it. Mr. Bradbury would know. He did not get involved in what it took to fix it or repair it.

Asked if there was any additional damage to the surrounding area on the ramp, Mr. Fernandes said that was all he had seen. Someone told him to look at the bush. He was not even at the airport when the event occurred, so he did not even know if the helicopter had caused the damage. One of the pilots might have told him that and he walked out there once and looked at the bush.

Mr. Fernandes was asked to describe the circumstances of the accident. He said he had no idea. He did not investigate it. He was in Gainesville. Mr. Bowie was at office and he said he would handle it. He would take care of it. Mr. Bowie did everything. He reported it. He called Wayne Bradbury. He spoke with Mr. Smith. He participated in any investigation that there was, if there was one. Mr. Fernandes did not have any involvement in it.

Asked whether Mr. Smith was the subject of any action on the part of the FAA as a result of the accident, Mr. Fernandes said not to his knowledge, but he was not involved in it. No one told him that Mr. Smith's certificate was suspended or that he was no longer on flight status. Mr. Fernandes did not ever relieve Mr. Smith from duty in the jets or the helicopters.

Asked how often SK Jets had to receive audits to maintain its ARGUS platinum rating, Mr. Fernandes said every two years. He thought the company had received two audits since it had first received its platinum rating.

Asked whether the company had a separate safety management system (SMS) manual, Mr. Fernandes said yes. It contained all of their policies and procedures related to safety, including accident notification and that sort of thing. Asked whether the FRAT was in the GOM, Mr. Fernandes said yes.

Asked whether Mr. Smith had filled out a FRAT for the accident flight, Mr. Fernandes said he presumed there was one. He did not see it because he was not at the office when Mr. Smith departed. Mr. Fernandes was asked who normally reviewed the FRATs. He said nobody did unless the risk score exceeded a threshold. The pilot completed it and was not required to do anything if it did not exceed the maximum risk number. If the total score was more than 20, they had to call him or the director of safety or the director of operations to discuss whether they

could depart. If the score was more than 45, they were not supposed to do the flight unless some of the risks could be mitigated.

Mr. Fernandes was asked whether the Aviation Digital Data Service (ADDS) was one of the company's approved weather sources. He said no. Asked whether the company had a login for ADDS, he said no. He said that he used FltPlan.com almost exclusively. For backup he used www.weather.com to check general conditions. That was his personal preference. All of the pilots had their backup systems, but they all started with the approved programs.

Mr. Fernandes was asked if he was around the weekend of the accident. He said that he took a check ride with Mr. Smith on Friday morning. He went home to his residence in Gainesville on Friday afternoon and he was in Gainesville until 2PM on Monday. He came back to St. Augustine at that time because of the accident. He stated that he lived in Gainesville and commuted to St. Augustine.

Mr. Smith had told Mr. Fernandes that Friday was his 50th wedding anniversary and he wanted to leave around noon and come back on Saturday around noon. Aaron Dyess had given notice that he was going to be leaving the company, so Mr. Smith wanted to check Mr. Fernandes out as a backup helicopter pilot in case Mayo wanted to be run people up to Mayo from St. Augustine while Mr. Smith was gone. Mr. Smith and Tim Murphy and Aaron Dyess were the three primary helicopter pilots and Aaron was at Eglin Air Force Base and Tim was going to be gone, so Mr. Smith wanted Mr. Fernandes to cover the helicopter from Friday at afternoon until Saturday afternoon. Mr. Dyess ended up coming back to St. Augustine before Friday, so Mr. Fernandes did not have to cover the helicopter, and Mr. Smith had offered to perform the check ride on Friday anyway, so they did it. They had planned to meet about 0900, so Mr. Fernandes arrived about 0800 and studied for the oral exam. Mr. Smith arrived around 0915 or 0930, said he wanted to look at some emails and do some business and went in his office. They did the oral examination in Mr. Fernandes' office for about an hour and then Mr. Fernandes pulled the helicopter out, did a preflight inspection, and Mr. Smith came out and they went over the preflight about 1030. Mr. Fernandes had noted that the tail rotor driveshaft in the transmission bay area had a small amount of fore-aft play in it. Mr. Smith explained that the tail-mounted compressor ran off the drive shaft in the other helicopter, so there was no play, but there was in this helicopter. He pointed out that this was normal. They flew about 1.2 hours in the air, 1.4 hours block time.

When they returned, they put the helicopter on the cart and let it sit outside for a little while. Mr. Smith went back into his office and finished some paperwork. Mr. Dyess popped in and went in his office and talked with Mr. Smith for a while. Mr. Smith left early. Mr. Fernandes was not sure what time. Perhaps around 1400, but that was a guess. He was certain it was before 1700. He did not have any further communications with Mr. Smith.

Mr. Fernandes said he received a pass-down email Mr. Smith sent out after Saturday night. The pass-down was an email the schedulers sent to management to advise them about what happened the night before and whether there had been any flights. Mr. Smith sent it out that day because he was serving as the scheduler that weekend for some period of time, perhaps Saturday night. Mr.

Fernandes could not recall the details of the message. He thought Mr. Smith said he had watered the company Christmas tree.

Mr. Fernandes was asked if he had ever heard about any of the pilots feeling pressured to take a flight. He said no, he never did. Most pilots did not refuse flights unless there was a situation that made them uncomfortable. In those circumstances, he would tell schedulers that if the pilot refused, they should go the next crew. Any pilot could turn a flight down any time they wanted, for example, if they had a prior commitment or did not feel well. Mr. Fernandes was asked whether he would tell the schedulers to call the next pilot if the first pilot turned a flight for weather. Mr. Fernandes said what would happen if there was a weather-related issue was that the pilots would generally call him, either before or afterward. Mr. Dyess had turned flights down and not called him, however. An example would be if there was ¼ mile visibility in Gainesville. Then they did not have to call him. Asked whether he would tell the dispatcher to go to the next crew if the first crew turned down a flight for weather, Mr. Fernandes said not for weather, only if they had other commitments. Once a pilot turned down a flight for weather, the scheduler would call him or the director of safety immediately and they would make alternate plans. They would ask Mayo if they wanted to go on the jet. If not, the company might suggest that they move the operating room time. He might give them an estimate of when the weather conditions were likely to improve.

Mr. Fernandes was asked to describe which specific information in the approved weather sources applied to the company's weather minimums. He said that was the captain's responsibility. The captain either accepted a flight based on the approved weather products or he did not. Mr. Fernandes did not ask for any details. Asked whether a forecast for ceilings below 1,000 feet AGL should mean a no-go, Mr. Fernandes said that would be up to captain. The timing of the forecast was important. There were a million issues that come into play in terms of whether they thought they could complete a trip within the required parameters. If a pilot had concerns, they could call him. He usually just called and asked them what the weather was and they told him and that was it. Asked how he would expect a pilot to apply the weather information if the destination forecast was below company minimums, he said, "I would never know that." Asked whether he had any expectation about how pilots were supposed to apply weather information to company minimums, he said it was the pilots' responsibility to determine if the weather met company requirements. They could either accept or reject the flight. Mr. Fernandes did not get involved in that on a daily basis. That was the policy. Asked what he would expect a pilot to do if the ceiling was forecast to be 400 feet overcast during a trip. He said that the pilot would refuse the flight if he thought it did not meet the requirements of the FARs.

Mr. Fernandes was asked if Mayo passengers had been supportive of pilots' weather-related decision making. He said yes, pretty much every passenger. They were very understanding. If you told them the weather was unsafe, it was done. They were supportive.

Asked how many medical flights per month were conducted by the company, on average, in the last year, Mr. Fernandes said it varied a lot. The director of charter would know. Mayo accepted organs as they were offered.

Mr. Fernandes was asked about the accident pilot's attitude toward flying. He said Mr. Smith loved it. It was a passion for him. Asked to describe Mr. Smith's personality, Mr. Fernandes said he had always admired Mr. Smith's drive. He was always looking for ways to do things better. He wasn't a quitter. Mr. Fernandes liked him. That was why he had worked for him for ten years. Mr. Smith went to NBAA meetings every year, stayed up on current business practices, and wanted that ARGUS platinum rating. He had never noticed any hazardous attitudes in Mr. Smith that were described in FAA pilot training materials, such as anti-authority, impulsive, macho, invulnerable, or resignation. He was just like another line pilot. He was not bossy.

Mr. Smith was healthy. He came to work every day. Mr. Fernandes did not think he had ever seen him with a cold. He did not ever remember Mr. Smith staying home because he was sick. Mr. Smith did not got sick that often, and he had not experienced any recent illnesses. He drank infrequently and did not smoke. He had not experienced any significant recent changes in his health, finances, or personal life, and he had not reported any sleeping difficulties.

Mr. Fernandes was asked if he had ever flown at night with Mr. Smith. He said yes. Asked to describe a typical flight, Mr. Fernandes said that Mr. Smith was always the captain and Mr. Fernandes did the FO duties. Mr. Fernandes filed the flight plan, checked the weather, and obtained any NOTAMS. They would discuss the weather and the NOTAMS. He could not remember any incidents or problems when flying with Mr. Smith. Asked whether he had performed any night flights in the helicopter with Mr. Smith, Mr. Fernandes said the two flights to Mayo they had done together were night flights in the Agusta. The conditions were VFR night. They were transporting a team to Mayo that arrived in St. Augustine on a jet. It was a 13-minute flight to Mayo. Mr. Smith had flown to the hospital with a doctor in the front left seat. After arriving at Mayo, Mr. Fernandes climbed into the front left seat and flew the helicopter back to St. Augustine with Mr. Smith serving as his instructor. Mr. Fernandes did not recall for certain what altitude they used. Helicopter flying was new to him. When the other pilots were flying that route, the helicopter was usually flown at a thousand feet, or perhaps as low as 700 or 800 feet.

Mr. Fernandes was asked about the state of the company. He said it had been declining because of the economy. The company had been growing before the economy started to decline. The company's pilot pay was better than other places he had worked. He had never noticed any problems with morale. He thought everyone got along with everybody else. He thought the size of the workforce was appropriate for the amount of work they had to perform. There had not been any significant recent staffing increases or cuts. One pilot, Mr. Dyess had recently given notice that he was going to be leaving the company.

Asked whether the company provided pilots with controlled flight into terrain or spatial disorientation training, Mr. Fernandes said that part of the 135 check ride involved spatial disorientation. They talked about whiteout conditions and landing in snow. The PTS required them to be able to make a 180-degree turn with a view limiting device and to conduct an ASR approach. The examiner would give headings and determine that the pilot could fly basic instruments.

Mr. Fernandes was asked which helicopter was most commonly used for medical flights and he said the Agusta 109. Asked why that one was preferred, he said it was part of the contract with Mayo that they preferred the Agusta, at least he presumed it was a contract reason or a Mayo preference. Asked how the auto flight features on the Agusta were supposed to be used, he said he did not know. He was not a Part 135 helicopter pilot. That would be up to the pilots. There was no policy.

Mr. Fernandes was asked if there were any particular hazards in the accident area. He said he had flown there and there were a few small areas that they called a black hole that were small, perhaps a mile in diameter, but there were residences scattered throughout that area, with little lights all over. On the other side of the river there was some type of factory one could see from a long way away. The closer one got to Gainesville, the more there were various little towns along the way.

Asked to clarify whether he was qualified to fly the medical flights, Mr. Fernandes said he had not been qualified for Part 135 helicopter until the Friday before the accident. Asked whether he was qualified currently, Mr. Fernandes said yes, but he would not accept any flight except a flight to Mayo and back, or for maintenance.

Mr. Fernandes was asked if he was aware of any past FAA violations at SK. He said he did not know of any pilots who had committed a violation since he had worked at the company. They had hired a pilot who had experienced a TFR violation some years back and had a problem with ARGUS, but no one had had a violation while they were at the company.

Asked why Mr. Smith was so passionate about the platinum rating, Mr. Fernandes said if a broker had a lot of quotes and the prices were similar, they were probably going to use a platinum operator because their safety was supposed to be higher and their processes more in tune with best practices. It was a business tool.

Mr. Fernandes was asked if Mr. Smith had ever failed a check ride. He said yes, about two to three years before the accident. FAA inspector Steve Weaver had come over and Mr. Smith was scheduled to do a Part 135 check ride in the Agusta. On that day, the autopilot would not stay coupled on the approach, so they could not continue the ride until they got the autopilot fixed. Mr. Weaver could not come out for the check ride after they got the autopilot fixed. Mr. Smith decided to fly to Orlando because one of the POIs in Orlando did helicopter check rides and could do it then. They got together and did the check ride. The maximum airspeed for the category A IFR approach was 90 knots. Mr. Smith exceeded that during a simulated approach in VFR conditions and did not pass the IFR portion of the check ride.

Asked whether the Agusta 109 that hit the bushes was N109SK, Mr. Fernandes said yes. The Agusta that the company currently owned was an overhaul of that helicopter. The tail number had changed to 35SK. They had changed a portion of tail boom. The helicopter 35SK was in Lakeland, Florida for maintenance at the time of the interview.

Asked to clarify whether he was the chief pilot at the time of the December 2007 accident involving the Agusta 109 and did not get involved because Mr. Bowie said he would handle it,

Mr. Fernandes said Mr. Bowie lived pretty close to the hangar and Mr. Fernandes was in Gainesville at the time. Mr. Bowie was at the airport or on the way to the airport and said he would take care of it and he and Mr. Bradbury took care of it. They did not ask Mr. Fernandes for help. It was not that big a deal. They pushed the helicopter into the hangar and Mr. Fernandes was not involved in it.

Asked whether there had been any change to the company's training or procedures as a result of accident, Mr. Fernandes said there had been a slight change in the systems training because the hydraulics were a little bit different than in the A2 model than the A model. There were some tiny little differences. He had to change some of their systems training in the manual. Bill Edwards and Steve Weaver had signed off on the changes for him at the Orlando FSDO.

Asked whether there had been any changes to GOM procedures, requiring pilots to stay further away from the bushes for example, Mr. Fernandes said that to him it would be kind of similar to a situation where a pilot taxied onto a ramp and for whatever reason, the wingtip of his plane hit airplane next to him. He said, "That's just like, 'How'd that happen.' We would have a safety meeting and discuss it with the pilot, but probably not change anything." To his knowledge they did not make any changes. Asked whether he had a safety meeting with Mr. Smith, Mr. Fernandes said, "Oh yea, we had meetings about it. That's how I kind of found out about it. I talked to Brian about it several times about when it was going to come back up and I'm sure he told me there were a couple of holes in the fuselage and they were going to have to change that in maintenance and it was going to be a month. I was aware of what was going on globally, but I didn't participate in it. I mean I was talking to Brian. We talked about the incident and how it happened and in my opinion it was kind of a misjudgment issue. The entry that he made, I do it all the time. There wasn't anything illegal about it. I guess he just got a little bit too low too fast and the tail rotor clipped the bushes, I mean is my understanding." Asked to explain what he meant by too low, too fast, he said, "He came over the bush. I wasn't here. I didn't see what happened. We discussed what happened I'm sure. I mean I talked to Brian a lot about it and Brian did all the investigation. Hoke came over the bush and instead of landing here, he landed here. He crossed the bush at an altitude where the tail rotor hit the bush. That's what I mean when I say too low, too fast. I mean maybe he should have been a little bit higher over the bush." Asked whether Mr. Smith was coming in for a landing, Mr. Fernandes said, Maybe he was taxiing. I don't know. Maybe he was turning when he hit the bush. I don't really remember. I know that the tail rotor struck the bush. I don't know if maybe he came onto the ramp and then he was turning, because I didn't get involved in talking to Hoke. We had meetings and it was an incident." Asked whether it was an incident, Mr. Fernandes said he did not know. The tail rotor hit the bush. Brian did it all and I didn't get involved in it to any great extent and the way it was explained to me was it wasn't intentional and Hoke got the tail rotor in the bush. I don't know if he turned and hit the bush. I don't exactly know. I know he was coming I think from somewhere else and now he was landing. Whether he came onto the pad I don't really remember." Mr. Fernandes said it was a long time ago. Asked whether there were witnesses to the event, Mr. Fernandes said there were witnesses, but he did not recall who they were.

Asked what would happen if the weather was clearly too low and a pilot flew anyway, Mr. Fernandes said that was an unfair question because he did not think that could ever happen. If Mr. Dyess was on his way somewhere and someone showed Mr. Fernandes a report indicating

that the weather was IFR, Mr. Fernandes would contact the pilot right away and ask him about the conditions. It was up to the captain to make the final decision about whether it was a go or a no-go.

Mr. Fernandes was asked what his reaction would be if the pilot admitted that they had done it, but they wanted to accomplish the mission. He said that would never happen, nobody would ever do it. Tim Murphy and Steve Stout would avoid the slightest cloud, but if they told him they did something wrong, he would tell them not to fly again, not to leave, and they would have to send another crew. Mr. Fernandes said they once had an issue with a pilot's medical certificate and grounded him immediately and swapped the crew. Mr. Fernandes said he would not let anybody fly if they were trying to do something unsafe. If the weather became IFR, the pilots would land and call him.

Asked whether the releasing officials could release themselves for a flight, Mr. Fernandes said no, they could not release themselves for a flight.

Asked to clarify his earlier comment that Mr. Smith had gotten too low and clipped the bushes, Mr. Fernandes said he was just giving his opinion. Asked whether he was giving his opinion based on the damage that he saw on the pad, Mr. Fernandes said yes, someone had taken him out there and showed him the damage to the bush. He did not know exactly when and where and why the tail rotor hit the bush. Asked to clarify his statement that they used the entry Mr. Smith had used all the time and that he himself had used it, Mr. Fernandes said he was just guessing that maybe that was what happened. It could have been that Mr. Smith was already on the ramp. He did not know. He could not remember. Mostly Mr. Bowie took control of that. Mr. Fernandes just listened because he was not there at the time.

Mr. Fernandes was asked if there was any information he could provide that he thought could be useful to the investigation that he had not already been asked about and he said no. Asked if there was anyone else investigators should speak with and he said no.

The interview ended at 1215.

Interview: Leigh Meryl McIntosh, Captain, Assistant Director of Operations, Director of Safety – SK Jets
Date: January 6, 2012
Location: SK Jets Headquarters, St Augustine, FL
Time: 1230 EST

Present: William Bramble and David Helson - National Transportation Safety Board (NTSB); Steve Moore – Federal Aviation Administration.

Ms. McIntosh was represented by Mr. Michael B. Ely – Hassell, Moorhead & Carroll.

Ms. McIntosh stated the following information:

She was the assistant director of operations, and she functioned as the acting director of operations until such time as the FAA could authorize her to be the official director of operations. She had been the assistant director of operations since November 2008. Her date of hire with the company was February 28, 2006. She had started at the company as a first officer. A year and a half later, in September 2007, she had upgraded to captain. She had been a captain for just over a year when she was offered the position of assistant director of operations. In January 2011, she took on the additional role of director of safety after the former director of safety, Huey Martin, moved on. He was now the chief pilot at an operator at Opelika, Florida.

Ms. McIntosh held an airline transport pilot (ATP) certificate, a commercial pilot certificate with single engine land and instrument ratings, and a Learjet series type rating. Her total flight time was over 4,000 hours. She had about 1,200 hours when she was hired. She had been told it was the lowest amount of anyone who was hired at SK Jets. That was during the boom.

When Ms. McIntosh officially became the director of operations, the company was going to separate that position from the director of safety position. She stated that ideally the director of safety should report to top of management and should be someone independent. That was how it was shown on the chart. As assistant director of operations, she had reported to Mr. Smith.

Ms. McIntosh provided an overview of her responsibilities as the assistant director of operations and director of safety. The assist director of operations oversaw the operation of the company and the director of safety oversaw the overall safety of the company.

Ms. McIntosh was asked how she had dealt with the potential for conflict of interest she mentioned between the director of operations and the director of safety positions. She said it had never come up. Mr. Smith was very into safety. Any problems anyone had would go directly to him. Most came directly to him or the chief pilot. As the assistant director of operations, Ms. McIntosh primarily maintained all the company manuals, including the General Operating Manual (GOM), Safety Management System (SMS) Manual, and training manuals. Her role in updating the manuals did not create a conflict for her as director of safety. It could create a potential conflict for pilots, however, because they needed to feel free to address safety issues

without fear of reprimand, and they should not be hesitant to go to the director of operations. Separation of these duties would be for the company's benefit.

Ms. McIntosh described the safety culture at SK Jets. She said they were oriented towards the ARGUS standards and everything that entailed. Their SMS was based on an ARGUS manual and they had their own manuals for it. ARGUS was one of the leaders in aviation safety, so they were one of the best people to model the manuals after. Safety management was a four block system. There was a safety policy letter in the GOM and SMS manual. It was signed by a top manager, Mr. Smith. There were safety risk management practices, basically the Flight Risk Analysis Tool (FRAT) form, as far as the pilots are concerned. There was safety promotion, which involved top management communicating that they were concerned about safety. There was safety assurance, which involved internal and external audits.

Asked about the interaction between the safety department and flight operations, Ms. McIntosh said she was the safety department. As far as interaction with operations, she was a line pilot too. She was in the cockpit and had flown with everyone at the company. She heard their normal day-to-day talk. They were free to come to her officially, although she was not sure whether that had happened. She sent out safety newsletters every month. The company also had an anonymous box in the pilot ready room where pilots could submit safety reports. She said it did not get used often, but every once in a while it did.

Ms. McIntosh was asked how she identified safety concerns. She said that when they implemented the SMS program, they did an overall audit. That audit was described in the SMS manual. They went over a risk management matrix. After that initial audit, they were looking at small things continually. They performed internal evaluation protocols (IEPs), based on forms ARGUS provided. They consisted of about 10 questions to make sure the company was doing things the best way. If they were not, that item was put on a list of things to be changed. That helped the company keep up with industry best practices because ARGUS was on the cutting edge.

The company also made use of ARGUS's Prism SMS toolkit online, which provided safety newsletters. There was an ARGUS fatigue video that the pilots had to watch. That had come from Prism They had quarterly research briefs. Basically, ARGUS analyzed all the reports of incidents they had received and provided statistics on them. It was an internal aviation safety reporting (ASR) program. SK Jets contributed reports to the system. For example, Ms. McIntosh would submit a report about the accident flight.

Asked what kind of safety concerns had been reported using the box, Ms. McIntosh said there were some before she became director of safety. One involved brakes on the tug and one involved slippery fuel in the hangar. Since she became the director of safety, someone had made a report about where the company vehicle was parked in the hangar. On another occasion, someone reported cutting their finger on a glass in the airplane and they had decided to wrap the glasses in paper towels. Ms. McIntosh had come up with the solution for that problem.

Her primary method of getting safety information out to the pilot group was through a safety newsletter that was disseminated electronically. Nearly all employees had a smart phone, so they

received it on their phone. She also emailed them to notify them about posts to a password-protected pilot web site where they could view safety information. It had headlines and links to information about safety-related information. All manual revisions, including safety manual revisions, were posted that way. The pilots had to reply and confirm that they had downloaded the revision.

Asked whether the company had safety meetings, Ms. McIntosh said they technically had a safety committee, but since she had been director of safety, it had pretty much just been done during management meetings. There was supposed to be a random line pilot involved and she did not think they had included a line pilot in those meetings. They had kind of combined management meetings with safety meetings. They had not done it intentionally, but it had been that way for about a year, since she had started. She remembered attending them as a pilot under the previous director of safety. It had been a suggestion of ARGUS to include a pilot in the meetings, but with the low number of pilots the company had, they were reluctant to call pilots in and interrupt their rest. They tried not to bother the pilots when they were at home. They let them do their thing. Asked to clarify when ARGUS had made that suggestion, she said it must have been the audit before last. Asked whether the company was required to report to ARGUS that they were no longer following that practice, she said no, and they had not. The information still got out informally. In a small company it was not possible to have every single person there.

Ms. McIntosh was asked how often the company held safety meetings. She said they really just discussed safety during management meetings. Informally, they discussed safety matters all the time. Formally, per their SMS program, the meetings were quarterly.

Ms. McIntosh discussed the process for changing company manuals. She wrote the manuals. Before any manual was changed, they had to discuss it with department it would affect. Last year, for example, they had changed something about the fueling procedures and she had consulted with the director of maintenance before the change. Usually it was a combination of her, the director of operations and the chief pilot having input.

Ms. McIntosh was asked about her main safety concerns at the company. She said she did not have any safety concerns. She said she would like to have more safety committee meetings, but she did not feel that having fewer had hurt their safety. Their safety culture was very high or they would not have ARGUS platinum and ISBAO 2 ratings.

Asked to describe the internal audits in more detail, Ms. McIntosh said they were typically ten items that ARGUS gave them via the SMS toolkit online. I would be something like, “Do you have a procedure for X? How is X accomplished?” She would meet with whomever it affected and they would talk about it. Usually it was a short conversation. Most of the time they complied and if not it went on her to-do list of things they needed to add to the GOM. Those audits were performed monthly. They did operations/safety one month and maintenance the next.

Asked whether there were additional audits performed by outside entities in addition to ARGUS, Ms. McIntosh said none that she knew.

Ms. McIntosh described her role in external safety audits. There had been three to her knowledge, and she was part of the last two, as the assistant director of operations. Mr. Fernandes and she had handled the operations portion which was intense. They were definitely thorough. That was why the company's GOM was four inches thick instead of half an inch thick. The last one was done in December 2010. She became the director of safety the next month. As a result of that audit, they had maintained their platinum rating. It had gone smoothly.

Asked whether corrective actions were required as a result of the ARGUS audits, Ms. McIntosh said yes. If they went into any company they were going to find something. The only thing she could think of off the top of her head is that nowhere did the company say in its manuals that pilots were required to wear headsets during critical phases of flight. The only place it was mentioned was in their international operations manual. That had been corrected in the GOM – headsets were to be worn during critical phases of flight. Another one was a word in a safety policy. Instead of "will" it should be "shall." There was nothing major. If it was significant, they would have had to correct it before ARGUS said the company had passed.

Asked what role she played during the 2008 audit, Ms. McIntosh said she was a brand new assistant director of operations, and she was still learning. She was only there half a day during the audit because she ended up flying. She was involved in the preparation for that audit. ARGUS had sent a checklist in advance and they went over it with them from cover to cover and picked out any discrepancies. That was one of the reasons the last audit had gone so smoothly. ARGUS would refer to a page number and the information would be there.

After the audit, ARGUS sent a final audit report. Where ARGUS saw room for improvement, they made suggestions. They did not call them corrective actions. SK Jets had passed its last audit, completed a year earlier. Asked whether ARGUS audit results were available to the public, Ms. McIntosh said she did not know. Asked what kind of contact the company had with ARGUS between audits, Ms. McIntosh said continuing contact came through an online program. ARGUS posted stuff there all the time. They also sent emails providing updates.

Asked whether she was authorized to release flights, Ms. McIntosh said yes. She did not do it often because she was in rotation as a pilot and the company did not want to interrupt her rest. She had not authorized a flight in a long time. That was why they had schedulers who were authorized. The procedures for flight release were spelled out in section A of the manual. Asked whether she checked the weather, flight plan, or fuel loading prior to releasing a flight, Ms. McIntosh said no, that was the responsibility of the pilot in command (PIC). The company's operations specifications said refer to the General Operating Manual (GOM) section A. It was a two-tier release process. The PIC authorized their portion of the release by signing the weight and balance form.

Ms. McIntosh was asked to describe her knowledge of the contract with Mayo. She said she was not familiar with details of the contract. Asked whether Mayo required the company to have a particular ARGUS rating, she said she had no knowledge of the contract requirements. Asked whether Mayo had ever visited the company and done any type of inspection or audit, she said she did not know.

(The interview paused at 1312 and resumed at 1430.)

Ms. McIntosh was asked if she had ever been a company instructor. She said she was a ground instructor. She did not perform any flight training or check rides. Asked what her role was in providing training, she said that the chief pilot was ultimately responsible for the training of the pilots. He did his process, coming up with a list of training that was coming due. If he was not available to do the company ground training, he would ask Ms. McIntosh to do some of it. Asked whether she regularly provided part of the training in her role as director of safety, she said no, there was a safety section in the special sections that was created by the director of safety, but it did not have to be taught by the director of safety.

SK Jets' manuals included profiles for specific maneuvers. That was included in the specific aircraft training manuals. Helicopter maneuver profiles were included. Chapter three provided a description and Appendix A contained the maneuvers. That was an FAA-approved document. Asked whether the maneuver profiles included approach and departure profiles in and out of the company's ramp area, she said she did not know the helicopter maneuvers.

For the last three to four year, Ms. McIntosh had attended annual recurrent training in the Learjet 31A with Mr. Smith at Bombardier. The training had gone well. Mr. Smith was a good pilot. It was fun to fly with him. Training could be fun because you got to do things in a simulator that you did not get to do in airplane. Asked whether Mr. Smith had ever had any problems in training, Ms. McIntosh said no, he was good. Asked whether, to her knowledge, Mr. Smith had ever failed any training check rides, Ms. McIntosh said she had heard he had failed one helicopter check ride, but she had no direct knowledge of it.

Ms. McIntosh was asked which company helicopter pilots had been authorized for instrument flight in the company's operations specifications section H. She said as far as she knew it was just Mr. Smith. She did not know if there had been anyone else listed in the past. Asked how Mr. Smith's check ride failure had affected section H, Ms. McIntosh said that although she had no direct knowledge of the check ride failure, she thought that they did not lose the authorization for Mr. Smith to conduct the company's helicopter instrument flights because he just re-took the check ride and passed it. She did not know how long that had taken. Asked whether the company still had a section H for helicopters, she said no. Asked why, she said that was a question for the chief pilot. The section was removed maybe a year ago. Her understanding was that the reason they did not keep it was because they never used it. It was very rare to fly under instrument flight rules (IFR) in the helicopter and that was all section H covered. It was the equivalent of section C for airplanes.

Asked if she was aware of any accidents, incidents, or enforcement actions against Mr. Smith prior to the accident, she said she had heard about the tail rotor hitting the bush on the company pad. She was not present at the time. All she knew about it was from the rumor mill. Asked whether that had occurred around the time she became the assistant director of operations, she said she did not know when it occurred. She became the assistant director of operations in November 2008. Asked whether she had participated in any meetings or discussions regarding the event, she said no. Asked whether the assistant director of operations might have participated

in safety meetings related to the event, she said that position had been a new position created for her.

Asked whether she had ever flown with a Learjet pilot named Darrin Felton at SK Jets, Ms. McIntosh said yes. Asked whether he had ever talked to her about the event with the tail rotor, she said she did not remember. He had not been there very long. Asked whether she had ever had occasion to fly with Mr. Smith outside of training, she said that she flew with him a couple of times a year outside of training. He was generally the flying pilot when they flew together. She characterized his flying abilities as good. His decision making was good. She had never had any problems in either area. Mr. Smith loved to fly, which was why he flew all of the legs. Nobody else had discussed having any problems or issues with Mr. Smith either.

Asked whether she played any role on the morning of the accident in planning or scheduling the accident flight, she said she had nothing to do with it. She just woke up in Indianapolis on a trip and saw that the trip was on the schedule. That was all she knew about it until the airplane became overdue.

Asked how she was notified about the accident, Ms. McIntosh said that the chief pilot called her and said that they had an overdue airplane. She and the chief pilot discussed what needed to be done, including starting the emergency response plan (ERP). She received the call from the chief pilot about 0730 eastern standard time (EST). Asked what role she played in the emergency response thereafter, Ms. McIntosh said that in the company's ERP, she was the emergency response center director. The backup was Mr. Fernandes. He took that role initially because Ms. McIntosh was on a trip. They had a couple phone calls back and forth, but until she returned to SK, she was flying. She departed Indianapolis for Orlando while the helicopter was still just overdue. When she landed in Orlando, the helicopter had been found and they decided it was best to come home. That decision was made about 1300. At that point she flew back to St. Augustine.

Ms. McIntosh was asked to discuss scheduling policies for crews. She said that she was not a scheduler, but a call would come into the main phone line. There was a scheduler covering the phone line 24/7. The scheduler would find out when and where the flight was to be made, how many passengers, and the type of plane that was being requested. The company complied with 135 flight and duty time limits. The pilot could not work more than 10 hours in 24 hours, they had to have at least 10 hours of uninterrupted rest in the previous 24 hours, and they had to have at least 13 days off per quarter, no more than 35 hours in 7 consecutive days. Asked how closely the company adhered to those rules, Ms. McIntosh said they did not break the rules.

Asked to clarify the nature of the trip she was on, on the day of the accident, she said that they left St. Augustine empty on Christmas day. They went up a day early because it was a long day and they needed to adhere to those time and duty restrictions. They needed to get up there and get to the hotel. Live legs started the next day out of Indianapolis.

Asked whether safety newsletter contents came mostly from ARGUS, she said yes. Asked whether it contained helicopter-specific information, she said sometimes it did. It was a mix. The

most recent issue talked about overruns in Key West, Florida, which was important to SK Jets because they flew there.

Asked to describe any interactions she had with Mr. Smith in the 72 hours before the accident, Ms. McIntosh said her only interaction with Mr. Smith between Friday, December 23, 2011, and Monday, December 26, 2011, was an email Mr. Smith sent her on Christmas Day saying that he had left some money for her in her mailbox to cover some expenses on an upcoming trip she was scheduled to fly. She did not reply to the message. She also received the pass-down email Mr. Smith wrote over the weekend, but that was sent to a lot of people. The last time she actually saw Mr. Smith was at the company Christmas party on December 20, 2011. She had spoken with Mr. Smith a lot in the last few weeks, and he had been in good spirits.

Ms. McIntosh was asked whether she reviewed the FRAT forms and she said that she did. Asked when she typically reviewed them, she said she reviewed them as she received them. Asked when she usually received them, she said when the trip got back, the pilot would include the form with the trip paperwork and the scheduler would put the form in her mailbox, usually the day after the trip. Asked if she ever saw a FRAT from that had been filled out for the accident flight, she said no. It would have been on the aircraft. It was designed to be filled out for each leg and when a pilot returned, they would put it in the box with trip paperwork at end.

Ms. McIntosh was asked about Mr. Smith's personality. She said that he was outgoing, very friendly, and personable. He had a good business sense. He loved to fly. He did not exhibit any of the five hazardous attitudes described in FAA pilot training literature. Ms. McIntosh never had any concerns about Mr. Smith's decision making.

Mr. Smith's general health was fine. He only drank occasionally and she never saw him do it within the timeframe during which he needed to abstain from alcohol before a flight. Asked whether she had observed any recent signs of illness, Ms. McIntosh said no. She was unaware of any recent changes in his health, finances, or personal life. He had not mentioned having any sleeping difficulties. The last leg she flew with Mr. Smith was a quick trip to Nassau and Ft. Lauderdale in October 2011. It was a day trip. They flew a jet. She did not remember the weather, but she did not think it was low IFR. Nothing unusual occurred. It was a standard trip. Mr. Smith was the pilot flying. Asked whether Mr. Smith was open to her input as a first officer, Ms. McIntosh said always, but she did not thing she made any suggestions during that trip. Asked to describe Mr. Smith's general level of flying proficiency, she said that it was where it needed to be to be a professional pilot.

Asked whether she had ever had the opportunity to see how Mr. Smith handled an abnormal or emergency situation in flight, Ms. McIntosh said she had in recurrent training. Asked how he handled such situations, she said they passed the training every year. Asked whether she had seen him handle such a situation during an actual flight, she said no. Asked whether she had ever had to take the controls unexpectedly when flying with Mr. Smith, she said no.

Asked to describe her typical work schedule, Ms. McIntosh said it was hit or miss. She estimated that she averaged 10 trips and about 40 flight hours per month.

Ms. McIntosh was asked if she felt supported when turning down flights for safety-related reasons. She said yes, she had turned down flights for weather on multiple occasions. There had been no pushback from management. Asked whether there had been any pushback from the Mayo Clinic, she said she did not deal directly with Mayo. Asked whether there had been any pushback from Mayo staff on the airplane, she said no.

Ms. McIntosh was asked what she would do if a pilot left without filling out a FRAT form. She said she would call them and ask what their excuse was. Asked what she would say if they told her they did not fill it out because they never came up with too many points, she said most people did not. Asked whether she had ever had to ask Mr. Smith for his FRAT form after a flight, Ms. McIntosh said no. Asked whether she saved the FRAT forms, she said she did not save them officially. She looked at the numbers to see if there was a trend and to see if they were getting high numbers on trips. She also tried to see for the pilot using the form whether it was accurate, and whether they were using it. She had amended some forms.

Asked what position she was in when she had flown with Mr. Felton, Ms. McIntosh said she was the captain. Asked if she could recall why Mr. Felton left the company, Ms. McIntosh said he went to Flexjet. It was a career change. She said she only had a vague recollection of him. Most of the new hires at SK jets had not flown jets before, but he had been flying “heavy iron” before he came to the company, so it was a step down for him. That was what Ms. McIntosh remembered.

Asked if she recalled Jim Holmes, she said that Mr. Holmes’ name sounded familiar, but she could not recall what he looked like or when he was at the company. She said the helicopter guys were their own little clique. Asked whether she had any knowledge why he left, Ms. McIntosh said no, she did not remember who he was, she just recognized the name.

When asked, she said she had nothing to add.

This concluded the interview at 1513.

Interview: Derrick Hoke Smith, General Manager – SK Jets
Date: January 6, 2012
Location: SK Jets Headquarters, St Augustine, FL
Time: 1528 EST

Present: David Helson - National Transportation Safety Board (NTSB); Bill Bramble - National Transportation Safety Board (NTSB); Leigh McIntosh – SK Jets; Steve Moore – Federal Aviation Administration.

Mr. Smith was represented by Mr. Michael B. Ely – Hassell, Moorhead & Carroll.

Mr. Smith stated the following information:

His name was Derrick Hoke Smith and he was employed by SK Logistics, doing business as SK Jets, as General Manager (GM). He said he had worked as GM at SK Jets for 8-9 years. He had started with SK Jets working part-time doing accounting. He said he then took on the position of Vice President and General Manager. He said his responsibilities included billing, accounting, human resources and the administrative work that was not covered by the Operations department because he was not a pilot. He held no pilot licenses or ratings and stated that he knew very little about aircraft. He had no role in the flight operations other than signing the pilots' paychecks. He said flight operations kept him informed but only in a very general sense and that was to verify that flights were getting billed. When asked if that summarized his interaction with the flight operations department, Mr. Smith said yes and added that there was a time when his father, Mr. Hoke Smith [President] or Gary Fernandes [Chief Pilot] decided to get rid of a pilot they told Mr. Smith to break the news. He said that is how he started with SK Jets, his father would ask him to come by and fire someone. He stated that he did not make the decisions, just did the heavy lifting.

When asked about audits, Mr. Smith stated that the Aviation Research Group, United States (ARGUS), International Standard for Business Aircraft Operations (IS-BAO) and the Federal Aviation Administration (FAA) had conducted audits on SK Jets. He said that his role in those audits was that he paid for them and that he was in charge of the drug program so the auditor would simply ask if SK had a drug program, with the exception of the FAA. He said the part of the FAA that does drug enforcement had done two or three audits and they had actually looked at the records so it was more detailed. Mr. Smith was asked about the results of those audits and stated that they passed them all with flying colors.

When asked what role he played in setting up contracts for Mayo, Mr. Smith said he played no role because the relationship had been there prior to him working at SK Jets. He said he had read the contract but could not recall any specific details. Mr. Smith was asked how long SK Jets held the contract with Mayo and he stated that for a long time there was a gentlemen's agreement between Mayo and Hoke and then at some point, around the time Mayo built their new hospital, they decided they needed to do an RFP and an actual contract. Mr. Smith said that SK Jets had had that quite a while too. He said that the contract came up for renewal a while ago and thought

the contracts were for a period of three years. Mr. Smith could not recall the contract renewal process because it was similar for Jackson Memorial and the United States Forestry Service.

Mr. Smith stated that he had flown in some of the company aircraft but never with passengers or on revenue flights. Mr. Smith stated that his professional background included being a public defender in Jacksonville, Florida for two years and a prosecutor in Lake City, Florida prior to that.

When asked about Mr. Hoke Smith's 72 hour history, Mr. Derrick Smith said he was in Pine City, Minnesota from December 21, 2011 until the time of the accident visiting his in-laws. His daughter was staying with Mr. Hoke Smith while he was out of town. Mr. Smith said he had no phone calls within the 72 hour time period because unfortunately cell phone reception was somewhat spotty. He said that the last time he saw his father in person was on December 20, 2011 to open Christmas presents at his father's house before he left for Minnesota.

When asked if he had any concerns about his father's decision making in flying, Mr. Smith stated "none at all." He said he never saw Mr. Hoke Smith berate a pilot for refusing to fly and in fact there were occasionally times that he wanted to, but his father told him it was the Captain's decision. When asked for an example, Mr. Smith said he vaguely remembered when a pilot did not want to fly because of weather and he commented later to the Chief Pilot about why they did not say something about it and his father said the go/no-go decision was up to the captain. Mr. Smith said his father was supportive of the pilots in their decision making. When asked about how many flights SK Jets conducted per month, Mr. Smith said that he would have to look in the records. He also stated that no employee had ever come to him and express any safety-related concerns.

Mr. Smith was asked about Mr. Hoke Smith's general health and he said that his father was healthier that him most of the time. He believed his father was taking blood pressure medication but was not certain. He said that Mr. Hoke Smith did not smoke and drank very little (occasionally wine with dinner). He said he was not aware of any recent illnesses, significant changes in health, finances nor personal life. When asked if his father had any sleeping difficulties, Mr. Smith said no, his father could sit down in a chair and go to sleep if he wanted and wake up wide awake. Mr. Smith said that as far as he knew, his father got a regular night's sleep. He stated that he wished that he had his father's energy. When asked about his father's 72-hour activities, he said all he knew was that his father was home on Christmas day.

When asked if he had ever seen his father handle an abnormal or emergency situation in flight, Mr. Smith responded "not in person." He added that he had flown with him in airplanes as a kid in bad weather and never thought anything about it. He said he had never flown with him in a helicopter in bad weather and in fact the only time he flew with his father in a helicopter was in an Agusta 109 up to Georgia a long time ago.

When asked if the company was in a growth or decline, Mr. Smith said they were in the middle of a recession so they had to keep a close eye on things. He said he assumed the pilot pay was fairly competitive because they did not seem to be losing anyone. He was not aware of the size of the pilot staff but the total staff was about 24. He stated the financial condition of the

company had been better but things were improving. He said they had renegotiated some loans and charter business was starting to pick up. He said the medical business was hard to predict and that they could go periods where there was nothing happening and then a whole bunch at once. He said there was no pattern.

When asked if he was aware of an incident involving his father in the Agusta 109, Mr. Smith stated that there was a tail rotor failure. He said that the weight on the tail rotor came off and it tore the gearbox in half. He said this occurred when his father was taking off and had to turn around and land. He said the copilot onboard the aircraft, whose name Mr. Smith could not remember, commented that he did not even realize there was something wrong. Mr. Smith said he was not at the office when it occurred. He said that a mechanic explained to him that the counterweight came loose. He said other than being able tell it was broken, he was unable to describe any extent on the damage. Mr. Smith thought he recalled that is was a bright and sunny day however it was a while ago. He said that Agusta, the aircraft manufacturer, had to replace the gearbox and other "stuff like that." He said he assumed the insurance company was involved and said the aircraft was repaired and went back into service.

When asked if he was familiar with a former employee by the name of Jim Holmes, Mr. Smith first confused him with a different former employee then said he could not picture him. Mr. Smith was asked if the incident with the helicopter was while ago and he said he did not know and that he had a real vague sense of time.

When asked Mr. Smith said he had nothing to add.

Interview ended at 1630.

Interview: Mindy Burchfield, Procurement Transplant Coordinator – Mayo Clinic Florida
Date: January 24, 2012
Location: via telephone
Time: 0905 EST

Present: Bill Bramble, David Helson – National Transportation Safety Board (NTSB); Leigh McIntosh – SK Jets, Inc.

Ms. Burchfield was represented by Mr. Steven Nelson, Mayo Clinic.

During the interview, Ms. Burchfield stated the following information:

She had worked for the Mayo Clinic Florida in this position for a little more than 4 years and reported to Yolanda Washington Brown. She did not have any employees that reported to her and the Organ Procurement Department had 9 people total including 3 coordinators, 5 technicians, and their supervisors. She said the department was an entity of the transplant center.

Ms. Burchfield described her duties and responsibilities. She said the coordinators took in all offers for organ recipients including heart, lung, liver and kidneys. If they accepted an organ for transplant, her role was to set up their team going out to get the organ, coordinate with the organ procurement organization (OPO) where the donor was located, the times, and coordinate with the transplant team at the hospital. She said she was the middleman between the donor and recipient at the transplant center.

She said the initial notification came electronically through a computerized system. The offer provided everything they needed to know about the donor, and the information was relayed to the physician. Once the physician decided if the organ was suitable for transplant, they could sometimes end up waiting as the OPO set up other organs for transplant or working with the OPO to manage any required tests such as a cardiac catheterization for the heart, and she would also work with the OPO on getting the lab results in the range that was suitable for a transplant organ. She said once they decided to get the organ, she arranged to get the team there at the appropriate time. She called SK Jets to set up transportation. The type of transportation was determined by the type of organ, size of team required. Once the team was set up, she would call the hospital and notify the operating room, surgeons, blood bank, and the floors to let them know a recipient was coming in. She said once the team arrived at the donor hospital, the technicians relayed information about how it was going, how the organ looked, how long they estimated it will last, and the time of cross clamp and cold profusion. She said the clock started ticking at that point and she would relay information back to the transplant hospital to make sure the recipient was going to be ready. She said that was where the coordinator's procurement role stopped, unless something happened such as finding out the organ was not useable.

Ms. Burchfield stated that the type transportation was determined by the transportation company and was dependent upon what they had available and the distance they needed to travel. If it was local, they would drive. If it was farther away, it might be a helicopter or an airplane but it also

depended on weather and how many people were going, and what they had available. She said the mode of transportation was determined by SK Jets in conjunction with Mayo Clinic, telling them how many people were going, where they were going, and the type of organ; if it was a heart, they needed a helicopter to get it back in time.

Ms. Burchfield said that SK Jets was the only provider of transportation and they did 99 percent of the transports. She said about the only time they did not was when the organs were already procured by someone else and transportation was already at the location.

Regarding what mode of transportation was used; Ms. Burchfield stated that they would advise SK Jets that they preferred a helicopter if it was available and SK Jets would advise them what was available. If it was too far away, they knew that an airplane was required. She said they would not drive anywhere that was more than a couple hours away and ultimately, it was SK Jets who told them what they could or could not do.

Ms. Burchfield said that initially she would call SK Jets and let them know what time they needed to be at the donor hospital, how many people were going, and what type of organ they wanted to obtain. She would then discuss with them the available aircraft, how to get the team there, and how to get the team and the organ back to Mayo Clinic. She said the logistics were discussed between her and a coordinator at SK Jets to determine the pickup times for the team.

When asked if flights were ever turned down by SK Jets, Ms. Burchfield said “oh yeah, weather is a big factor for the helicopters”. She said when she called to set up a flight, they would check the weather and to see if it was ok. She said there were also occasions when an aircraft was not available and SK Jets would broker another plane. She stated that sometimes if the weather was not acceptable, SK Jets would inform them that they would need to delay the flights due to weather and she would have to delay the operating room times.

Ms. Burchfield said that she had no role in flight planning or checking weather for a flight and that Mayo had no criteria for weather minimums to conduct a flight. She said they left that up to SK Jets. She said she had no role in any type of flight planning regarding altitudes, routes and that she had not received any training on air traffic control services or aviation weather information.

Ms. Burchfield stated that Mayo Clinic did not have a manual or written guidance for coordinators on how to arrange a flight. She said the process was guided by experience in determining what the needed and when they needed it.

When asked if Mayo Clinic had any type of formal safety reporting system, she stated that they had one, but she could not recall exactly what the procedure was. She stated that people would bring up safety issues and it would go up the chain of command. She said they had an incident reporting form they could use but she was not sure if that would be used, or if people would just go directly to a supervisor with a safety issue. She said she felt comfortable using either method to report a safety issue.

When asked if she had heard any transplant team members express concern about the safety of the flights, she stated that she had heard of a few incidents second hand. She said she had heard about one incident from Dr. Stephanie Blanken who told her about a hard landing at the Mayo Clinic helipad where the helicopter almost hit the side of the building or just came down really hard. She also recalled that doctors or technicians had reported a couple of instances of hitting deer or birds on the runway in St. Augustine.

Regarding the incident Dr. Blanken had told her about, Ms. Burchfield recalled that it had occurred a couple of years earlier and it was such a hard landing that it had shaken the doctor up a little bit. She thought David Hines might have been on that flight as well, but she did not know who the flight crew was.

Ms. Burchfield said she had not heard of any other safety concerns about the flights and she had not heard any of the team members express concern about flying with any particular crew or individual. She said that as far as she knew, everybody felt very safe flying with SK Jets. She said "you hear little things" but everybody felt safe.

Ms. Burchfield stated that she was not the person that dealt with the contract between Mayo and SK Jets and she was not sure of the terms. She did not think the contract stated that SK Jets was the sole provider of transportation, but they did treat them that way. She thought there was nothing restricting them from using a different provider but she was not familiar with the exact wording in the contract, as she was not responsible for that.

She said she had not been involved in any audits of SK Jets. She stated that they had sent out a request for information about 2 years before the accident when it was time to renew the contract with SK Jets. She said she had sat in on a committee that reviewed the information. Everything requested had been received and they looked it over.

Regarding the day of the accident, Ms. Burchfield said she had been working on the case all of Christmas day and she knew that they were going to be getting a heart and liver. Throughout the day, they had been waiting on test results for the heart. Once the OPO got the test results and had all of the organs placed for transplant, the OPO coordinator (Lisa) called at 0018 to advise that they were ready to set an operating room time of around 0600. She said the ORO had to give them at least 4 hours notice in order to get everything ready, so they had plenty of time. She said she called SK Jets to set up transportation for both teams (liver and heart). She said that for the liver they always planned on sending a surgeon, assistant, and profusionist. She said the assistant was usually a fellow, resident, or technician. The thoracic team depended on who the surgeon was. If it was Dr. Blanken, who usually flew out for thoracic procurement, she always wanted an assistant. Sometimes there was an assistant and a profusionist. She said that in the case of the accident trip Dr. Bonilla was on call and this was only the second time he had gone out by himself. She said there was supposed to be another thoracic team there from Duke to procure the lungs, and they were going to have some help. She stated that because of this, she initially set up just the surgeon and profusionist, so the thoracic team had two people going and the abdominal team had three.

Ms. Burchfield said that the liver could survive longer after it was out of the body, and with Gainesville being so close, flying would only saved about 10 minutes total time but it cost a lot more. She said they usually drove to Gainesville for an abdominal team but they almost always sent a thoracic team by air, at least on the way back. She said they had previously used the Agusta. If the Agusta was available, the abdominal team might go in it, but they would never go in the Jet Ranger because it was single engine and the timing was not as critical for a liver. She said the heart team could not drive because it was so time critical.

She stated that when she set up the accident trip, she called Rita at SK Jets and advised her that the operating room was scheduled for 0600. She arranged to have the abdominal team picked up at 0400, and the thoracic team to be picked up at 0515. She said that, initially, Dr. Bonilla had told her he wanted an assistant so she was going to start rearranging the transportation since they had a new jet ranger and not the helicopter they were used to. She said technicians had advised her that the new helicopter was too small for three people and their equipment. She said that before she changed the transportation, however, Dr. Bonilla called her back and said he did not need an assistant, just a profusionist. She said at that point, she started to call everyone; Dr. Nguyen, his assistant Anna, and his profusionist Sherry. She said when she started to make the arrangements, it was right after midnight and she had originally called Johnny to go with Dr. Bonilla but he had advised her that David was on call after midnight, so she called David. She said if Dr. Bonilla had needed an assistant, they both would have gone. She said once she had the team set up, she started making calls to the hospital to set up the transplant. She said to set up a transplant she had to post it with the operating room, and call the surgeons that do the transplants, the assistants, the blood bank, and let the floors know what time the transplant would occur. She said all of those calls were made after midnight, and then she went back to sleep.

Ms. Burchfield said the next call she received was from David at 0516. She said he was the profusionist and he had called her from his personal cell phone to advise her that the helicopter was not there yet. She said she thought that was very unusual, because they were supposed to be there at 0515 and they were never late. She said they were always early and she could not think of a time when they had been late before. She said she did not know if he had received another call but he advised her thereafter that he had talked to someone at SK Jets and the helicopter was on the way. She said she advised him to let her know of any further delays because she had to set up the time when the heart would be back so that the recipient would not be in the operating room too early. She said she did not hear from him again and that he had not given her any other information about who he talked to or who the crew was for the flight. She said she did not have any other contact with SK Jets that night and that she would have called them about the delay if David had not already talked to someone.

Ms. Burchfield said that she had not ever been on one of the organ procurement flights. She said that she had gone on one driving trip but no flights. She said she had never gone on a helicopter or airplane flight with SK Jets.

Ms. Burchfield said ground transportation was provided by SK Jets, but they never drove to Gainesville for a heart. She stated that it took about 1 hour 40 minutes to 1 hour 45 minutes, depending on traffic, to drive from Gainesville to Mayo Clinic. She stated that to take the plane, it was about 1 hour 25 minutes to 1 hour 30 minutes total, which included a 45-minute drive to

St. Augustine, a 25-minute flight, and another 15-minute drive to the hospital. She said that it was about 40 to 45 minutes to fly from Gainesville to Mayo Clinic in the Agusta or the Jet Ranger.

Ms. Burchfield said she thought that they wanted to have a heart recirculating and beating within 3 or 4 hours at the most, preferably within 2 or 3 hours, but a surgeon would be better able to determine that. She stated that Dr. Landolfo, Dr. Agnew, and Dr. O'Dell were the heart transplant surgeons.

Ms. Burchfield said that she did not know the pilot, except through work, and she had never flown with him. She stated that based on the little interaction they had, she thought he seemed like a very nice guy.

Ms. Burchfield said that she called Rita at SK Jets about 0020 and advised her that they needed to be at Shands hospital at 0600. She said Rita told her that the Jet Ranger was available and the abdominal team could go by plane or car. Ms. Burchfield asked if the Agusta was available but it was not. The Agusta was supposed to have been out for only a few weeks, but it had actually been unavailable for about 5 or 6 months. She had heard it was out for certifications.

Ms. Burchfield stated that David was a profusionist and Johnny was both an assistant and a profusionist. She said that three of their five technicians were qualified to do both. She could not recall David's background but said he had a lot of OR experience, and she thought he was a "scrub tech".

Ms. Burchfield said that Dr. Nguyen was an abdominal surgeon and the head of the transplant surgeons. He was going to be procuring the liver, Anna was assisting, and Sherry was profusing. Rob Fox was set to be assisting the heart transplant surgeon.

Ms. Burchfield was expecting David to call her with a visual on the heart around 0645, which was when the surgeon would have opened the chest and determined that the heart was good. She stated that, based on that time, she had estimated that the heart would be back to Mayo at 0915. She went off duty at 0700, and that was when she realized something was wrong because she had not heard from David.

Ms. Burchfield said that she was expecting the helicopter to land with the heart at Mayo about 0915. She said they did not discuss the heart times with SK Jets. They only advised them when the team needed to be at the donor hospital.

She stated that Dr. Blanken worked at Mayo Clinic.

Ms. Burchfield said she was not aware of any staff or technicians saying they did not feel safe flying with SK Jets and she was not aware of any staff or technicians saying they had felt unsafe in any particular aircraft before the accident.

She was not aware of any times that SK Jets was willing to take a flight but the medical staff had refused to fly.

Ms. Burchfield was asked how many trips were arranged each month. She replied “a lot”. She said they did about 30 to 40 transplants each month split between the three coordinators. She said some were local and some were brought in from farther away.

Ms. Burchfield said her shift was on the weekends, and it started Friday at 0700 and went until Monday at 0700.

She stated that she did not recall telling SK Jets on the night of the accident that the time frame was more critical for the heart than for the liver but it was understood.

She said that they called SK Jets for just about every one of the transplants unless there was a donor at Mayo Clinic. She said, however, that they did not use SK Jets for kidneys, because they were usually flown in by someone else arranged by the OPO.

When asked she said that she had nothing to add.

The interview ended at 1015.

Interview: Brian Paul Bowie, Former Director of Operations – SK Jets
Date: February 23, 2012
Location: via telephone
Time: 0805 EST

Present: Bob Gretz, David Helson – National Transportation Safety Board (NTSB); Bob Hendrickson – Federal Aviation Administration (FAA).

Mr. Bowie stated that he did not want representation for the interview.

During the interview, Mr. Bowie stated the following information:

He was employed as the chief pilot at Maximo Air and had worked for SK Jets from about November 2001 until November 2008. Prior to working for SK Jets, he had worked as a flight instructor for about 3 years and conducted Grand Canyon tours. He had also worked at Transtates Airlines for about 5 years, where he was the chief instructor in the ATR. He worked for Midway airlines, based out of Raleigh Durham until they went out of business about 6 months later and then he was hired by SK Jets in 2001. He estimated that he had logged about 9,000 hours total flight time, all in fixed wing aircraft.

Mr. Bowie said he was initially hired by SK Jets as a first officer (FO) flying Lear Jets. He liked helping in the office and was eventually upgraded to captain (CA) and then became the director of operations (DO). He said he flew all of the company Lear jets except for the Lear 60.

Mr. Bowie said that he left SK Jets because the economy was starting to look bad and he thought the company should have been focusing more on sales but they were not. He said the company was not going the direction he thought it should be going so he left to accept another job as chief pilot of Maximo Air.

Mr. Bowie thought the safety culture at the company was good and that they had always strived to improve it. When he was first hired, it was a small company but it grew and they tried to grow the safety program at the same time by introducing a SMS (safety management system) and by taking part in ARGUS (ARGUS International, Inc) audits.

He said they took training very seriously and that at one point they had hired an instructor to conduct all of the flight crew training.

Mr. Bowie said the biggest safety concerns at the company had been time and duty issues. He said they were always pushing time and duty to the maximum and it was a challenge to come up with plans to cover medical flights when crews were near 14 hours of duty. He said it was very fast paced and that many times the medical flights occurred in the middle of the night. The schedule and rushed nature of the medical flights was the biggest challenge. He said the company maintenance was good and there were no worries about maintenance issues.

Mr. Bowie said they would try to make the flights legal by holding the aircraft back or in one case he recalled there was a medical flight and they would have them fly somewhere in the morning to stay in a hotel until a scheduled flight at 5:00 in the afternoon in order to force the crew to be legal for the late afternoon flight. He thought it would have been more prudent to send the crew the night before to get a good night sleep instead of having to try to get sleep in a hotel in the middle of the day.

He said they had to look at the scenarios as they popped up trying to reduce the time and duty issues and to plan the crews so as to have crews available that would be able to stay within 14 hours of duty time.

He said they tried to keep a couple of crews in reserve based on what was going on but they had a lot of charters at the time. The medical flights were tricky because they were unplanned and they could have zero on one day and then have six all in a short time frame.

Mr. Bowie said they scheduled the flight crews on a rotating call basis using a 10 hour look back for rest. He said they really could not assign rest periods because they did not know when the work was going to be there. He said they used a basic rotation and focused on making sure each crewmember had 13 days free from duty in each quarter. He said they did not schedule rest periods where a crewmember was free from being on call but they made sure they got 13 days off in each quarter free from being called for work. He said when someone was called for a trip, that was when they looked back to see if they had 10 hours rest prior to starting. He said they knew it was not the best scenario, but it was really tough to cover the medical flights.

Mr. Bowie said that if a pilot called in tired or fatigued, or did not want to take a flight due to weather, he would not make them go if he was consulted. He said there were occasions when it had happened. He said sometimes they had extra crews to cover if someone was too tired to fly, and if an inexperienced captain was uncomfortable with weather conditions, sometimes they would ask a more experienced captain to take the flight.

When asked about pressure to fly, Mr. Bowie said there was always pressure from Mayo Clinic to complete the medical flights but it was based on the need to do the medical flights in a timely manner and did not necessarily come from any person. He recalled for example, a time when there were medical flights to do but hurricane Charlie was moving through the area and it was not safe to fly. He said another time there were medical flights to North Carolina but there had been ice storms there and it was not safe to fly. In that case, he recalled that they delayed flights for about 24 hours. He stated that there was not pressure from any one at Mayo Clinic; it was more just pressure to complete the mission. He said they would sometimes look at other options like flying into Jacksonville International if the weather was bad in St. Augustine.

Mr. Bowie said that when he was the DO, he never made anyone fly when they should not. He said there was not any direct pressure from Mr. Hoke Smith either except that he wanted them to complete the missions. He said most of the time they could make it work in the jets but it was more of a problem with weather in the helicopters. He said if a pilot did not want to take a helicopter flight due to weather, then Mr. Smith would take it since he was the only instrument

rated helicopter pilot. He said they would offer it to one of the regular pilots first, but if he did not want to take it they would call Mr. Smith.

Mr. Bowie said there had been some accidents and incidents at SK Jets. He recalled that when he had only been at the company about 5 months, there was a helicopter the crashed off the coast of Savanna and later there was a Lear 25 that flamed out both engines on final approach then had a hard landing. He said Mr. Smith had an accident with a helicopter in 2007 when he mis-judged some bushes and there was also an occasion when an airplane hit a deer.

Mr. Bowie said he was the DO when Mr. Smith hit the bushes. He recalled that the weather was not very good and they had offered the flight to another pilot who refused to go, so they offered the flight to Mr. Smith, since he was instrument rated, and he said yes. He said Mr. Smith departed on the flight but came back because the weather was bad, and then hit the bushes on the way back.

He said the options were to use an ambulance or to use the Agusta and that Mr. Smith had decided the weather was good enough to go in the helicopter. He said that Mr. Smith came back because he determined the weather was not going to be VFR (visual flight rules) at the Mayo Clinic helipad and he would not be able to land there as they could not land in IFR (instrument flight rules) weather at the helipad. He stated that if they knew it was IFR the whole way, they would use an ambulance.

Mr. Bowie said he went out afterwards to look at the helicopter. He said the tail rotor had hit the bushes and a couple of pieces of the rotor had broken off and gone through the skin of the tail. He said at the time he had looked through the NTSB regulations and based on the damage that he saw, he did not think it was a reportable event. He said later they determined it was and ended up reporting the event late. He said they learned from that occurrence that they should just call the NTSB to get help in determining if an event needed to be reported. He said he thought the regulations had changed since then to clarify the wording on what needed to be reported but at the time; his interpretation was that it was not a reportable event.

Mr. Bowie said he was not involved in any follow up action and he recalled that there had been no enforcement action taken against the company or the pilot that he knew of. He recalled that the POI (Principal Operations Inspector), Bill Edwards, had advised them to report all occurrences in the future.

Mr. Bowie said that he knew Mr. Smith “pretty good” and that they had a business relationship. He said while he was the DO, he had constantly tried to improve the company and that Mr. Smith mostly stayed out of it and let him do what he wanted as DO.

He stated that he had flown with Mr. Smith a few times, mostly as an FO, when Mr. Smith was giving him line checks. He said aside from the line checks, when he flew with him, Mr. Smith was usually the pilot flying when there were passengers on board. He said he thought Mr. Smith’s flying skills were “OK” and that he did not see any major issues. He said that he had an airline background so one of the things he had noticed with everyone in charter flying was a lack of CRM (crew resource management) and lack of crew mentality. Regarding Mr. Smith’s

decision making skills, he said that he never saw an issue with that and that Mr. Smith had never done anything that made him nervous.

Mr. Bowie said that he thought Mr. Smith was a strong willed business person but when he was flying, he was easy to get along with. He said if Mr. Smith was ever to "get on you a little" it was about customer service and dealing with the passengers, and not about flying. He said Mr. Smith mostly flew most of the time when the passengers were on board but later on started letting others fly more.

Mr. Bowie stated that he was involved in the process of preparing for ARGUS audits. He said he did not get involved in the safety department and SMS but was mostly focused on the operational issues and making sure the company met the required standards such as mountain airport restrictions; for example. He said the audits by ARGUS included thorough inspections of records, procedures, the GOM (General Operations Manual) and other manuals as well as interviews with various people at the company. They also did an operational control audit of their dispatch department. He thought the audits were modeled after Department of Defense inspections as the auditors had a background in that area.

He said he was not aware of any audits or inspections conducted by Mayo Clinic and he had no involvement in negotiating the contract with Mayo.

Mr. Bowie stated that when he had decided to leave the company, the economy was not doing well and he thought the company should have been more aggressive in selling flights. He said they were not doing that. Instead they were focusing on saving money and actually downsized by getting rid of sales personnel. He stated that he wanted some stability so he started looking for something else and ultimately left to take the chief pilot job he has held since then.

Mr. Bowie stated that the individual who first turned down the flight when Mr. Smith ended up hitting the bushes was James Holmes. He said it was hard to describe Mr. Holmes. That he was not really a trouble maker but he was not a team player. For example; he said when a flight was to be cancelled due to weather, most other pilots would help look for alternative solutions but Mr. Holmes would just say "no".

He stated that as DO, he had always been supportive of pilots who said they could not take a flight due to weather.

Mr. Bowie stated that ARGUS conducted audits of the company every two years and that he had been at SK Jets for two of those audits. He said they always found a few items in an audit that needed to be corrected. He recalled that in the first audit he was involved with; most of the issues were related to SMS since it was fairly new at the time. They corrected those issues and then there were more, minor issues, on the next audit. He said the company ended up buying the ARGUS developed SMS program since it was approved already. He recalled that the cost to purchase the SMS program from ARGUS was about $6,000 but he could not recall if that fee was annually or if it covered two years until the next audit.

Mr. Bowie recalled that he was at the company for an audit in the summer of 2006 and another in 2008. He thought the first platinum rating was earned in 2006 and renewed in 2008 but was not sure. He said the audits were conducted over a 2 or 3 day period and included an auditor for maintenance, one for operations, and that there may have been a third one as well.

Mr. Bowie thought that the audits cost about $10,000 but he was not sure who paid for them. He recalled that Sentient Jet may have paid for the first ARGUS audit at SK Jets because SK Jets had a contract to cover flying for Sentient and an ARGUS rating was required to cover the flights.

When asked if ARGUS considered previous accidents and incidents in the audits, Mr. Bowie said they did and that they also looked at pilot records too. He stated that if there had been an accident where the company was at fault, he thought they would lose the Argus rating. He stated that a pilot could lose an ARGUS rating for up to 3 years following an accident or a violation and if a pilot lost his rating, he would not be able to conduct any flights where ARGUS qualification was required. He stated that he was not aware of Mr. Smith's status with ARGUS after his accident. He recalled that ARGUS had asked in the audit about Mr. Smith's accident but he could not recall if they had inquired about the accident near Savanna or the Lear Jet hard landing.

Regarding the accident Mr. Smith had in 2007, Mr. Bowie could not recall if he had flown an instrument approach into the airport. He recalled that Mr. Smith had flown to the ramp and spun around and hit the tail rotor on the bushes or that he flew in over the top of them; he was not sure.

Mr. Bowie stated that when the pilots were on call, they scheduled them on a "straight rotation" and if a flight came up, they were pulled off rotation. He said the medical flights were a problem to schedule and if you were first in the rotation, you were probably going to get called. If you got to sleep through the night without getting a call, you were happy. He said the flight schedule was unpredictable and they might have none for a few days, followed by six in a short period of time.

When asked, he said he had nothing to add.

The interview ended at 0920.

Interview: Darin Edward Felton, Former Employee – SK Jets
Date: February 23, 2012
Location: via telephone
Time: 1300 EST

Present: Bob Gretz, David Helson – National Transportation Safety Board (NTSB); Bob Hendrickson – Federal Aviation Administration (FAA).

Mr. Felton stated that he did not want representation for the interview.

During the interview, Mr. Felton stated the following information:

He was a managing partner at Heritage Cremation and Memorial Chapel in the Daytona Beach area. He said he worked for SK Jets / SK Logistics and started there in about October 2007. He first went to Bombardier in Dallas to receive his Lear Jet training then started flying at SK Jets in December 2008. He stated that he worked there for about four months and referred to a resignation letter drafted by his attorney and dated March 26, 2008.

Prior to SK Jets, he said he worked in central Missouri for a part 135 charter company flying Navajos and Chieftains. He went to Embry-Riddle Aeronautical University to complete his bachelor degree and then worked at Custom Air Transport flying a 727. He said once they went out of business, he went to work at SK Jets, then worked at Flex Jet until he was furloughed a few years later. He estimated that he had logged over 3,000 hours total flight time in fixed wing aircraft and about 1 hour in rotorcraft.

Mr. Felton said he left SK Jets because he felt there were a host of safety issues that he was concerned about. For example, he said there was an aircraft that had a repeated problem with a fire warning light going off in flight and the chief pilot had told the pilots to just cover it with a post it note. He said he was also concerned about flight time and duty issues and on the day of his first flight at the company in December 2007, the owner Mr. Hoke Smith had an accident in a helicopter. He witnessed the accident and afterwards heard a mechanic say he had been advised to put the helicopter in another hangar, cover with a tarp, and not report it to anyone. After he heard that, he called the FAA hotline to report it.

Mr. Felton said that he was advised by Mr. Derrick Smith and Mr. Gary Fernandes that any written report provided to the FAA regarding the event had to be reviewed by them first.

Mr. Felton stated that on the day of the accident in 2007, he was the pilot not flying in the right seat on a Lear Jet flight to St. Augustine (SGJ). He recalled that they had conducted an ILS approach into runway 31 and they broke out of the clouds right about minimums on the approach. As they taxied too the hangar, he said he and the other pilot were shocked to see the Agusta helicopter there with rotor turning. He did not know how it could fly with the weather at the time. He stated that they taxied in, unloaded the passengers (an organ procurement team) and

organ and then loaded them onto the Agusta and they took off with Mr. Hoke Smith on a flight to Mayo Clinic. He said another pilot, Huey Martin and the night manager Mike Dighton were there as well. He said they were all in shock that Mr. Smith would take off in that kind of weather. A few minutes later, Mr. Smith returned.

Mr. Felton said the helicopter came down the runway, made a turn toward the hangar ramp, then turned and the tail rotor barely missed the fuel farm and then struck some bushes on the edge of the ramp. He said the helicopter immediately climbed up about 20-30 feet then came shuttering back down to the ground. He stated that Mr. Smith climbed out of the helicopter and "walked off cussing". Mr. Felton said the rotor was still turning and he went over to help the people out of the helicopter. He said he was about 6' 4' tall and was concerned the people could get hurt because the helicopter was tilted so the rotor was low enough that he had to duck under it. He said Mr. Smith came back a few minutes later with his car to take the people and the organ to Mayo Clinic.

Mr. Felton said this all occurred early in the morning and there was debris all over the ramp from the rotor cutting up the bushes. He said on his way home, he called Mr. James Holmes to tell him what had occurred. Mr. Felton said he came back later in the afternoon and the ramp had been cleaned up and the bushes had been trimmed down to below the level where the rotor had hit them. He was advised by a mechanic that the NTSB was supposed to come over soon to investigate the Lear jet hard landing, so they were instructed to move the helicopter and cover it up.

Mr. Felton recalled that later in the week, or the next week, after he learned that it was being covered up, he called the FAA hotline to report it. He thought that he had left his contact info on the hotline and that the POI (principal operations inspector), Bill Edwards called him later to discuss it. He said he also sent Mr. Edwards a letter describing the event and recalled that they had a few discussions about it. He also talked to Mr. Edwards about the flight time and duty time issues and reported that the pilots had been advised not to write up any maintenance discrepancies in the aircraft logbooks. He said they had been advised by the company to just write up issues on post it notes and leave them in the logbook so they could decide when or if they would address the maintenance issues.

Mr. Felton stated that a month or two later he was scheduled to fly an airplane with no nacelle heat and that when he said he did not want to fly it the chief pilot, Gary Fernandes, asked him "if he would rather lose his job". Mr. Felton stated that this type of behavior was more the rule than the exception at SK Jets.

Mr. Felton said that the company had two lawyers that would constantly try to intimidate the younger pilots and used PRIA (pilot records improvement act) background checks and erroneous reports to pilots' prospective future employers to hinder their careers. As an example, Mr. Felton stated that when he left SK Jets, his next employer conducted a PRIA background check. He found out that SK Jets had advised his new employer that he was denied an upgrade to captain while working at SK Jets, when he had not even been offered that opportunity while he worked there.

Mr. Felton said that he had also called ARGUS to notify them that he believed SK Jets was falsifying flight time records and that some of the pilots did not have enough flight time to meet the ARGUS minimum requirements. Specifically, he stated that three captains, Huey Martin, Craig Grass, and Leigh McIntosh did not meet the ARGUS minimums and when he had talked to them about their flight experience, they had told him they were advised not to discuss it. He said it was an issue because the company had a contract to fly for Sentient Jet, and the contract required that pilots meet the ARGUS minimums. He said he also advised the POI, Mr. Edwards that they should not be in business because they were unsafe.

He stated that people at the company had wondered why Mr. Smith's wife drove him to work at night and he had heard that Mr. Smith had a night driving restriction on his driver's license due to a vision problem.

Mr. Felton described the work schedule as "7 days on and 7 days on". He stated that pilots were on call continuously and if they did not get called, the company would define that time as a day off after the fact. He said he emailed the chief pilot to voice his concern and to try to get the policy in writing but the chief pilot would never respond in writing, only verbally. He stated that the chief pilot would publish a memo detailing the proper interpretation of rest rules but verbally tell the pilots to do something different.

He said that if a pilot was called out for a flight, the company would schedule them for 10 hours rest when they returned. He said that when on call, once a flight was assigned, they would look back 10 hours to define the rest period.

He stated that the company pressured pilots to take flights and if they did not, they would fire them and then make the pilots pay back a training contract. He said that the training contract was about $11,000 and he thought it covered two years. He said when he left; he was required to pay back $3,500 when he left the company.

Mr. Felton could not recall ever flying with Mr. Hoke Smith, said he had a professional business relationship with him, and described him as a "cowboy" and a very "bold pilot". He said that there was not any direct pressure on the crews from Mr. Smith; it came indirectly through the chief pilot.

Regarding the accident in 2007, he was asked if was told by any of the passengers why the flight turned around. He said he thought Mr. Smith was flying VFR (visual flight rules) and he was told by others that the transponder was turned off. He was also told that he could not get altitude due to the weather and there was a tower a few miles north of the field that he was concerned about.

He said the weather was about 300 foot ceiling and 2 miles visibility and that Mr. Smith had not done an instrument approach when he came back.

He said he thought he had mentioned the hotline call to other pilots and that may have been how the chief pilot knew it was him. He said there was also information that he shared with Mr.

Edwards that the company somehow found out that he had told him. He said that after the chief pilot found out that he had called the hotline, his schedule went “from bad to worse”.

Mr. Felton was asked to clarify the intimidation he had mentioned earlier. He stated that it was not any one particular thing but that the company might downgrade a pilot, not upgrade, or they might get assigned all of the unfavorable trips.

He said that everyone was exhausted on a regular basis and most of the pilots, except the ones that were upgraded with low experience, were concerned about safety.

Mr. Felton said the director of operations at the time was Brain Bowie and described him as “a descent individual who tried to do the right things but was trumped by the owner, and the owner’s son”.

Regarding the schedules, Mr. Felton said they were on call 24 hours a day, not on shifts. He said they would give a pilot 10 hours rest after a trip but then would regularly interrupt the rest period with calls and additional assignments. He said they also would extend crew duty times or make pilots fly over the limit by calling the flights a part 91 reposition.

He was asked to clarify what he knew about the falsifying of flight times. He stated that he thought a few of the pilots had “fudged their time by about 1,000 hours”. He said he flew with Leigh McIntosh and Huey Martin and asked them about it and they said they were not supposed to talk about their flight time. He said when he advised ARGUS about the flight time issues, he had multiple discussions with them. He thought that ARGUS kept a database of flight time and experience for all ARGUS qualified pilots.

Mr. Felton said that he had talked to the chief pilot and the director of operations about his concerns but he had not talked to Mr. Hoke Smith. He said Mr. Smith was “a little volatile” and did not seem to be receptive to input from pilots.

Mr. Felton said he thought he had done everything he could do in order to prevent this accident by talking to FAA and ARGUS.

The interview ended at 1410.

Interview: Danielle Cornell, Executive Director – LifeQuest
Date: February 24, 2012
Location: via telephone
Time: 1025 EST

Present: Bob Gretz, David Helson – National Transportation Safety Board (NTSB); Bob Hendrickson – Federal Aviation Administration (FAA).

Ms. Cornell stated that she did not want representation for the interview.

During the interview, Ms. Cornell stated the following information:

She was the Executive Director for LifeQuest, an Organ Procurement Office (OPO), where she worked for about 19 years. There were 58 OPOs in the country, with 4 in Florida. The OPOs received government oversight from the Centers for Medicare & Medicaid Services (CMS). Ms. Cornell's OPO covered Northern Florida, which was her Donation Service Area (DSA). There were 65 hospitals in her DSA; however, only 2 hospitals in the DSA were organ transplant centers, Mayo Clinic and Shands Cair. All 65 hospitals, including the two transplant centers, were donor hospitals. Her office was located about 1 mile from Shands Cair Hospital in Gainesville. The accident flight coming to retrieve an organ from Shands Cair was coincidence as they would travel to any of the 65 hospitals in the DSA, or another hospital in the Southeast region, wherever the organ might be.

She said all transplant teams arranged their own flights. LifeQuest did not arrange air travel for any of the transplant teams. Ms. Cornell stated that most OPOs did arrange air travel for the teams, but LifeQuest chose not to be involved in that process. She said they did provide ground transport via car or ambulance to and from the local airport from the hospital when a team needed it.

Typically, the OPO received notice/referral from one of the 65 hospitals that had a patient who might be an eligible donor. If the patient's heart had stopped, they were not eligible to donate organs. Most donations came from patients who were "brain dead," but using a ventilator. Once the OPO received the notice of a possible donor, a national computer database was used to check for suitable recipients within the region. Although Ms. Cornell's DSA was Northern Florida, her region was Southeastern United States. Suitable recipients received priority based on their need. For example, a potential recipient with less than a 72-hour life expectancy would be classified as a "status 1" region recipient. If there were no status 1 region recipients, then the organ would go to a recipient in the DSA. In 2011, the OPO placed 449 organs; of which, 216 went to the Mayo Clinic in Jacksonville.

There were different levels of urgency depending on the organ. A heart lasted less than 4 hours outside of a body, but the shorter duration outside the body, the better the chance of a successful transplant. A lung would last about 5 to 6 hours, whereas a pancreas could last 6 to 12 hours. A kidney could last several days outside of a human body. As such, hearts and lungs typically travel by air while ground transport was used for other organs.

The surgeons who would be performing the transplants always travel to harvest the organs. They needed to ensure the organs were healthy and the correct size for the intended recipient. On the morning of the accident, a liver and heart from the same donor was intended to go to the Mayo Clinic in Jacksonville. A Mayo Clinic "Liver Team" arrived at Shands Cair Hospital via ground transportation. The Liver Team typically traveled by ground transport as livers were not as time critical as hearts. Additionally, livers take longer to remove from the donor and the Liver Team would typically start working 30 to 40 minutes before the "Heart Team" arrived. Ms. Cornell was not aware of the Mayo Clinic heart team ever traveling to Gainesville by ground; however, she believed it was feasible as it was a 90-minute drive.

Ms. Cornell added that her OPO does not provide air transportation. They previously did; however, in 2004, when she became director, she felt that she did not have expertise in air transportation for other organizations. Additionally, she felt hospitals could save money by arranging their own air transportation, rather than relying on the OPO as a "middle man." Her OPO would arrange short-haul ground transportation to meet an aircraft. For example, if an airplane landed at Gainesville Airport, the OPO would send an ambulance to take the team from the airport to Shands Cair in Gainesville. Ms. Cornell's OPO was in the minority; of the 58 OPOs in the country, about 50 arranged their own air transportation and 8 did not.

Ms. Cornell had little to no interaction with flight crews or the medical teams. Her staff had a lot of contact with the medical teams, but not the flight crews. Previously, from approximately 1993 to 2000, when she was an Organ Procurement Coordinator (OPC), Ms. Cornell flew often and knew the accident pilot very well. Back then, the OPO would procure the air transportation and an OPC would go on the flight. Mr. Smith had the only helicopter in the area and the OPCs would not "tie up" an EMS helicopter. Ms Cornell stated that Mr. Smith was an excellent pilot and very safety conscience. He took time to educate passengers and "talk through" the passengers that were scared of flying. From 1993 to 1998, Ms. Cornell often sat in the front of a Bell 206 and talked with Mr. Smith. In 1998, he purchased an Augusta that had a more comfortable back seat and then she usually sat in the back and did not talk to him. Ms. Cornell added that OPCs stopped going on the flights when the OPO stopped procuring the flights in 2004.

Following the accident, Ms. Cornell learned that Mayo Clinic would no longer use helicopters to transport organs. They contracted with University Air Center in Gainesville for fixed-wing only. She thought they flew Citations and an Eclipse jet. The fixed wing will land at Craig airport, which was closer to the Mayo Clinic than Saint Augustine.

The interview ended at 1105.

Interview: Johnny Vasquez, Profusionist / Surgical Assistant, Mayo Clinic Jacksonville
Date: February 27, 2012
Location: Via telephone
Time: 0810 EST

Present: Bill Bramble, David Helson – National Transportation Safety Board (NTSB); Bob Hendrickson – Federal Aviation Administration (FAA).

Mr. Vasquez was represented by Mr. Stephen Nelson, Mayo Clinic Jacksonville.

During the interview, Mr. Vasquez stated the following information:

He had worked in the Mayo Clinic Jacksonville Organ Procurement and Transplant Department since 2005, but he had been involved with organ procurement and organ transplants in the operating room since 1999. Mayo Clinic Jacksonville had developed its organ transplant department in 1999. At that time, experienced surgical technicians were going out with the surgeons to get organs and help the surgeons put them in. In 2005, the clinic decided to hire separate physician's assistants, and Mr. Vasquez went into that clinical area. Occasionally he still assisted in the operating room when there were a lot of organs to be transplanted.

Mr. Vasquez was asked to describe his role in the organ procurement department. He said he was qualified as a surgical assistant and as a profusionist. If multiple surgeons were going to retrieve an organ, however, he normally performed the role of profusionist. In that role, he was responsible for all of the supplies, medications, and liquids needed for the organ and he maintained custody of the organ until it was turned over to the operating room. When he performed the role of assistant, a profusionist from the department accompanied him and the physician. In that case, Mr. Vasquez was the one who helped the surgeons remove the organs from the donor.

Mr. Vasquez had traveled on organ procurement flights since the fall of 1999 when Mayo Clinic began training him. He had begun working for Mayo Clinic Jacksonville part time in 1996, he became full time in 1999, and he was officially full time in 2000, after he retired from the Navy.

Asked whether Mayo Clinic Jacksonville's organ transplant flights were always carried out by SK Logistics, he said yes, but occasionally a charter plane from another company would be used if they were out of aircraft. SK Logistics provided Lear jets ranging from the Lear 25 to the Lear 60 and Bell and Agusta helicopters as well. The Agusta was the helicopter that was most often used. It was the one that was set up for the clinic's use and it was the most comfortable.

Mr. Vasquez was asked where he normally sat when he rode in the helicopter. He said that about half the time he sat in the back and about half the time he sat in the front. The surgeon on board usually wanted to sit up front. Mr. Vasquez was asked whether he performed any flight-related tasks when he sat up front, such as identifying locations or pointing out air traffic. He said no, he performed no official duties related to flying. Asked whether he had received aviation-related training for transplant flights, he said he had received no official training from SK Jets, but they

informed him about where safety cushions and egress points were located. They also showed him how to get in and out of the aircraft, warned him to watch his head, and told him what to stay away from and what not to touch. Asked whether he had received aviation-related training from anyone else, he said no.

Mr. Vasquez was asked how the helipads were managed and who controlled the flights in and out of them. He said he had no knowledge of that.

Asked what he knew about the agreement between Mayo Clinic Jacksonville and SK Logistics, as far as what kind of transportation they were supposed to provide and when, he said he had no knowledge of that. Those were decisions that were made above him. He was never involved in any meetings about that.

Mr. Vasquez was asked to describe his schedule with respect to organ procurement-related duties. He said he was on call 7 days a week, 24 hours a day. Asked whether he had an assigned shift or a rest period, he said that he and the others in his department served in a primary or secondary on-call status. The status was rotated.

Asked how often he was typically called out on flights, he said it varied quite a bit depending on how busy they were. He estimated that it occurred, on average, once or twice a week. The flights occurred at all times of the day and night. There was no set schedule for organ procurements.

The weather conditions encountered by the transplant flights varied. It was hard to see at night, but it was good weather. They might run into some weather when they were up in the air, but it was average weather, it just depended on where they were going. Asked whether he could always see the ground during flights, he said no, not if they were in a plane and they were flying very high. Asked if he could always see the ground during helicopter flights, he said yes, they could always see the ground. Occasionally, they would run into some cloudy weather but they could always see the ground.

Asked whether he had had any safety concerns related to the flights, Mr. Vasquez said none come to mind. They were always good flights. Asked whether anyone else in his department had expressed flight-related safety concerns for any reason, he said no.

Mr. Vasquez was asked to describe what he would do if he had a flight-related safety concern. He said he could go directly to the pilots. Asked whether he had a reason to do that, he said no. Asked whether there was a safety reporting program at Mayo he said none that he knew about, but he felt he could approach his supervisor if he felt that the issue was not being resolved at SK.

Mr. Vasquez was asked if he recalled ever being aboard an SK Logistics flight when something occurred to the aircraft, or any type of incident occurred. He said yes, during a procurement trip they were approaching the field in St. Augustine and a bird strike occurred as they were nearing touchdown. The same week, on a return coming from south to north, there was a deer strike. Both flights involved airplanes rather than helicopters. Asked whether there had been any events in the helicopters that had resulted in damage, he said no such instances had been reported to him.

Asked how go / no-go decisions were made for organ transplant flights, he said that if the weather was not good enough, the pilot would say they could not take the helicopter and they would use another form of transportation. Asked if they had ever turned around enroute during a helicopter flight because of bad weather, he said yes. Asked if he could recall when that had occurred, he said he could not recall a specific date. He was usually busy as serving as profusionist and calling the operating room to let them know that he was coming back with the organ. He thought they might have turned around enroute two or three times over the years. On one occasion, they were on their way back from a donor hospital in the Agusta when a storm came up and the pilot could not see, so they diverted to Daytona field and waited for weather to dissipate before taking off again. They might have been coming from Orlando. He could not remember what year that occurred or who the pilot was.

On another night, he was on a flight with a thoracic surgeon and Mr. Smith. They took off and it was determined that they could not see anything because of fog or something. They could not see enough to continue the flight, so they turned around and flew back to SK Logistics. They ended up bringing the organ to Mayo Clinic in a ground vehicle driven by Mr. Smith. Mr. Vasquez had been sitting in the back during that flight. Asked whether Mr. Smith said anything afterward about his decision to terminate the flight, Mr. Vasquez said no. Asked if he recalled anything unusual about the landing during that flight, he said no, he had flown in the military before, and all flights seemed the same to him. Asked whether anybody had helped them out of the aircraft, he said not that he remembered. Perhaps the pilots who were still there on the ramp with the Lear jet helped, but he could not remember anyone helping them out. He was busy making arrangements with the operating room at the time. Mr. Vasquez was asked if anyone had mentioned anything about damage to the helicopter or problems with the landing and he said no. He could not recall what year that incident occurred or where they were coming from. It had been a few years. He thought Dr. Sadeji was the thoracic surgeon aboard the helicopter during that flight.

Mr. Vasquez was asked how often he rode aboard flights with Mr. Smith serving as the pilot and he said about once a week in the helicopter. Asked when he took his last flight with Mr. Smith, he said he could not recall. Asked how the flights went when he flew with Mr. Smith, Mr. Vasquez said all the flights were good. Mr. Smith was always on time and professional.

Asked to describe Mr. Smith’s personality, he said that he was respectful and caring. He was always making sure they were comfortable and safe.

Asked whether he had ever had occasion to point out hazards to Mr. Smith during a flight, Mr. Vasquez said no, he just sat up front and enjoyed the scenery. Asked whether they ever had any conversations, Mr. Vasquez said that they had some general talk about their families but they usually kept conversation to a minimum so that Mr. Smith could listen to the air traffic controllers. Asked whether he played any role in arranging the accident flight, Mr. Vasquez said no, he did not have any participation in setting up the accident flight. Mr. Vasquez was supposed to have been on that flight but they had switched schedules and Dr. Bonilla understood that there was going to be another surgeon from Duke, so he had informed the scheduler to keep Mr. Vasquez home that morning.

Mr. Vasquez was still riding aboard organ procurement flights. After the accident, Mayo Clinic Jacksonville began using a company out of Gainesville known as University Air. They flew Citation jets. They were not using helicopters. It was his understanding that Mayo had decided they would no longer be using helicopters.

Mr. Vasquez had worked with David Hines before. To his knowledge, Mr. Hines felt good about the flights. He had had no problems. Asked whether Mr. Hines had ever expressed any concerns about Mr. Smith or about any particular flight, Mr. Vasquez said no. Asked whether Mr. Hines had ever told him about any safety-related incidents that might have occurred during his flight, Mr. Vasquez said not that he could recall. Usually they were partners, but they switched sometimes due to vacation schedules. Mr. Hines was only qualified as a profusionist, whereas Mr. Vasquez was dual-qualified as a surgical tech first assistant and profusionist.

Mr. Vasquez had worked with Dr. Bonilla. Dr. Bonilla also had no concerns about the flights. He seemed totally at ease with them. He never mentioned anything to Mr. Vasquez.

Asked whether he had ever drive to Gainesville with a team to retrieve a heart, Mr. Vasquez said if they had driven, they drove to do the organ procurement, but they usually tried to fly the organ back. Asked whether they always flew the organ back if it was a heart, he said yes, they tried to get any thoracic organ back as safely and as quickly as possible. Flying was the recommended method, to reduce the time it was sitting on ice.

Asked whether he had made any organ transplant flights to Gainesville, he said yes. Asked whether some of them had taken place at night he said yes. Asked if some of those trips had been in a helicopter he said yes. Asked whether it was difficult to see at night in some areas between Jacksonville and Gainesville he said yes, adding that it was very dark over some of the wooded areas.

Mr. Vasquez was not a pilot. Asked about the altitudes that were typically flown between St. Augustine and Gainesville or between Jacksonville and Gainesville he said he did not know exactly. They were pretty high up, but they could see small lights. When they flew from St. Augustine to the Mayo Clinic in Jacksonville they did not fly as high because it was a shorter flight.

Mr. Vasquez had extensive prior experience with helicopters. He had served as a U.S. Navy corpsman and medic and he had ridden aboard helicopters with U.S. Marines.

Asked if he could recall the last time he had flown with Mr. Smith he said it had been a while since he had flown with Mr. Smith in a helicopter. Asked whether there were other helicopter pilots with whom he had flown in recent years, he said he had flown with a Mr. Dyess and a pilot whose first name was Steve. There had been two other pilots in the past. One of their names might have been Jim.

Asked whether he recalled any negative interactions with any pilots other than Mr. Smith, Mr. Vasquez said no, they would discuss where they were going and time estimates.

Asked whether he recalled a fixed-wing pilot named Darrin Felton he said no, he was bad with names and would have to see him in person.

Asked whether he recalled any pilots expressing concerns about safety issues he said no.

Asked whether he had anything to add, Mr. Vasquez said no.

The interview ended at 0900.

Interview: Dr. Stephanie Blanken, Cardio Thoracic Surgeon – Mayo Clinic Jacksonville
Date: February 27, 2012
Location: Via telephone
Time: 1010 EST

Present: Bill Bramble, David Helson – National Transportation Safety Board (NTSB); Bob Hendrickson – Federal Aviation Administration (FAA).

Dr. Blanken was represented by Mr. Stephen Nelson, Mayo Clinic Jacksonville.

During the interview, Dr. Blanken stated the following information:

Her current position was associate surgeon in the cardiothoracic department at Mayo Clinic Jacksonville. Her date of hire there was March 2010.

Her primary role and responsibility was heart and lung organ procurement. She was on call 24/7 and whenever a heart or lung became available for harvest she would be called out at any time of day or night and arrangements would be made for her to go to the hospital where the brain dead donor was present. She would ensure that the organ was appropriately checked out, she would do the surgical procedure to remove the organ, and she would bring it back to the Mayo Clinic.

Asked how she usually traveled to the donor hospitals, she said that there was a process in place whereby they were usually driven by suburban to the airport and then a variety of different arrangements were made. If the donor was in the local area then they might drive to the donor hospital. If the organ was in another city then a flight would be used to transport her to the donor hospital. She usually rode in an ambulance from a nearby airport to the donor hospital, took another ambulance ride back to the airport, and then took either an ambulance or a helicopter ride back to the Mayo Clinic. On a few occasions, a helicopter transported her directly from the donor hospital to the Mayo Clinic to reduce the time that the organ was profused. For heart and lungs there was a time limit of about four hours to get the organ into the recipient.

Dr. Blanken was asked whether using the helicopter was the norm, prior to the accident. She said they did not take it if the organ was in the Jacksonville area. If they were flying out a certain distance, it was the norm to take a helicopter back from the airport in St. Augustine to Mayo Clinic Jacksonville in order to get the organ to the recipient as quickly as possible. The helicopter was not used for all procurements, but it was used for about 70 percent of the heart and lung procurements. Asked how often the helicopter was used to transplant a heart from St. Augustine to the Mayo Clinic, Dr. Blanken said that most of the time the helicopter was used for that leg, but on a few occasions they flew directly from the Mayo Clinic to the donor hospital and back, usually when it was just a short run to another hospital in the state of Florida.

Dr. Blanken was asked where she usually sat during the helicopter flights and she said that she almost always sat in front. Asked what kind of helicopters they flew in, she said they flew in an Agusta and a Jet Ranger. Prior to the accident, she had ridden twice in the accident helicopter.

Dr. Blanken had a private pilot's license, but she was not current. She did not work as a pilot at Mayo Clinic. Asked whether she had any role in assisting the pilot, identifying air traffic, or pointing out obstructions during takeoff or landing, or assisted the pilots in any other ways, she said that on occasion she had helped the pilot look for air traffic, but that was about it. She was usually just enjoying the flight.

Asked whether she had received any training for the conduct of flights, as far as her role on the helicopter, Dr. Blanken said that her job here was to bring the organ back as safely as possible. She did not work in any capacity as a pilot, nor was she responsible for the flying of the aircraft. Asked whether she had received any training on the safety and conduct of flights, she said passengers were told at the beginning of a flight the necessity of seatbelt usage, how to exit and enter the helicopter appropriately, and that sort of thing.

Dr. Blanken was asked if she had ever had any concerns about flight safety. She said she had not She said there was always a little bit of apprehension before a landing, especially when they were landing on top of a hospital on a landing pad that appeared to be small, but she thought that was a fairly normal sentiment. Asked whether any of her colleagues had expressed safety concerns about the flights, she said that the people with whom she worked had not expressed any safety concerns.

Asked whether anything had happened on any particular flights that had concerned her, Dr. Blanken said only on one occasion. The hydraulics went out in a Jet Ranger just prior to landing. The pilot said hold on, and it was difficult for him to make the landing at Mayo Clinic Jacksonville. It was tricky for him, but he did a wonderful job. The pilot's name was Aaron. She did not know his last name.

Dr. Blanken was asked how she would have handled any safety concerns, if she had them. She said that she would have spoken with her supervisor. Asked whether there was a set policy or safety program or whether that would have been her personal strategy for handling the situation, she said she was sure there was a set policy, and her read on it for herself would be to first go to her supervisor and she had done so in the past when she had had safety concerns that were unrelated to flying. Asked for an example, she said she had brought to her supervisor's attention information about a driver who kept putting his foot on the brakes all the time. She told her supervisor it was making her car sick. Her supervisor had discussed that with other people and the driver was no longer working for the Mayo Clinic. Ask for other examples, she said that she also worked in intensive care and she had discussed concerns with her supervisor about different situations there and he had always been very open with her about finding solutions.

Asked how many times per week, before the accident, she had taken a helicopter flight for organ procurement, she said about once per week. Asked whether she had ever flown with Mr. Smith she said yes. It was difficult for her to estimate how often that had occurred, but it was probably about 1/3rd of the time, or a little less than that.

Asked for her thoughts on how Mr. Smith handled those flights, she said he handled them very well. She had no concerns, aside from what she had said about normal apprehension during takeoff and landing. She had no specific concerns about any of the pilots with whom she had

worked. Asked what she thought of Mr. Smith's flying skills, she said that since she was not a helicopter pilot she had to say that she was impressed with anyone who could fly a helicopter. She had a little bit of understanding of how difficult it was. From her limited understanding, she thought Mr. Smith and the other pilots were doing a really excellent job.

Dr. Blanken was asked how she would characterize Mr. Smith's personality. She said that she had very much enjoyed talking with him during the flights. He was extremely approachable. They had exchanged life stories. She had gotten to know him extensively over the last two years. He took the transplant program very seriously. Once, when an ambulance did not show up to meet them at the St. Augustine airport, he had driven the organ and the team to Mayo Clinic Jacksonville in his car. He took his job extremely seriously. He was very responsible. He understood well the time sensitive nature of the heart and lung transplants.

Asked whether she had any knowledge about the conditions of the agreement between the Mayo Clinic and SK Jets, Dr. Blanken said she did not know it in any detail, other than that they SK Jets was the provider. Part of it was that a helicopter was supposed to be available for the transplants. She had never read the contract and she did not know any more details. Asked whether within the agreement, or outside of it, there were any particular requirements regarding the type of aircraft that were to be available, or the type of equipment that was to be aboard the aircraft, Dr. Blanken said no, she just understood that there was supposed to be a helicopter available. For a short time period there was not a helicopter available when the helicopters were undergoing maintenance.

Dr. Blanken was asked whether the incident involving the hydraulic failure was the only aviation safety-related incident that she had encountered and she said yes. Asked whether anyone else had described any incidents like that, she said no, they had not. Asked whether the pilots had ever talked about any safety issues involving particular crews or particular aircraft, she said no they had not. If there had been a weather problem, they were very up front and they would tell the team that they had to hold off and wait for the weather to clear. They would provide an update every fifteen minutes. They were very good about doing that.

Dr. Blanken was asked in what type of weather she had ridden in the helicopters. She said they would only fly when the weather was clear. Asked whether they had ever taken off and had to divert or turn around after they were airborne, she said they had probably done so on two occasions in the helicopter where there had been a little change in the clouds and the pilots had arranged for flight following and changed altitude. They had always been very careful about the weather and the flight conditions.

Asked how Mayo Clinic Jacksonville was conducting organ procurement trips after the accident, Dr. Blanken said that for a short period after the crash they were just using ground transportation, but they had subsequently begun using a mix of fixed-wing flights and ground transportation. They were not currently using helicopters. Asked whether that was a temporary or a permanent change, she said she did not know.

Dr. Blanken was asked to describe her flight experience. She said that she had about 80 flight hours. She did not hold any type ratings and she was not instrument rated.

Asked what altitudes the helicopter typically flew, she said the helicopters usually flew at an altitude that was between 500 and 1,000 feet. The altitudes were typically about the same for day versus night flights.

Asked what percentage of the helicopter flights occurred at night, she stated that most of the flights were at night. Almost all of the procurements occurred at night. Asked whether, during those night flights, there were times when there was not much in the way of a visible horizon and the pilot had to use ground light patterns for external visual references, she said there were a fair number of ground light in the area so yes. Asked whether she had made the trip between Jacksonville and Gainesville in a helicopter at night, she said she could not recall. Asked whether she had ever been in a situation during a helicopter flight where the visibility was obscured and she could not see the ground, she said that might have happened once or twice. Usually the conditions were very clear. On occasion there were forest fires and they would have to change routes to get around the smoke. She recalled the pilot named Aaron notifying flight following to say he was going off course. It took him a little longer to get around it so that he could see clearly. Asked whether the ground was completely obscured, she said no, if it looked like they would be flying into a storm or smoke, action was taken to prevent that. Asked whether the pilots always avoided losing external visual references at night, Dr. Blanken said yes.

Asked to clarify how much time was available for transporting a heart between a donor and a recipient, Dr. Blanken said that for hearts and lungs, the shorter the time the better. For hearts specifically, the time from cross-clamp at the donor hospital to reprofusion with the recipient could be no more than 4 hours, the shorter the better. Two hours would be great. Asked how much of that 4 hours was available for travel time, she said about 2.5 hours was available for transit. Livers were not as time-critical. She provided a rough estimate of 12 hours but said that she was not the right person to ask about livers.

Asked how long it had been since her last flight with Mr. Smith, she said that she had flown with Mr. Smith about 6 days before the accident in the helicopter. Asked whether they had any conversations, she said it was a short flight from St. Augustine to the Mayo Clinic Jacksonville, so they had not discussed much. Asked how that flight went, Dr. Blanken said that the only thing that was a little bit different was that she had asked Mr. Smith whether they were encountering a very stiff headwind because they were only traveling at 80 knots ground speed in the helicopter and Mr. Smith said no. That had been a surprise to Dr. Blanken. Asked why she thought the helicopter was flying at 80 knots, she said she did not know. It was only the second time she had flown in the Bell and it was a little surprising to her that it did not seem to have as much power as the other Jet Ranger they flew on. Asked to describe the helicopter's external and internal condition, she said that externally it appeared to be in good condition. It was painted a bright yellow color. Inside it was in good condition too. The other Jet Ranger had a peculiar odor and this one did not. A tech who was flying with her had remarked that at least this helicopter did not smell bad.

Dr. Blanken was asked whether she had worked with Mr. Hines and she said yes. Asked what her impressions were about how Dr. Hines felt about the flights, she said that he enjoyed flying.

Asked whether he had ever mentioned being involved in any safety-related incidents or accidents, Dr. Blanken said no.

Dr. Blanken was asked how well she knew Dr. Bonilla. She said she did not know him very well. He had just come on staff two months before the accident. She had ridden on one flight with him to show him how it was done. After that, they had done another procurement together on the ground in St. Augustine. The accident flight was the first flight where he rode alone on the helicopter without another surgeon present.

Asked whether there had been any other occasions where SK Jets had said the weather was too bad and it was not going to improve soon, she said yes. Once, the staff at the other hospital had to wait for the Mayo Clinic team to arrive for approximately three hours.

Dr. Blanken was asked how the flight instrumentation on the accident helicopter compared to that of the other Bell helicopter operated by SK Jets. She said it looked pretty much the same. Both helicopters had a GPS unit installed in the instrument panel.

Asked whether she had anything to add, she said no, except that the other helicopter pilot’s name was Tim.

The interview ended at 1100.

Interview: Mark Charles St. George, Director Supply Chain – Mayo Clinic Jacksonville
Date: February 27, 2012
Location: via telephone
Time: 1300 EST

Present: Bill Bramble, David Helson – National Transportation Safety Board (NTSB); Bob Hendrickson – Federal Aviation Administration (FAA).

Mr. St George was represented by Mr. Stephen Nelson, Mayo Clinic Jacksonville.

During the interview, Mr. St George stated the following information:

He was the director of supply chain for Mayo Clinic Florida also known as Mayo Clinic Jacksonville. He was hired in June almost 23 years ago and had worked in his current position for about 20 years.

In describing his position, Mr. St George said he was part of a supply chain group that was a shared service, one chain that covered all of Mayo. He said he was responsible for all activities on that campus as well as within the region. For example; he said they were closing on a new hospital in Waycross on March 1. He said he was responsible for all supply chain activities including logistics and distribution. He said contracting did not reside at that location except for local contracting and this particular contract with SK Jets was part of a local agreement. He said to sum it up; he was the liaison and supply chain executive for Mayo clinic in this region; which included Florida and Georgia.

Mr. St George stated that he initially got engaged in the process of working with the organ procurement office during the 2006 bid process for the service agreement because their standard business practice required a bid process for any expense which was expected to be over $100,000. He said they spent about $1.2 million per year on organ transport. He said in 2006 there was a bid process which was followed up in 2009 by a similar process because they had negotiated a 3 year cycle.

Mr. St George said they first developed a request for information (RFI) to review available services and there were several in the market at that time. He said the RFI focused on safety and service dimensions. They formed a team made up of a physician and clinical and administrative staff, primarily from the transplant program, to review the information received through the RFIs and he recalled that they had two bids; one in 2006 and one in 2009. After review, the team made their recommendation about whether to issue a request for proposal (RFP). He said the RFP was a request that got more into the business aspects and was more quantitative than qualitative. The RFP was used to determine if the bidders met safety and service requirements, and tertiary to that was whether they met certain cost dimensions.

He said the RFI was worded such that higher importance was placed on safety, reliability, dependability, availability, qualification of pilots, well maintained aircraft, jet and helicopter availability, then bottom was price. There was also consideration given to compliance with RFI

specifications, adequacy of financial resources; and overall quality and completeness of response.

He did not recall how many bidders there were in 2006 but thought that in 2009 they had Craig Air Center, University Air Center, and SK Logistics/SK Jets and that the whole bidding process took about 2 and a half to three months.

Regarding determination of a bidder's level of safety, he stated that some of the questions in the RFI were related to aviation quality management, pilot performance and proficiency programs for normal and emergency conditions, and flight interruptions due to aircraft equipment and maintenance, aircraft equipment and flight log record reviews and engine power checks. He said the RFI required that one captain and one co-captain must be on each flight and there were also questions regarding certificate actions by the FAA and about the training programs.

Regarding the requirement for one captain and one co-captain on each flight, he said the RFI did not differentiate between fixed wing and helicopter operation; that each required two pilots. He said he was not aware of any negotiation to fly the helicopters with only one pilot.

Mr. St George stated that the RFI asked for the number of aircraft, type, location, number of seats, methods of being available for callout 24 hours a day. He said the language in the RFI stated that the bidder had to have services available 24 hours a day with pilots that met minimum qualifications and be able to be wheels up from St Augustine airport with the team on board within 90 minutes of receiving the call. He said the specific aircraft available were not listed in the RFI but it was considered during the bidding process.

Regarding aircraft equipment, Mr. St George said the agreement required that airplane transport services had to be operated in such a way as to meet or exceed minimum standards under Federal Aviation Regulations (FAR) Part 135. He said the bidder needed to certify that they conducted IFR (instrument flight rules) airplane operations with all aircraft that were to be utilized and that there be room enough for all passengers, room for equipment storage, and a means to secure all equipment. He said there was not a separate requirement for helicopter operations; that those requirements fell under the same umbrella as the ones listed for airplanes.

Mr. St George stated that the items in the RFI were requirements that became part of the contract. Within the RFI there were a lot of questions related to data and about records and manuals, weather documents and training manuals, weather monitoring, and documentation of training records.

He stated that the agreement required quarterly business reviews and that was built into the agreements in 2006 and 2009. The data that was included in the RFI and RFP was attached to the contract and became part of the documents. He said at the business reviews, the company provided them with data and records for review. As the contract manager, he said he would coordinate the business reviews with the operations group who worked with them on a daily basis.

Mr. St George recalled that the last meeting was in the fall of 2011. He said that one was not a business review but a meeting he called with Mr. Hoke Smith and the lead mechanic at SK Jets. To discuss some concerns he had about the company. At the meeting they agreed to have a business review in January 2012 to address the concerns.

Mr. St George said he started to have some concerns in August 2011 because the Agusta that was usually used for their flights was in disrepair and ended up not being available for months. He said the practice (Mayo Clinic) engaged him to discuss why the aircraft was not available. He said that Mr. Smith and the lead mechanic wanted to discuss alternative aircraft that might be available. Mr. St George said he felt the reasons why the aircraft was not available were never satisfactory. For example; he was told the Agusta needed Italian mechanics that had to be brought in to repair it. He said the practice was working with him to find out if the aircraft could get repaired and he did not see acceptable level of response from SK Jets and he felt it was appropriate for them to try to discuss different options. He said before the holidays he started looking at other operators to cover the flying for Mayo clinic.

Mr. St George stated that Mr. Smith was aware he was looking at other operators and that he had pointed out to Mr. Smith that the agreement was not exclusive; that it was within Mayo Clinic's rights to secure other aircraft if SK Jets could not make theirs available. He said he agreed, at Mr. Smith's request, to schedule a meeting in January 2012 with the practice so that Mr. Smith could understand exactly what their requirements were for helicopter flights.

Regarding the problems with the Agusta, he was told that the front landing gear was broken, and jammed up into the nose of the aircraft. He said he did not see any viable reason why they could not service the aircraft and began to question their ability to do so. He said when the problem was not being addressed; he knew it was time to start looking at options with other companies. He said he was concerned about the company's financial ability to service the aircraft because of the recent behavior. He stated that Mr. Hoke Smith began to visit him personally when he had previously had a business manger that would do that. He said that business manager had left and other employees had been leaving as well. He said the primary aircraft they used fell into disrepair in August of 2011 and then in November, it was still in that condition. He said something similar had happened the previous year but in that case, the helicopter was down for a few months and then was repaired. He said SK Jets had argued that the Bell satisfied the conditions of the contract but the Agusta was the preferred helicopter because it was larger, more comfortable, and had a good safety record.

He said the previous year they had worked with them while the helicopter was being repaired but this time, he was concerned the company was unable to meet their financial obligations.

Regarding independent outside auditors, he said they did not have a requirement I the contract for them but the agreement gave Mayo the ability to review their records, audit their books and accounts for a period of five years. He said until recently, they had not had any reason to do so but based on the recent events, his first course of action was to look at other options.

Mr. St George stated that as part of the RFP process, they were made aware of a number of incidents and accidents at SK Jets. He said during the 2009 bidding process they looked at

compliance with FAA standards and specific accidents but they were not aware of any that had occurred since 2009 until this accident in December 2011. He said they were aware of an accident in 2002 when a helicopter operated by SK Jets had crashed in the ocean while operating under a US Navy contract to a platform 30 miles off the coast of Savanna. He said they investigated that further with ARGUS and the FAA by calling Ed Wandall at ARGUS. He said there was a hard landing in July 2007 after a dual engine flameout. He said that had been an older aircraft and the NTSB had not determined what caused the engines to lose power simultaneously. There was also an event on December 22, 2007 when a tail rotor came in contact with a bush and damaged the tail rotor assembly, and in August 2008, a Lear hit a deer on landing and damaged the landing gear doors and landing lights.

Mr. St George said that at the time, they followed up on those issues by interviewing Ed Wandall from ARGUS. He stated that SK Jets had an ARGUS Platinum rating, the highest available, and they wanted to find out what the ratings meant and how it related to the previous incidents. He said the information was provided to the practice and based on the overall safety rating, they thought it made sense to move forward with SK Jets. He said they also looked at flight hours compared to other companies. He said SK Jets was flying about four times as many hours as the competitors; their total flight hours per year were about 2,000 hours and the nearest competitor was about 500 hours.

Mr. St George said he did not go to the FAA to inquire about the previous incidents. When asked if consulted the FAA about SK Jets safety record during the 2009 bidding process, he said he had as long as ARGUS was tied to the FAA. He said he received that information from Ed Wandall who was the safety program manager for ARGUS. He said he wanted to know how the company could have a platinum rating after have the accidents on record. He stated that Ed Wandall explained all the ratings to them and reviewed the reports with them. He said the competitors were not rated as highly by ARGUS; they had gold ratings, fewer hours flown, and fewer aircraft. He said based on those factors, and their history of many years safe flight with them, they felt it was prudent to move forward with SK Jets.

He stated that Ed Wandall went over the ratings and discussed the audit reports with him. He was not provided a copy of the ARGUS audit report, only took notes to provide to the practice. He recalled that he received an email from Chuck Higgins at SK Jets advising that the audit report was intended for the company's internal use only. He said Mr. Higgins provided an excerpt of the audit report in an email and provided copies of the company certificates. He said ARGUS did not provide him a copy of the reports nor did they offer him a copy for a fee.

Mr. St George was not aware of any aviation training provided to the transplant teams that traveled on the helicopters. He said they did not have any role in the conduct of the flights except to have knowledge of the terms of the agreement in the RFP.

Regarding the Mayo Clinic transportation policy and procedures, when asked if they were written in a manual or document available to the people involved in the flight he said they had received a lot of assistance from their colleagues in Rochester, Minnesota for establishing charter service agreements. He said he would not refer to it as a policy per se, but they had used some of the flight standards established in Rochester in this year's bidding process; for example,

requirements for essential equipment, preferred equipment, and costs. He said there were a number of operational and safety dimensions that were included in the previous RFI and RFP process but they had been more refined recently. He said there was a Mayo Clinic transportation Board and there were flight standards for organ procurement and patient transport. He was not aware of those standards existing in 2009; those changes were made at some point after the 2009 bidding process. He said the sections of the 2009 agreement related to transportation policy were referring mainly to catering costs and not related to safety or flight standards.

Mr. St George said he did not ever go on the organ procurement flights and he had never flown with Mr. Smith. He had not heard any team members express concern about safety, only complaints about the size of the Bell helicopter, and the lack of comfort as compared to the Agusta they were used to. He said some of those complaints were what prompted them to start moving in the direction they were with respect to SK Jets. He said the practice was always more comfortable with SK Jets because of the long relationship and familiarity with the pilots. He said there was a strong relationship between the practice and SK Jets. He said he had not heard of any concerns about the safety of the crews.

He stated that since the accident in December 2011, they had formed a new agreement with University Air Service in Gainesville. He said it was very similar to the 2006 and 2009 process but because of the sensitivity of what had occurred, they were even more focused on safety issues. He said they engaged subject matter experts from the Rochester campus to assist. Along with the bidding process, they reviewed each of the bidder's sites, their maintenance departments, operations, dispatch units, and all the documentation they requested previously. The flight standards he mentioned previously were integrated into the process, including specific questions about helicopter operations. The bid process engaged Craig Air Service, University Air Service (UAC), Malone Air Charter, and Executive Air Services. The selection of UAC was made by a team of eight people and approved by leadership. Malone Air Charter was selected as a back up and the agreements included the ability to be terminated without cause with 90 days notice.

He said the agreements were for both fixed wing and helicopter operations but it was unclear at the time whether they would use the helicopters. He said UAC had based a Citation and crew at Craig airport in Jacksonville and if they needed another one, they could fly one out of Gainesville in about 15 minutes. He said the Citation had a good safety record and if they decided to use helicopter, UAC had demonstrated they had access to an Agusta.

Mr. St George stated that the previous agreements had also included a termination clause but it was changed from 30 to 90 days for the most recent contract.

He said he was not a pilot and did not know how the landing gear on SK Jets Agusta got lodged up in the nose. They did not tell him how and he was mostly concerned with whether they could get it repaired.

He said his office was unaware that SK Jets was operating the helicopters with only one pilot. The agreement stipulated that there would be two pilots at all times and was not specific to

helicopters or airplanes. He said they were also required to demonstrate that they were "certified to conduct IFR airplane operations under FAR Part 135 for all aircraft proposed to be utilized".

He said they did not have an ongoing relationship with ARGUS and had only contacted them the one time to get background on the ratings and SK Jets previous accident. He said the ARGUS Platinum rating was not a requirement going forward. He felt it was more important to look at what is happening with FAA inspections. In the future, they will be having quarterly business meetings at the operators' site and they are required to provide them copies of any report received from the FAA within 72 hours, and how they are going to address them. He said as they went through this process, they realized the FAA reports were more important than ARGUS.

Regarding the help from Rochester, he said it was more clinical expertise than operational. He said they sent down a physician, and an administrative representative from their transportation board. He said it was a relatively new group formed out of what occurred here in Florida. Prior to that, the three main groups, from Arizona, Rochester, and Florida each had their own relationships developed locally. The three regions each had their own standards but since this accident, they were trying to standardize across the whole company. He said the standards are still being worked o at an enterprise level and are not yet completed.

When asked he said he had nothing to add.

The interview ended at 1425.

Interview: William Henry Edwards, Principal Operations Inspector – Federal Aviation Administration
Date: February 28, 2012
Location: via telephone
Time: 0920 EST

Present: Bill Bramble, David Helson – National Transportation Safety Board (NTSB); Bob Hendrickson – Federal Aviation Administration (FAA).

Mr. Edwards was represented by Ms. Betty Reed, Federal Aviation Administration.

During the interview, Mr. Edwards stated the following information:

He was employed by the FAA as a Principal operations inspector (POI) at the Orlando FSDO (Flight Standards District Office) and had been a POI for about 15 years. He was the POI for SK Jets from about October 2005 until about March 2009. He said it was the policy of the FAA to rotate POIs around so there was less familiarity with operators and to obtain a different viewpoint because each POI had different strengths and weaknesses.

Mr. Edwards stated that from 1976 to 1996 he worked in the general aviation field as an instructor, commuter pilot, director of operations (DO), chief instructor and chief pilot under FAR (Federal Aviation Regulations) Part 141. He said he had a myriad of jobs which included flying people and also flying traffic patrol and flew all kinds of aircraft from single engine to jets. He estimated that he had logged about 15,000 hours total flight time; all of which was in fixed wing aircraft. He had acquired type ratings in an EMB-120, an IA Jet (Westwind), LR Jet, and a Hawker HS 125.

He described his role as POI as ensuring passenger safety by reviewing and approving training programs, accepting manuals such as the general operations manual (GOM) and minimum equipment list (MEL) and there procedures for use, as well as conducting check rides and overseeing the check airmen at the companies who had them.

He said his normal surveillance involved, at SK Jets for example, five R (required) items covering PRIA (Pilot Records Improvement Act) records, GOM, training program, pilot records, and trip records.

Mr. Edwards said that during the time he was overseeing SK Jets in 2005 to 2009, he had been assigned a total of about 11 to 15 certificates to oversee and he had one assistant, Inspector Steve Weaver. He said compared to the others he was overseeing, SK Jets was a medium sized fleet. He had a much larger certificate, AvantAir, a Part 135 operator that had a fleet which grew from about 23 aircraft to about 55 aircraft during that time. He also had oversight of some smaller operators with only one or two airplanes, for example; he said he had one which had only a King Air and a Lear Jet. He had mostly jet operators.

When asked how he would characterize his workload, he said it was “always intense” and there was never a moment when there was not work to do. But he did have an assistant at the time helping with a lot of the check rides and inspections.

When asked if he recalled any areas of special emphasis at SK Jets, he stated that he had done some research on PTRS (program tracking and reporting system) to refresh his memory in preparation for this interview as it had been about 7 years since he worked with SK Jets. He said they had focused inspections in the past and he could not find as much information as he thought he would be able to. He recalled that before he had oversight of SK Jets he had been involved in a focused inspection at SK Jets and there were a lot of areas of operations with compliance issues that were corrected and then when he did have oversight of the certificate, there were some additional focused inspections but they were about 3 to 4 years ago and he could not recall any specific issues and looking through PTRS; he could not find any.

Mr. Edwards said most of his time was spent on approving training programs, reviewing revisions to the GOM and MEL, and adding and removing aircraft from the certificate. He said they were a busy certificate like a third of the ones he managed which took about 80 percent of his time. He said they managed airplanes for other people so the airplanes were constantly coming and going. He said that was a lot of his workload along with conducting some check rides, but he said his main focus with SK Jets was inspections and certificate management.

When asked if there were any issues that required extra attention, he recalled an incident in April 2006. He said he had gone up to observe Mr. Hoke Smith conduct a Part 135.293A oral and he brought two pilots in simultaneously. He said when the pilots did not provide the correct answers; Mr. Smith gave them training on the spot. Mr. Edwards said he stopped the orals and issued a letter to Mr. Smith advising him he could not do that. He said that later in 2009, Mr. Smith was doing the same thing again so Mr. Edwards removed his check airman authorization for everything except to conduct line checks in the Lear 60.

He said there was another issue that he could not find in the records, when someone had reported that Mr. Smith had a night restriction on his driver’s license. Mr. Edwards said he went to SK Jets and asked to see Mr. Smith’s pilot certificate and driver’s license for photo identification and there was no night restriction on the license.

Mr. Edwards said they had several instances of pilots complaining about SK Jets early in his time as POI. He said most of the complaints were issues with what was considered to be “on duty”. He said they had a very different operation because they were on call 24 hours 7 days a week for the medical flights in case there was a heart to be harvested. He said it was a very difficult operation for the individuals to manage and he had two companies that did that. He said after he talked to them they changed to a rotation, as of about 3 years ago. He said they had a rotation so that when a person was called out; the next person would go on duty. He said he told them that they could not keep a pilot on duty 24 hours a day and that they had said they were not but Mr. Edwards argued that they were. He said he had looked back through the PTRS data and had learned how helpful it was when remarks were included to know what was done 6 or 7 years earlier. He said they did not always include comments in the PTRS reports.

Mr. Edwards recalled that there was an event where a Lear hit a deer on landing which he did not think caused enough damage to warrant an NTSB report. There was also an occurrence where a Lear 25, which he suspected had run out of gas, crashed onto the runway and completely damaged the airplane. He said it had been towed to the hangar and by the time they had arrived to take a look, they were advised that the fuel tanks split and drained all of the fuel in the crash. He said he and the other inspectors suspected that it had run out of fuel but they could not prove it. He stated that SK Jets was "not always forthcoming" with information on some issues. He said they conducted a 44709 ride on both of the crew members. He recalled that during the ride, he took them up to 12,500 and shut down one engine and pulled the other to flight idle and told them to restart the first one. He said they did that and some landings and they went over emergency procedures, and that the crew did fine. He said they had claimed that the engine flamed out on approach so he had asked them why they did not do a restart and that was what he focused on in the 44709 ride.

Mr. Edwards said there was another event when Mr. Smith was flying a helicopter and the tail rotor hit the bushes while he was maneuvering around the ramp in St. Augustine (SGJ). He said the company had pulled the helicopter into the hangar because they were going to fix it. He said the FAA found out about it from an anonymous phone call. He said Inspector Gary Videk had done the investigation for the FAA and Mr. Edwards took part in the investigation. He said as a result of the investigation, Inspector Videk had recommended counseling but the North Florida FSDO, probably Mr. Edwards in combination with Steve weaver and management decided to give Mr. Smith a 44709 ride. He said Mr. Weaver conducted the 44709 ride as he was a helicopter pilot.

Mr. Edwards could not recall a long after the event the FAA was notified but estimated it could have been a few days or even a week or two. He did not recall if a dash 9 form had been filed and said he could not even find the incident report. He said he was not a helicopter pilot and that was why Gary Videk responded to the report but he did not know if Inspector Videk had gone up there in person since it was first reported as an incident. He did not see the helicopter until later. He recalled that at some point an NTSB investigator was at SK Jets hangar to look at the Lear that had hit the deer on landing previously and saw the helicopter in the hangar. He said the NTSB investigator saw that the broken rotor had cut through the stringers and that it should be reported as an accident. He said he did not where the investigation went from there. He was responsible for the pilot and had him do a 44709 ride, which was completed successfully.

Regarding the 44709 ride, he said he did not recall having any discussions with Mr. Smith or interviewing him about the event. He did not recall doing the investigation and that at the time the dash 23 forms (FAA Form 8020.23) were not electronic, until a few years ago. He said he could probably look in files for the old paper copy but as he recalled from the 44709 ride, it was nothing other than satisfactory.

Mr. Edwards stated that the PTRS reports indicated there were a lot of complaints about SK jets from pilots that were leaving the company. There had been complaints about how they operated but when he went to SK Jets to work on any changes; they did not resist the suggestions or changes. He said that when they found areas of non compliance, they corrected them.

Mr. Edwards said he had not worked with Mr. Smith much; that he usually worked with the chief pilot, Gary Fernandes, and the assistant director of operations (DO), Brian Bowie. He said Mr. Smith was more involved in flying at the time. He said he did not want to put a bad light on the company but that there had been complaints about them, and his office did investigate and did what they could.

Mr. Edwards said that the complaints had not come directly to him; they came to the FSDO management and were handled by management. They made the entries into PTRS and brought in a team to look at the operator through a focused inspection. He said he would have to look back and see if there were any EIR's (enforcement investigation report) that were done on the inspection. He recalled that he had had a number of discussions with the chief pilot and assistant DO regarding complaints about rest rules and pilots being on call 24 hours a day. Mr. Edwards said the results of the focused inspection should show up in PTRS.

When asked, Mr. Edwards said he had not received any complaints or concerns from SK jets management about rest rules but over time they had come to an understanding about what was rest and what was not rest. He did not recall if the company had added any guidance in the GOM or safety manual regarding rest rules. He said that after the discussions with the company, he did not recall any further complaints about rest time during the time he was POI for SK Jets.

Mr. Edwards was asked why SK Jets was not issued Operations Specification paragraph A021 pertaining to air ambulance and emergency medical service (EMS) flights. He stated that paragraph A021 was for companies that were going to carry patients with a doctor and/or nurse on board. He said in the case of SK Jets, they were just carrying passengers between airports and hospitals and that was no different than flying two businessmen somewhere to conduct their business, and then fly them back; there were no patients involved.

Mr. Edwards was asked to comment on FAA Advisory Circular (AC) 135-14A, dated 1991 which included a definition of an air ambulance and EMS operation as one in which body organs were transported for medical reasons. He said all he could do was use the current guidance that was provided to him which was the FAA Order 8900. He said he also looked at current notices that had not been included in the 8900 yet and at the FARs. He said the ACs were nice to do but were not required. He said an inspector had to comply with the 8900, notices and orders, then look at regulations to see if an operator complied with them. He said if it was just an AC, the operator could tell you to "pound sand". He said operators complied with most of the stuff in the 8900 but they could only make them comply with the FARs. Regarding ACs he said they tried to instill them in an operator to gain a higher level of safety but they were like briefing cards; there was nothing in the handbook (Order 8900) to prescribe what a briefing card should look like but ACs provided that guidance. He said the operators do not have to follow the ACs but most operators do and they are used to raise the safety bar.

Mr. Edwards was asked if a POI's surveillance included looking at an operator's financial stability. He stated that the handbook had a whole section that dealt with a company in financial stress. He said if they found out about that, they notified FAA management and one result was that surveillance was increased. He said it was difficult for them to prove a company was in financial stress and that a lot of the time they (FAA) found out very late. Sometimes they would

find out by talking with people at the company about what was going on there; and there were signs to look for such as airplanes leaving the company, pilots leaving the company, and high turnover rate of employees. He did not recall seeing any of those signs while he was the POI of SK Jets.

Regarding the incident with the bushes, he said it had been a long time ago and he did not want to speculate about what happened. He recalled some pilots telling him the story of what had happened but he could not recall the details. Regarding whether or not Mr. Smith took off in marginal weather conditions, he said the report did not indicate that but he had heard some talk of that. He could not recall the details. He said he was not a helicopter pilot so he was not familiar with helicopter operations but his recollection was that Mr. Smith was not illegal and if he turned around to come back because of weather; that was probably a good decision.

When asked how Mr. Edwards would deal with conflicting pilot reports, he said he could pull up weather for the surrounding area on the day in question. There was National Weather Service (NWS) data that was available that he had used before. He stated that, in his opinion, when there were two pilots with different stories, the truth was somewhere in between. He said in that case, he would have brought his assistant in since he was a helicopter pilot and now a POI himself. He said the weather minimums were different for helicopters than fixed wing so even though there was a helicopter pilot and a fixed wing pilot saying the weather was bad, they would not believe either one until they checked themselves. He said they did an investigation and there was no violation or enforcement action that he could recall except the 44709 ride for Mr. Smith. When asked if his hands were tied when the witnesses disagreed, he said that there were ways to go back and verify the weather even years later.

Mr. Edwards did not know why the event did not show up in PTRS until six months later and thought maybe that was when they found out about it. He said he had looked in PTRS and he noted that it was dated 6/6/2008.

When asked if there was any enforcement action that could have been taken when the company failed to report the accident, he said the NTS had rules for reporting accidents and the FAA had rules for reporting SDRs (service difficulty reports) so he would have to look at what maintenance was required under FAR Part 135 and he was not sure what reports were required for a helicopter.

He said generally the FAA did not violate a company if they failed to make a report to the NTSB since he did not oversee accidents; his job was to oversee company operations. He said if the company put the helicopter back in service without the proper maintenance being accomplished, that was when the FAA would violate them.

Mr. Edwards described Mr. Hoke Smith as a business man who started his company with one helicopter and grew it into a medium sized jet operation. He said he did not mind “bucking him” but if Mr. Smith found that he was not being dealt with properly, he would go to management. Mr. Edwards said you had to know what you were doing around somebody like Mr. Smith because while he might seem mild mannered, if he thought you were not doing your job right he would take it straight to management. He was okay to deal with but could be tough, Mr.

Edwards said that was how any the “self made guys” were as it was part of their life and not like someone who just showed up and bought a company.

Regarding improvements at the company while he was POI, Mr. Edwards said they had made changes in the GOM and training program. He said he was the kind of inspector that went by the regulations, the handbook, then notices and ACs. He said when a new POI was assigned and you found non-safety related issues it usually took about two years to get the ball rolling and to get the desired changes made. He said the company had been looking at international operations and had conducted a proving flight to Europe in a Challenger. He did not think they ever completed the approval for international revenue flight operations. Mr. Edwards said that anytime there was something brought up that needed to be addressed, Mr. Smith had done it.

Mr. Edwards was asked about the impact of ARGUS. He stated that ARGUS was able to go in to a company and say and do things the FAA could not and that operators were sometimes more willing to cooperate with ARGUS because they wanted the ARGUS rating to help their business. In general, he said operators with an ARGUS rating tended to be more compliant with regulations and tried harder because ARGUS had that rating to hold over their heads. They really wanted the rating to open them up to additional clientele.

Mr. Edwards thought that ARGUS was a positive force in the industry but he could not pinpoint any one specific incident to show that. He had observed that companies seemed to be a lot more concerned about their operations when ARGUS was involved. He said he was working hand in hand with SK Jets about the same time when ARGUS was around. He found that SK Jets was always compliant with any requests that were related to regulations or the handbook.

Mr. Edwards said the last time he spoke to Mr. Smith was about 2009 when he was at SK Jets. He was not even sure if he had talked to Mr. Smith on that occasion as he was there to meet with the chief pilot. If he did talk to Mr. Smith, it was usually for 5 minutes or less. When asked about his interaction with the chief pilot, Mr. Fernandes, Mr. Edwards said “he was a lawyer”. He also stated that he was a good pilot, good check airman, and was very conscientious about his job. He said it seemed the chief pilot tried to do the right thing.

He said he was not aware of Mr. Smith having any acquaintances working at the Orlando FSDO.

Regarding oversight of flights contracted through Mayo Clinic, Mr. Edwards said he did not have any involvement in the Mayo contract and his oversight of those flights was only through his normal surveillance of SK Jets Part 135 operations.

He had no knowledge of the current disposition of the SK Jets operating certificate. When asked if he had anything else to add, Mr. Edwards said based on his recollection and looking through the records, he would say that overall SK Jets was satisfactory, that they had a few maintenance issues but on the operations side it was a well run company that was an average busy company with a lot of things happening.

The interview ended at 1050.

Interview: Bill Joe Meadows, Aviation Safety Inspector, Federal Aviation Administration
Date: February 28, 2012
Location: via telephone
Time: 1230 EST

Present: Bill Bramble, David Helson – National Transportation Safety Board (NTSB); Bob Hendrickson – Federal Aviation Administration (FAA).

Mr. Meadows was represented by Mr. Brooke Lewis, Federal Aviation Administration.

During the interview, Mr. Meadows stated the following information:

He had worked at the Federal Aviation Administration's (FAA's) Orlando Flight Standards District Office (FSDO) as an aviation safety inspector. He had worked as an aviation safety inspector since he was hired by the FAA in 1997.

He was responsible for the oversight of the SK Logistics / SK Jets certificate at the time of the interview, and he had been since September 2011. He had been a principal operations inspector (POI) for Part 135 air carriers since 1998 or 1999, when he had completed his FAA training.

Before going to work for the FAA, he worked in corporate and Part 135 flying. His last job before he began working for the FAA involved working as a pilot performing mosquito control-related activities for the city of Jacksonville, Florida.

Mr. Meadows's total flight time was 7,500 hours. That included about 500 hours of rotorcraft time. He held one type rating for the Cessna 500. He had flow the following helicopters: Robinson R22, Robinson R44, Hughes 300, and Bell Jet Ranger.

His FAA office was located in Orlando Florida.

While serving as POI of SK Logistics, Mr. Meadows was responsible for about 9 air carrier certificates. The largest carrier he oversaw had over 200 pilots and about 50 aircraft. The smallest had one aircraft and one pilot.

Mr. Meadows estimated that about 10 percent of the time he spent performing surveillance on air carriers had been devoted to SK Logistics. Asked how he would characterize his workload, he said he did not lack for things to do. He had one assistant who helped with all of his duties.

Asked to describe his overall role and responsibility as a POI, he said it was to help air carriers stay in compliance with FARs. He performed surveillance including observation of actual flights, training, and reviewing, approving, and accepting documents. He also answered questions.

Asked what kinds of surveillance activities he had performed on SK Logistics, he said he had been to their location four times since September 2011. He had conducted one flight check with one of their jet crews, and he had interacted on the phone with SK about once every two weeks.

Most of his time spent dealing with SK had involved doing “routine stuff,” such as answering questions about things the company planned to do in the future as it related to training programs and dealing with their manuals.

Mr. Meadows was asked if there was any particular area he spent most of his time addressing with SK. He said that he considered them to be a normal Part 135 air carrier. There was nothing in particular going on with them except that he had recently finished up the approval of their use of electronic flight bags.

Asked whether there had been any areas of special emphasis in the surveillance of SK Jets, he said that there had been no special emphasis associated with SK Logistics. Asked if he was aware of any focused inspections, he said SK Logistics had in the past undergone random focused inspections.

Asked whether the approval of company manuals was one of his responsibilities, Mr. Meadows said yes. Any required manual approvals would carry his signature. Asked how often changes were made in SK Logistics’s manuals, Mr. Meadows said that the FAA made changes from time to time which required carriers to review or change their procedures or manuals. In the case of SK Logistics, they had added a new helicopter to their certificate and that had required some training program revisions. Other revisions occurred as necessitated by the FAA and changes in the carrier’s operating procedures.

Asked whether approving the company’s ops specs was also his responsibility he said yes it was, but he could not remember doing any revisions to SK Logistics’s ops specs, except for FAA template changes or something like that.

Mr. Meadows was asked what he knew about SK Logistics’s contract with the Mayo Clinic. He said he knew that they flew organs, but he did not know who their particular customers were, but he thought it was a huge part of their business.

Asked why SK was not required to have paragraph AO21 for EMS or air ambulance services in their ops specs, he said SK had never requested that particular paragraph. As far as he knew, they had never conducted an air ambulance flight.

Asked whether it was his understanding that the flying of human organs for transplant and the flying of organ transplant teams would not be included in the definition of air ambulance operations, he said no, those activities would not be included.

Mr. Meadows was asked how he would know if SK was conducting an operation that required that particular paragraph to be included in their ops specs. He said that one of the company’s competitors would likely have complained. Otherwise, it would be hard to find out through normal surveillance, such as records checks and reviews.

Mr. Meadows was asked for his impression of SK Logistics’s safety culture and safety programs. He said that he considered them to be a normal carrier. The SK personnel with whom he

interacted were always cognizant of safety factors during their operation. He never got the impression that safety was not a factor in their flying.

Mr. Meadows said that when dealing with SK Logistics, he interacted almost exclusively with the chief pilot and occasionally with the assistant director of operations. Gary Fernandes was the chief pilot, and Leigh McIntosh was the assistant director of operations. Asked whether he had had any interaction with SK Logistics flight crewmembers, he said he had given one flight check to two crew members he did not personally know. He could not recall their names. He was impressed by their use of the company's electronic flight bag. Aside from that, he had not had any interaction with SK Logistics flight crewmembers, except for Mr. Fernandes and Ms. McIntosh.

Mr. Meadows was asked with whom his assistant had dealt at SK Logistics. He said he was fairly confident that his assistant, Rick Sheppard, had not had any dealings with SK Logistics.

Asked whether he had received any complaints from SK Logistics employees, Mr. Meadows said he had not. Asked whether he had received any reports or complaints about SK Logistics from people outside the company, he said he did not think so.

Mr. Meadows was asked whether he had had any interaction with the company over company policies and procedures dealing with flight crew scheduling and duty limits. He said that his discussions with the company on those policies and procedures had ranged from not at all to very little. Asked for his impression on how they were operating their schedules with respect to flight time and rest rules, Mr. Meadows said that when and if he reviewed any of their flight schedules he did not remember noticing any discrepancies. The sheets he would have looked at were all in compliance.

Mr. Meadows was asked for his impression of how the company conducted its training program. He said that because he had only been overseeing the company for a short period of time, the only interaction he had with them on that was observing the oral portion of a check ride given by Mr. Fernandes. It had been one of, if not the best, examples of oral questioning he had seen.

Mr. Meadows was asked if he was aware of the status of a request for air ambulance authorization that SK Logistics had submitted before he was assigned to the company. He said he was unaware of this request and had no paperwork on it.

Asked for his impression of the company's maintenance operation, Mr. Meadows said that he had no problems with it. He had only gotten on one airplane with them. He did not remember writing up any items of discrepancy maintenance-wise for the company. He had never noticed an inspection being past due or anything like that.

Asked whether he was aware of the company having any financial issues, or whether he had had any concerns about the viability of the company, Mr. Meadows said he did not look at that as part of his surveillance activities. Asked whether he had heard from anyone whether the company was in financial trouble, he said other carriers will say things about their competitors

and he had heard from other carriers that the reason that one of the Lear jets was not available for service was because the company was unwilling to pay to have it repaired.

Asked whether the helicopters that were on the company's certificate were being operated, he said he believed both Jet Rangers were being used. He did not know of any reason why any of their helicopters were not being used. Mr. Meadows was asked whether it was his understanding that the Agusta helicopter was being operated. He said it was his understanding that the company was able to use all of its helicopters. Asked whether, as far as he knew, there was no reason for the Agusta to be grounded or restricted from any flight, he said he knew of no such reason.

Mr. Meadows was asked whether he had knowledge of any previous accidents or incidents experienced by the company. He said he was aware of a tail strike with the Agusta and an event with one of the jets. Asked for more information about the Agusta tail strike, he said that the tail rotor had struck bushes close to the ramp at the company's facility. Asked if he knew any more about the flight during which that had occurred, he said that anything he said about it would be hearsay. It was his understanding that the helicopter was returning back to the company facility. Asked whether he knew why it was returning, he said that if he did, it would be because he heard it from another air carrier and he was afraid that he would mix it up with some other event that had happened.

Asked whether he had knowledge of any violations or enforcement actions against the company, Mr. Meadows said no, he did not know of any that were going on at the present time, nor did he know about any that had occurred in the past.

Asked what knowledge he had about ARGUS and its rating system, and what interaction he might have had with ARGUS, Mr. Meadows said that his interaction with ARGUS had been almost zero. ARGUS would tell the carriers if there was something wrong in an FAA database, and he had made some changes as a result to ensure that the database reflected actual aircraft and personnel. He thought SK Logistics had an ARGUS platinum rating, but he could not recall whether SK Logistics or one of its competitors had told him that.

Asked whether, when ARGUS conducted audits of SK Logistics, he played any role in those audits, Mr. Meadows said no. Asked whether ARGUS audit findings on the company were shared with him, he said no, that information had never been shared with him.

Asked whether he had had any interactions with E. Hoke Smith, since becoming POI of SK Logistics, he said he had seen Mr. Smith around, but they had never even shaken hands. Mr. Meadows was asked whether he and Mr. Smith had interacted prior to Mr. Meadows becoming the company's POI. He said that he had given about three Part 135 helicopter check rides to Mr. Smith. One had been in an Agusta 109 and the other two had been in Jet Rangers. Asked for his impression of Mr. Smith's flying skills, Mr. Meadows said that they were better than average. Asked about Mr. Smith's flight planning and decision making skills, Mr. Meadows said that he could not recall any discrepancies during those check rides. Asked whether these were instrument or VFR check rides, Mr. Meadows said that the Agusta check was probably the first one he had given him. It was probably an IFR check. The jet ranger checks would have been

VFR checks. Mr. Meadows had never flown with Mr. Smith in an airplane. Mr. Meadows had never heard any complaints from anyone else about Mr. Smith's flying skills or decision making.

Mr. Meadows was asked to describe Mr. Smith's personality or character, when he was flying. He said that when Mr. Smith was flying he was flying. He did what was required for the check and moved on. Asked about Mr. Smith's personality when he was not flying, Mr. Meadows said he never interacted with him on any other basis, so he really did not have an answer.

Asked about the current disposition of the SK Logistics air carrier certificate, Mr. Meadows said that the company still held a certificate, but their ops specs had been amended so they were not authorized to conduct air carrier operations. Their assistant director of operations had resigned. He thought he had an email on his computer indicating that the chief pilot had resigned as well. He had been told by another inspector that the company has filing for bankruptcy and that the company documents, including the ops specs, were in receivership. Whoever was controlling the bankruptcy had those documents.

Asked how he first learned about the accident, Mr. Meadows said he was on vacation and an inspector had called him. Mr. Meadows checked in with the office to see if anything was needed from him and he was not needed at that time. Shortly thereafter, he called the SK Logistics chief pilot to verify that the operation had been conducted in accordance with the company's operational control procedures and he was told that it had been. Asked why he had thought it important to verify whether the flight had been conducted in accordance with the company's operational control procedures, Mr. Meadows said because it was early morning flight before people normally came to work, and he was worried that they might not have followed the procedures. However, when he asked about it, they told him trained personnel had released the flight.

Mr. Meadows was asked whether he was aware of any occasions where the company had not followed its operational control procedures, he said he was not. Asked what procedures they would follow for a flight that was released at night or during the early morning hours, he said that before any air carrier pilot could begin a Part 135 flight, someone with operational control had to do checks to see if the pilots had had their required rest and if the aircraft was in an airworthy condition. That person was supposed to be trained. Mr. Meadows had been informed that the person who released the accident flight had been trained.

Mr. Meadows was asked what follow-up activity he had taken in response to the accident. He said he had verified with the chief pilot that company procedures had been followed and he had worked with the chief pilot to amend the ops specs to ensure that the company would not conduct air carrier operations again until Mr. Meadows agreed they could. His discussion and the amendment to the ops specs had occurred in late January 2012.

Asked why the ops specs had been amended to restrict air carrier operations, he said it had been his own decision. He got the impression from talking to the chief pilot that the aircraft were being taken back by their owners, possibly repossessed, and they were being moved around, and Mr. Meadows could not readily figure out what they were doing with them. Mr. Meadows was informed by another carrier that the assistant director of operations had taken a job with them,

and the chief pilot was becoming temporary and was not in the office as much. The chief pilot had agreed that the ops specs should be amended, so Mr. Meadows amended them.

Mr. Meadows was asked for his interpretation of the helicopter night weather minimums listed in the company's general operating manual, which were 1000 foot ceiling and 3 miles visibility. He said that those limitations were more conservative than the federal aviation regulations for Part 135 helicopter operations. Asked to describe FAA weather minimums for Part 135 helicopter operations, Mr. Meadows said he was afraid he would misquote them, so he preferred not to say.

Mr. Meadows was asked how he would expect SK Logistics to apply the company's weather minimums to the weather information that was available for the accident trip. He said that because the general operating manual was an accepted document, he would expect that the pilot and the person who had operational control and released the flight would consider whether any weather fell below the company minimums.

Mr. Meadows was asked whether he would expect the person exercising operational control during the release of the flight to be informed about the current weather conditions and to compare that information to company weather minimums and he said yes. Asked whether a pilot could release him or herself, if they were one of the individuals authorized to release a flight, or if someone else would have to release it, he said pilots were not supposed to release themselves unless the operator was a single-pilot air carrier.

Asked which types of weather reports he would expect a pilot to review before departing on the accident flight, he said that the pilot should review the METARs, TAFs and area forecast. There were probably not any PIREPs available because it was so early. The winds aloft would probably not be significant because of low altitudes that would be used during the flight. The pilot should review the NOTAMS. Those were the weather sources that the pilot was required to check. There were lots of other sources available, however.

Mr. Meadows was asked whether METARS were the source of information that the pilot should compare to company weather minimums when making a go/no-go decision or whether the TAF should be compared to the minimums as well. He said that all weather information was binding on the pilot to make a decision as to whether a flight could be safely continued. For VFR operations, the pilot should be expecting to stay in VFR conditions from departure to touchdown.

Mr. Meadows was asked if he thought a pilot would be in compliance with the company's general operating manual if the forecast said that the destination would be below company VFR minimums by the time of arrival but the METARs said that the conditions were above minimums at the time of departure. Mr. Meadows said he would not describe behavior that was inconsistent with the general operating manual as noncompliance. He thought that the go/no-go decision should be a shared decision between the person who was exercising operational control and the pilot. Asked whether he would still think this should be the case if the person releasing the flight was not a pilot, he said yes. That person was supposed to be trained when they were given the authority to release flights. Asked specifically whether he would expect them to participate in weather-related decision making, he said, that was what the FAA was trying to cause to happen.

Mr. Meadows was asked whether, in his experience, the TAF's in northern Florida often forecast low ceilings, mist or low visibility very early in the morning, particularly in the winter, but these forecasts often did not come to pass. He said he no longer flew very much often, and he never flew that early in the morning, so he could not say. Asked whether he considered "temporary" conditions in a TAF something that could happen but was not as likely as other information in the forecast, he said that he was tasked with making sure that the company complied with the federal aviation regulations and he could not say how that applied to company minimums. Asked what he would expect the company to do if a TAF said that the ceiling at the flight's destination was going to be below Part 135 helicopter minimums, he said that in accordance with Part 135 rules, in VFR operations, pilots could make their own assessment of the conditions, but they could not continue into weather that was below basic Part 91 VFR minimums.

Asked to clarify whether the forecast was considered useful information but the pilot was able to make real time decisions independent of the forecast during a flight, he said that for a VFR flight the weather conditions reflected in the TAF and the METAR must be at or above VFR minimums. If the weather conditions were forecast to be below VFR minimums, then the FAA would have a hard time finding that a pilot was in compliance if they caught wind of it. Asked how the FAA would know if the pilot conducted a flight where the conditions were forecast to deteriorate below minimums at the destination but the weather turned out to be better than forecast, he said that the FAA would not know about it. Asked whether, in such a situation, it would make a difference if the forecast indicated that the weather was only temporarily expected to be below minimums around the expected time of arrival, Mr. Meadows said that "tempo" conditions were counted for IFR-related decision making. Mr. Meadows was asked whether tempo conditions similarly applied to VFR decision making, he said he had never thought about that question and would have to research it further before he could provide an answer. He had never operated a helicopter under Part 135.

Mr. Meadows was asked whether SK Logistics was authorized to conduct IFR helicopter operations under Part 135 at the time of the accident and he said that he did not know.

Mr. Meadows was asked about the altitudes he would expect SK Logistics to use for VFR operations when flying from JAX to Gainesville at night. He said that he had no night helicopter flight time, and he felt he might give information that would be way off base if he answered that question.

Asked whether helicopter emergency medical evacuation services (HEMES) in Florida were required to use night vision goggles, he said he had not received any guidance on night vision goggles. Asked whether HEMES operators in Florida were required to have more than one pilot, he said he did not know. He had not been assigned to oversee any HEMES operators.

Mr. Meadows was asked if he was aware of any aircraft at SK Logistics that were in need of repair and were not operable at the time of the accident. He said that the only such situation he was certain about was that one or more of the Lear jets were in maintenance and were not available for flight operations. Asked to clarify the last time he had visited SK Logistics before the accident, Mr. Meadows said probably in November 2011. Asked whether, at that time, the Agusta 109 was being used for flights, he said he did not know that it was or was not flying. He

typically checked the records for flights and flight crews that were already away from base. He did not remember checking records for anybody who was flying the Agusta.

Mr. Meadows was asked what he would normally do if an operator had an accident and did not report it and someone anonymously called it in to the FAA. He said that he would contact the operator to see why they thought it was not a reportable accident. Asked what he would do if it turned out that counterweights had separated from the tail rotor and shot through stringers in the tail and the helicopter was in need of significant repair, he said he would have to review the NTSB regulations to determine what he would do. He had little experience with accident investigation. FAA standards required that events be reported to the FSDO. If the PMI (principal maintenance inspector) did not know about the accident, however, the FAA would start an investigation for noncompliance because such events were required to be reported to the FAA. Asked what required the operator to report such things, he said it was required because there was a Part 135 maintenance regulation which stated that any maintenance irregularity had to be reported to the FSDO, whether it stemmed from an accident or not.

Asked what he would do if he received a report that a pilot had taken off in weather conditions that were below VFR weather minimums for helicopter 135, he said the FAA was almost always going to investigate a complaint. If it occurred at an airport with published weather and the reported weather at the time of the flight was below FAA VFR weather minimums, they would start an investigation and possibly initiate enforcement action because of the reported weather at the departure airport, however helicopters could fly pretty low.

Mr. Meadows was asked whether a Part 135 company was required to follow weather minimums published in their general operating manual that were more restrictive than FAA weather minimums, after the general operating manual had been accepted by the FAA, he said yes, he would expect them to follow the minimums in their manual, but the FAA could not enforce the more restrictive minimums.

Asked whether this meant that a company could write anything they wanted in their manual but could actually do something else, as long as they followed the federal aviation regulations, Mr. Meadows said he knew of no federal aviation regulation that would prevail in court if the FAA was trying to enforce more restrictive limitations published in an accepted manual.

Asked to clarify whether he expected the person who released a Part 135 flight to participate in the weather-related decision making with the pilot, he said that upon further reflection he believed that the only two things that were required to be verified by the releaser were pilot rest and aircraft airworthiness. He said he had made an assumption earlier in this interview that weather would be a part of the releaser's decision making without knowing that for a fact. However, if that was the company's policy, then he would expect it to work that way.

Asked whether he had anything to add, Mr. Meadows said no.

The interview ended at 1410.

Interview: Edward Harold Wandall, Director of CHEQ – ARGUS International, Inc.
Mark Samuel Wulber, Director Audit Programs – ARGUS International, Inc.
Date: March 29, 2012
Location: via telephone
Time: 0910 EST

Present: Bill Bramble, Bob Gretz, David Helson – National Transportation Safety Board (NTSB).

During the interview, Mr. Wandall and Mr. Wulber stated the following information:

Mr. Wandall was the director of the CHEQ (Charter Evaluation and Qualification) program at ARGUS in Chalfont, Pennsylvania. He had worked for ARGUS International for about 9 years and had been the director of CHEQ for about 5 years. He was a certificated commercial pilot with multi engine and instrument ratings. He worked for 19 years in FAR part 135 charter operations. He had held positions as the supervisor and assistant manager for Doylestown Airport for 10 years. He had a Bachelor of Science in aeronautics and aviation management from Embry-Riddle Aeronautical University and had completed their accident investigation course. He was a full member of ISASI (International Society of Air Safety Investigators) and was a qualified IS-BAO (International Standard for Business Aircraft Operations) auditor.

Mr. Wandall stated the role of CHEQ was to look at all domestic Part 135 and participating international charter operators and evaluate their history, pilot information, and aircraft information. CHEQ was a due diligence tool that people could use to check that an aircraft was legal for use by an operator and that the pilots were qualified to operate the flights. For example, if a customer specified that a pilot must have 3,000 hours minimum to conduct the flight, they could verify it with the CHEQ system. He said domestically they conducted back ground checks on pilots every year through the FAA (Federal Aviation Administration) and checked for any fines, enforcement actions, suspensions, or revocations and their checks were in excess of those done through PRIA (Pilot Records Improvement Act).

Mr. Wulber was the Director of Audit Programs for Business Aviation at ARGUS International and was based in the Denver office located in Greenwood Village, Colorado. He had worked for ARGUS about 9 months. He had a degree in aviation technology from Purdue University. He held an ATP (Airline Transport Pilot) certificate with a number of type ratings and also held A & P (Aircraft and Powerplants) and FE (Flight Engineer) turbojet certificates, and a CFI (Certified Flight Instructor). He had been a chief pilot for a Part 135 operator in the Midwest, had worked as a pilot for FedEx, and was a safety and audit program manager at Executive Jet Management. He had also been a director of training and regulatory affairs at Executive Air Shares in Kansas City.

Mr. Wulber described his role as having overall responsibility for the audit programs at ARGUS, including the Platinum program. They conducted a large number of IS-BAO audits and Flight Safety Foundation Basic Aviation Risk Standards (BARS) program audits. He summarized his

role as having overall responsibility for the audit programs, auditor training, quality control, and development of audit standards.

Mr. Wandall described the history of ARGUS. He came to ARGUS in 2003. He stated that in about 1995 or 1996 the company was founded by Joe Moeggenberg who had originally been part of starting the EJM certificate which grew to be the largest on demand charter certificate. With all of the knowledge he gained he started an aviation consultancy and partnered with Mark Fischer who had an aviation and internet technology background. He said mark brought the ability to organize and search FAA databases. The name was derived from Aviation Research Group US. Researching aviation data was their forte. They did look backs on all instrument rated pilots and on registered aircraft. The industry wanted the ability to look at the charter operators. He said the FAA had a good system of doing that for Part 121 air carriers which included FAA managers assigned to oversee each airline, but the part 135 world was handled by the FSDOs (Flight Standards District Office). He said ARGUS had been contacted by a few of the fractional operators who wanted them to look at the Part 135 operators. He said they used the NTSB and FAA databases to start building their own database of all on demand operators. ARGUS collected history on all of the operators and started to evaluate them and in 1999 they came up with a way to rate an operator's history. He said, for example, if you wanted to look into the history of XOJET, you could log into the system, buy a report, and see what is listed for that operator.

Mr. Wandall said that operators were offered the opportunity to participate at a higher level and provide information about aircraft listed on their Operations Specifications, and pilot's flight times and qualifications. He said they independently verified all information on pilots even though the operator had done PRIA checks. The information provided was validated through the FAA database and assigned a score for warnings, fines, suspensions, and revocations. He said some operators did not qualify for an ARGUS rating. The reasons could be bad operating procedures or bad luck with respect to events at the operator but they looked only at objective data; things they could see and point to without making any assumptions. He said there were many variables and the best way to look at an operator was to conduct an audit.

He said in 1999 ARGUS started to work with a guy from the US Air Force Air Carrier Authorization Branch of the DOD (Department of Defense) at Scott AFB. They had developed a pretty extensive audit system following the Gander, Newfoundland crash. He said they had moved to an audit system that evaluated how a company operated rather than just looking at compliance issues. He said that knowledge helped ARGUS develop an audit standard to apply to the charter industry. If a company met the standard, they were afforded a Gold rating. If they allowed ARGUS to come in and conduct an audit, and met that standard, they would get a Platinum rating.

Mr. Wandall stated that in the first year they conducted 6 audits and now they did about a hundred audits a year. The participating operators grew from about 100 ten years ago to about 430 today. They had complete background histories on all of the pilots including total time, time in type, medical class, qualifications, and ratings. He said they had over 9,000 pilots and 2,400 aircraft in their system. He said that in 2004 they had audited enough operators to recognize that Part 135 industry was its own entity that cannot be compared to part 121 or part 91 operations so

they changed the audit standard to make it harder. In order to obtain a Platinum rating, they wanted to continually challenge the industry and make it a little harder each time. They did not want everyone to pass. He said in 2004 they were the first to require operators to have an SMS (Safety Management System) which the FAA had not even required. They also required operators to have an IEP (Internal Evaluation Program) and an emergency management process that was in excess of FAA regulatory standards.

Mr. Wandall said that about 4 years ago, they started to work with the international industry but it had been challenging. In the US, there is freedom of information but it was not so easy to collect information internationally and that has created a lot of work for the people in the Philadelphia office. For example, he said the Austrian government will not provide them with any pilot information so they need to collect it through the companies; which is a cumbersome process.

Operators have a subscription to the system and anyone who uses on-demand lift can buy a subscription and access the system to check on a company rating and the pilots.

In order to have a Platinum rating, an operator must meet the ARGUS audit standard, must provide all the information needed to evaluate the company and the pilots, and must keep the data current within 90 days at all times. In order to have a Gold Plus rating, an operator must meet the standard, must have all pilots listed in the system, and must have an audit for either ARGUS or another approved audit standard such as IS-BAO. This would also include companies who were audited by ARGUS but did not quite meet the Platinum standard. A Gold rating means the operator has provided a safety history and aircraft data. Additional ratings include “not rated’ but they still collect information on them from NTSB and FAA databases, and a “DNQ” (did not qualify) which is used for instances when a company had something in their history or something that was seen in an audit that ARGUS did not like. If someone wanted to see where the data came from, they could purchase a CHEQ report.

As an example, he said if you looked up XOJET, you would see that they had a Falcon that had a runway overrun in Rifle, CO and a few other incidents. He said most people used their Trip CHEQ; there were 30,000 issued last year. He said through that report, you could look to see if the operator’s safety standard was high enough to meet your requirements. You could ask the operator who the crew was going to be, to check the crew qualifications and the aircraft for legality and whether it had been involved in any previous events. You could check to see if the crew met flight time minimum standards.

He said all ARGUS trips required a two person crew. The pilot in command (PIC) had to have at least 3,000 total time and 1,500 PIC and the second in command (SIC) had to have at least 1,000 hours total time and 500 hours PIC time and there had to be at least 250 hours in type between the two of them. He said those minimums were based on the DOD standard for supplemental lift but if you felt that was too low, you could input your own requirements. He said, for example, Ford Motor Company required 5,000 hours.

Mr. Wandall was asked how an operator’s previous accidents and incidents factor into the ratings. He said the scoring system was proprietary but provided an overview of the factors

involved. He said they only considered things they could see and measure. For example, he mentioned an accident in Teterboro involving a Challenger [Platinum Jet] was considered a significant event and would be an extremely high scoring event in their system. He said they looked at FAA enforcement system. That system was broken down into administrative actions and certificate actions. If it was an administrative action, they would note it and put it in the system but it would not necessarily preclude an operator from flying because it could just involve a warning notice or letter of correction. A letter of correction was not even an adjudication of guilt but may require corrective action or training. He said a certificate action was more serious and required a much higher workload and expense, so the FAA preferred not to do that. Because of this, he said if there was a certificate action, it must have been something serious. He said that fines were at a lower level, suspensions were above that, and revocations were pretty serious. He said the customers came to them and advised what they were comfortable with and ARGUS set their threshold based on that input.

With respect to scoring previous events, he said they considered 36 months to be current. If an event occurred that recently it would affect a pilot's trip CHEQ. For a company, they scored an event in the most recent 3 years as significantly higher but kept the events in the system for 10 years. After the first 3 years, the score on the event would start to drop. The scoring considered the severity of the event as well as whether or not there were any fatalities. He said even if there were not fatalities, they were looking at whether the aircraft got out of the area it was supposed to be operated in. He said they had made a minor tweak to the scoring system in 2003.

Mr. Wandall was asked how a serious event would affect a rating, and how would a customer know. He said they never say if a company is safe, they do not know that, they just rate them based on the data collected. He said they were a due diligence tool. As an example, if a company like XOJET had an airplane go off the runway and the runway was just paved and not grooved, we do not know whether that was out of their hands but it is good information for the customer to know. Another example, he said when Excel Air was involved in a midair in Brazil. That aircraft was not on their certificate at the time so that influenced how the rating was affected. He said if there was some type of event, they might remove a company's rating and not restore it until they saw a report from the NTSB. He said he was not a real popular person in the industry because when there was an event, he was the one who removed an operator's rating. He said they had a board that reviewed the NTSB reports to determine if the rating should be restored.

Mr. Wandall said they looked at severity and currency so that if a company had an event 10 years prior, it would not have much effect on score. He said they also had situations where a large operator lost their rating because they had a lot of pilots with events on their records. In this industry accidents happened and they were trying to help reduce them. He said they did not have a process to guarantee safety, if they did, it would cost a lot more. He said one of their best companies had a significant event a while ago and that was what drove them to a higher standard but some companies could not recover from a significant event.

Mr. Wandall was asked to comment on how an FAA 44709 ride would be viewed in the system. He stated that they often would not see it. When they did a background check on a pilot, they might see a letter of correction was issued which could involve a check ride or some type of sign

off. They would include a simulator date but not whether it was a satisfactory or unsatisfactory rating. He said the way the industry is now; they just put someone in the simulator until they pass. He said the only data they had was a report on when the pilot satisfactorily completed a training event. If the FAA recorded a violation in the system, they would be able to see that. If a pilot certificate was suspended pending a 709 ride, he said that would also show up in the reports as well as a revocation. There would be a record of reinstatement and they would alert everyone who wanted to use that pilot if they ran a trip check. If the event happened within the previous 3 years, it would also be factored into the company's score.

Mr. Wandall said the Mayo Clinic was not a subscriber of their system unless it was a subscription under an individual's name. He said there was a Mayo Aviation that subscribed but he thought they were not related. He said he had spoken with a Mr. St George from the Mayo Clinic in 2009. The contact had been initiated by Katy Godwin, the director of charter at SK Logistics. He said they had a telephone discussion but he did not recall any specific questions Mr. St George had asked. He had discussed with him how the ARGUS system worked and what the different ratings meant. He did not recall if the discussed SK Jets history of accidents and incident but if asked, he would have shared that information. Mr. Wandall said he did not have any record of Mayo Clinic requesting any of the reports on SK Jets and he did not know if SK Jets provided that directly to Mayo Clinic. He said if asked, he would not have been able to provide copies of the audits because those belonged to the operator, who could give them to whomever they wished. He said if Mr. St George had asked, he would have been able to provide him more due diligence in the form of a CHEQ report.

Normally someone off the street would have to buy the report but since the company established the contact with them, he would have been happy to give a copy of the report. He said the NTSB could buy reports off the website. He referred to the sales department for current pricing but said they used to be $249, including a trip check, but the pricing had changed.

Mr. Wandall was asked if they had a process in place to deal with complaints about an operator. He stated that complaints were subjective and if he could not put his finger on something from some source, he could not do much with the information except keep their ears pricked up for any information. He said sometimes where there was smoke, there was fire but they did not deal in opinions, all he could do was look at the FAA and NTSB databases.

He was asked specifically how they would handle a situation where an employee of an operator notified them that the operator was not following the standards the audit was based on. He said they had a whistleblower process and would present information collected to the company to allow them an opportunity to address any accusations. If the information met a certain threshold, they could call for an audit.

Mr. Wandall did not recall if there had been a whistleblower at SK Jets. He said after the accident in December 2011, as they do following any accident, they sequestered all records pertaining to the company, review correspondence, communications, and any subscribers who had used the operator. He did not recall anything coming up when he did that review. He did not recall having a former SK Jets employee named Felton contact him about the company but

he could search his records to verify. He said the whistle blower program had only been utilized two times and he did not think either instance involved SK Jets.

Asked how ARGUS verified flight crew flight time records, Mr. Wandall said that the company reported pilot flight times to the FAA to meet regulatory requirements. ARGUS looked at the reported experience levels to see if they met client requirements. Asked how they would detect records that a pilot had falsified, he said that the operator signed an agreement with ARUGS. If ARGUS detected sudden changes in a pilot's flight time, they would contact the operator to ask for an explanation. ARGUS also examined trends in pilot flight times over a period of years to look for unusual changes. Often such changes resulted from a data entry error. Approximately a third of ARGUS's pilot flight experience data came from scheduling software used by operators, such as CT-FOS or BART. ARGUS received feeds from that software. The FAA used the software to audit pilot flight time when they came in to do an inspection, so ARGUS felt they could rely on it. In addition, ARGUS could ask for a copy of a pilot's logbook if they wished, or compare the reported flight time with a pilot's FAA medical records.

Mr. Wulber said that ARGUS audits were conducted on platinum operators every 24 months. Asked what follow-up activities occurred between audits, Mr. Wandall said that at the conclusion of an audit, an operator was given an out-briefing. If there were any findings, they were informed of that. Then they have the opportunity to correct those findings. That corrective action process could take one of two forms. If the issues were minor in nature, they could be handled through the submittal of documents, be they manual revisions or training program revisions. If the operator had significant gaps between the standard and what they were doing, or if they were a weak operator overall with lots of issues, then the auditors would require a gap audit. If the operator did not have any findings, and there was nothing of significance found in the audit, then they were just put on the 2-year cycle. Mr. Wulber commented that with respect to follow-up activities, the audit was just one part of the system. The auditor's function was an ongoing function, and the audit that took place every two years was just a part of that.

Asked whether ARUGS checked to see if an operator was following their own policies and procedures and whether they were complying with the terms of customer contracts, Mr. Wandall said they were looking to see whether the company's management activities were resulting in the desired output, and whether the company had proper controls in place, such as documented procedures and training, and whether the company was making sure that everyone understood those procedures and was operating as expected. ARGUS did not look at their customer contracts. The only way that would occur is if a company approached ARGUS and asked them to audit their operations for compliance with contractual requirements.

Mr. Wandall said that after searching his records for the name of the reported SK Jets whistle blower during the interview, he was able to identify some emails between the whistle blower and himself. He said that he had marked the contact as a whistleblower contact, but it was before ARGUS had formalized its whistleblower process. He said that ARGUS did follow up with the operator in this case. Asked to describe the nature of the complaint and the action ARGUS took as a result, he said the emails were somewhat confusing. It appeared that the person who contacted ARGUS, Mr. Darrin Felton, had recently separated from SK and was letting ARGUS know that one of the SK Jets pilot's flight times were inaccurate. He believed that there was a

600-hour discrepancy and was saying that the flight time for this pilot had been reported to ARGUS as having 3,000 hours when they actually had only 2,400 hours. Asked whether the whistleblower was referring to his own flight time or someone else's, Mr. Wandall said it appeared that the whistleblower had been referring to another pilot at the company. Mr. Wandall said he would have to research his records to document his response to this complaint, and it would take some time to pull that together, but he believed he would have contacted SK Jets and asked them to review the flight time records of the pilot of interest and check it out.

Asked whether it was accurate to say that ARGUS primarily monitored FAA and NTSB databases and various data feeds, such as computerized flight and duty time records between audits, Mr. Wulber said yes.

Mr. Wandall was asked to describe the history of past ARGUS audits conducted on SK Jets. He said that ARGUS audits were conducted on SK Jets in September 2006, October 2008, and January 2011, and the next audit would have occurred around January 2013. Asked why the interval between the second and third audit was longer than 24 months, Mr. Wandall said it could have been a scheduling constraint on ARGUS's part that caused them to be unable to accommodate the audit before the end of the 24-month period. If a scheduling conflict arose on the ARGUS side, they might review the operator and decide to extend the platinum certification until an audit could be arranged. He commented that ARGUS's auditor pool thinned out over the holidays. Asked whether that was the reason for the longer-than-normal time between audits in this case, Mr. Wandall said he would have to pull up communications to find out.

Asked whether SK Jets ever failed an audit, Mr. Wandall said that when he looked at their score history, he realized that SK Jets rating might have been reduced to gold plus in October 2008. He stated that there was an auditor recommendation in 2008 that SK Jets be reduced to gold plus until they showed that they met the ARGUS standard. The platinum rating was restored in December 2008. The reason for the gap in the platinum rating was due, in part, to SK Jets' efforts to concurrently schedule an ISBAO audit. The reduction to gold plus meant that SK Jets had undergone an audit and the auditor had identified issues that did not meet the platinum standard. Asked to describe those issues, Mr. Wandall said that he could not release that information without SK Jets permission.

Mr. Wandall was asked what he could say about E. Hoke Smith. He said he had had almost no interaction with Mr. Smith, other than meeting him a few times at trade shows. Mr. Wandall usually dealt with the SK Jets charter scheduler or administrator, Katie Godwin.

Asked who performed the last two audits on SK Jets, Mr. Wulber said Jim Cannon was operations auditor and lead auditor and Alan King was the maintenance auditor for the January 2011 audit. Tom Monfort was the operations auditor and Ed Barber was the maintenance auditor for the 2008 audit.

Mr. Wandall was asked if any SK Jets aircraft had been out of service for maintenance during the January 2011 audit. He said that was not something that would typically come out in an ARGUS audit. Asked whether it would come out if several aircraft were down for several months at a time for engine overhauls or other expensive maintenance tasks, he said he would have to go

back and read the 2011 audit report, but such items were not criteria for the audit. ARGUS would note if the operator was flying aircraft with overdue maintenance, however.

Asked whether the financial condition of a company was something ARGUS looked at, Mr. Wandall said not currently. ARGUS staff had discussed that issue internally on multiple occasions. Financial stress was something the FAA recognized as a risk factor, but it was difficult to obtain such information. Furthermore, Mr. Wandall could think of four or five major airlines that were operating under bankruptcy, and they were operating safely.

Mr. Wandall was asked to describe any SK Jets accidents that ARGUS knew about. He said they were aware of a helicopter accident involving N355D that was involved in offshore platform flying. They were aware of a dual-engine flameout that occurred in a fixed wing airplane, N70SK, on July 21, 2007, they were aware of an accident involving N109SK that occurred on 12/22/2007, and they were aware of the most recent accident that occurred on 12/26/2011. In addition, they had an incident record on a deer strike that occurred on 8/14/2008. Asked how ARGUS categorized the severity of those incidents, Mr. Wandall said that ARGUS's rating system was proprietary, but in general terms, the 2002 accident scored significantly. The event on July 21, 2007, had, according to the FAA, involved some sort of deficiency in the aircraft, so ARGUS had taken that into consideration. The deer strike had been an act of God. ARGUS did not have enough information on the most recent 2011 accident to score it. Asked to describe how ARGUS had categorized that event, he said it was "pretty significant."

Mr. Wandall was asked how ARGUS determined whether an operator would remain platinum rated if they had an event like that December 2007 accident. He said that the operator could be really bad and just be really lucky or they could have an FAA principal operations inspector who had just come from the major airline world who was used to issuing compliance letters. ARGUS's audit established their rating of a company and the only thing that would affect the rating is if they had another significant event. That was what had happened with SK Jets. After the December 2011 accident, ARGUS removed SK Jets platinum rating until they had a chance to review the NTSB's final report on the accident.

Asked whether the December 2007 accident played any role in the change in SK Jets status in October 2008, Mr. Wandall said no, the change in the rating occurred purely because of the audit. Asked whether ARGUS had any records describing what the FAA did as a result of the December 2007 accident, Mr. Wandall said he would have to look to see if the pilot or certificate had a fine, suspension, revocation, or correction associated with that same date. If ARGUS saw a violation and they saw it on two pilots, it would probably be associated with the event, but he did not see anything else coming from that event.

Mr. Wandall was asked whether the ARGUS platinum rating applied to a company's helicopter and fixed-wing operations or just its fixed-wing operations. He said it applied to the company and its operating certificate. Asked whether ARGUS standards specified that a company should operate its helicopter flights with two-person crews, or just the fixed wing flights, he said that the ARGUS rating was just one level of due diligence for a customer. ARGUS highly recommended that a customer evaluate each crewmember that would be flying a customer's passengers. That was accomplished through the TRIP CHEQ process, which looked to see whether qualified and

experienced crews were assigned that met the customer's minimum standards. An ARGUS requirement for the TRIP CHEQ was for the operator to have assigned a two-person professional crew. Asked what Mayo Clinic would have seen if they had requested a trip check for the December 26, 2011 accident flight, he said ARGUS would have been unable to generate a TRIP CHEQ report because it would have required them to select a second pilot.

Asked whether ARGUS minimum standards for crew qualifications included an instrument rating for helicopter pilots, he said that their standards required an ATP rating (which included an instrument rating) for pilots in command. The second in command could have a multi-engine instrument rating. Asked whether the flight crews had to have complied with the recency of experience requirements to be instrument current, Mr. Wandall said there was no way for ARGUS to validate recency of instrument experience. They just looked to see whether there was an ATP serving as the PIC, whether there was a two-person crew, and whether both crewmembers had the required number of flight hours.

Asked what ARGUS would do if their auditors discovered that an operator was not holding quarterly safety meetings as they had agreed to do during a previous audit. Mr. Wandall said it would be a finding that they were not living up to their processes and the standard. It would show up as a finding on the audit, and they would have to correct the deficiency in order to have the auditors recommend a platinum rating.

Mr. Wulber explained that the audit side was complementary to the data side. The audit team recommended a rating, but that rating had to be supported from the data side as well. The two together determined the rating that an operator held at any particular point in time.

Asked whether, during an audit, ARGUS looked to see how an operator was applying FAA rest rules, Mr. Wulber said ARGUS looked at the company's policies, whether they were maintaining their duty records, and whether the people who were processing the trips were referring to those and whether the people who had access to that information could follow the company procedures.

Asked how ARGUS viewed the difference between being in a rest period and being on call, Mr. Wulber said to the degree that the procedures said pilots must have x amount of rest, it was impossible to know in each case if a company's pilots were actually free from all duty. This issue got into the legal interpretation of the rest rules and it was one of the sticky areas in the on-demand industry. ARGUS would not know if a scheduler called a pilot twice while the pilot was in a rest period.

Asked whether ISBAO was a competitor with ARGUS and Wyvern, Mr. Wulber said ARGUS had its standard and performed audits to that standard as did Wyvern. ISBAO was a standard produced by the International Business Aviation Council. It was a third party to them. Most of ARGUS's auditors held ISBAO accreditation. ISBAO was not into the auditing as a part of their business. Asked whether ARGUS and Wyvern were the two big auditing companies, Mr. Wulber said that the Air Charter Safety Foundation was another auditing organization.

Asked how different it would be to standardize how the audits are done between ARGUS and Wyvern and whether their processes were very different, Mr. Wulber said there was a lot of crossover between the various audit programs. There might be things with each program that were unique. The Air Charter Safety Foundation had created a standard they referred to as the industry audit standard. One of their goals was to try and reduce the number of audits operators had to undergo because there was a cost associated with each audit.

Asked whether SK Jets had been able to get a platinum rating after their first accident in 2002 because it occurred four years before their first ARGUS audit, Mr. Wandall said that the score associated with that event would have moderated after 36 months. ARGUS had a scoring graph that showed what significant events had occurred. The influence of the accident on the rating did not drop off completely until 10 years after the accident. The FAA expunged accident information in 5 years. ARGUS tracked them for double that period of time.

Asked whether an accident would affect an operator's score if the crew was killed in an accident and the FAA did not take certificate action against operator, Mr. Wandall said they had a policy that indicated that they would only score an event once. If, in addition to the event, there was a fine for the operator and a suspension for two pilots, and maintenance fine, there would still only be one score for the event. It would simply go into the system with the highest score. Asked whether such an event would be considered a major mishap regardless of whether the FAA initiated some type of enforcement action, he said yes. Furthermore, if the pilots involved survived the accident and pilot error was found to be a contributing factor, they would carry that accident rating with them to a new company. Asked whether it would affect a company's score if a flight to an oil platform was outside of the company's FAA operations specifications, he said yes, even if the event did not result in loss of life, that sort of thing would score highly.

Mr. Wandall was asked whether a CHEQ report contained a summary of an operator's most recent ARGUS audit, Mr. Wandall said no, it contained a summary of the operator's safety history. Asked whether ARGUS updated the CHEQ report by performing audits on the operator, he said yes, but the audit results would only be reflected in the company's rating. Asked whether, the best snapshot of a company's score was contained in a CHEQ report, Mr. Wandall said yes, but the deepest level of diligence was to perform a TRIP CHEQ for every flight.

Mr. Wandall was informed that a former employee of SK Jets had reported that the company had bought ARGUS guidance for developing a safety management system. He was asked when that guidance was purchased by SK Jets. He said he could not say, because those purchase records were maintained by a different department, but he could obtain the information and send it by email.

Asked whether he remembered anyone saying there were deficiencies in SK Jet's safety programs and that was why they bought the SMS guidance, he said it was possible. ARGUS sought to increase the difficulty of their audit standards over time because they wanted to improve industry safety. In 2003 ARGUS standards did not require an SMS, but by 2005, a company might not make platinum if they did not have an SMS.

Mr. Wandall was asked what ARGUS would do if a whistleblower called up and said someone fudged their flight hours to be an ARGUS pilot and he said he would call the operator on it. ARGUS would require the whistleblowers to identify themselves, but they would keep the identity of the whistleblower anonymous. This was part of an ARGUS protocol that might have been developed as a result of the SK Jets whistleblower contact.

Mr. Wandall was asked whether ARGUS had access to flight time information a pilot reported on an application for a rating that was submitted to the FAA. He said no, not currently, but ARGUS was working with FlightSafety International to get a feed for that type of information. Mr. Wulber said he was not sure a type rating application required a pilot to complete the hours matrix on the 8710 form. He stated that of course there would be some pilots out there who would try to game the system and it would be hard to catch them. ARGUS tried to mitigate that risk by making sure the operator knew there was a process and that they had agree to follow it. If ARGUS found that the company was not playing by the rules, ARGUS could and would remove the rating.

Mr. Wandall was asked what ARGUS would do if they found a discrepancy in just one pilot's flight time records. He said that the first step would be to check it out with the operator and ask them to validate it. If they reported that the time was inaccurate, ARGUS would make sure they fixed it. After that, the company would know ARGUS was watching them. If ARGUS saw a systemic pattern, they would call for a desk audit of pilot logbooks. They followed ISO policy which meant they would sample 10 percent of the pilot group. The company would send copies of the logbooks. If the logbooks matched the records, the inquiry would end. If ARGUS found a discrepancy, they would ask for logbooks for another 10 percent of the pilots. If a discrepancy was found in that sample, ARGUS would remove the company's rating and audit the records of the entire pilot force. In one case they had had to do that and they had discovered that an administrative person was making clerical errors. Asked who selected the 10% sample of pilots, Mr. Wandall said he selected the sample.

Asked if he had anything else to add, Mr. Wandall said that he explained how ARGUS's rating system worked to anyone who inquired about an operator. ARGUS based its ratings on things it had seen or that had been put into the system that they could point to. Asked whether Mr. St. George from Mayo Clinic Jacksonville could have obtained a CHEQ report if he had asked for one, Mr. Wandall said yes, he would have told him there were events in the company's history and he might want to look at those events. He might want to do further research.

Asked whether Mayo Clinic would be able to purchase a subscription to obtain TRIP CHEQs, he said yes, or the operator could provide them for free. He suggested that every company give a TRIP CHEQ for every one of their flights. Asked whether SK Jets could have obtained a trip CHEQ for a helicopter flight with a single pilot crew, Mr. Wandall said no, they could not. The use of a single pilot crew was not an industry best practice. Use of a two-pilot crew was an ARGUS requirement. They would be unable to obtain a green TRIP CHEQ with a single pilot crew. If they had a two-pilot crew, then the TRIP CHEQ would show a green light if the pilots met the requirements, including minimum hours. The TRIP CHEQ might be yellow if the company met the platinum standard, the aircraft was on the operators certificate, and the PIC met the ARGUS requirements, but the SIC did not meet the ARGUS minimum time requirements. In

that case, a user could decide whether or not they were comfortable with that. If the TRIP CHEQ came back as red, that would mean there was something significantly wrong with the proposed flight, such as a fine, revocation, or suspension in the last three years. A red flag would be accompanied by a message telling the customer to contact ARGUS for more information.

The interview concluded at 1145.