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September 29, 2014

VIA U.S. MAIL:

Mr. Ralph E. Hicks
National Transportation Safety Board
Investigator-In-Charge (IIC)
Eastern Regional Office
45065 Riverside Parkway
Ashburn, VA 20147

RE: ACCIDENT- THOMSON-MCDUFFIE REGIONAL AIRPORT
REQUEST FOR MODIFICATION OF NTSB FACTUAL REPORT

Date of Accident:	February 20, 2013
Location:	Thomson, Georgia
NTSB ID:	ERA13MA139
Aircraft:	Beech 390/Premier lA
Aircraft Reg. No.:	N777VG
Our File No.:	13700

Dear Mr. Hicks:

This letter is submitted by our law firm on behalf of the City of Thomson, Georgia, and McDuffie County, Georgia, in reference to the National Transportation Safety Board's Factual Aviation Report and Narrative, which was recently released regarding the above referenced occurrence. The NTSB's Factual Report found and factually determined that the accident aircraft touched down on Runway 10 at the Thomson-McDuffie Regional Airport (KHQU) before the pilot attempted to perform a "go-around." The airplane lifted off at some point near the departure end ("DER") of Runway 10 and managed to climb to an altitude of only 59 feet above the ground, when the left wing struck a utility pole owned by Georgia Power Company (GPC Pole #48) located east of the DER of Runway 10. The airplane then collided with trees and terrain and was destroyed by impact forces and a post-crash fire.

The City of Thomson and McDuffie County, neither of which were parties to this investigation, believe that the NTSB's Factual Report contains incomplete or improper conclusions, inadvertent misstatements and incomplete statements of fact regarding: (1) the FAA's prior notice and/or knowledge of the subject pole struck and related wire span as possible obstructions; (2) pre-accident depictions of possible obstructions on associated aeronautical charts; (3) the glideslope angle for the runway 28 PAPI, both before and after the accident and actual "flight checks" performed by the FAA of obstructions east of KHQU; (4) the crew's failure to coordinate the use of required checklists for the before landing, balked landing and go-around phases of the subject flight; (5) Richard Z. Trammell being the only "Operator of Aircraft," as a matter of fact; and (6) the subject flight being operated under FAR Part 91, as a matter of fact.

1. The FAA had actual knowledge of the subject utility pole and related wire span as possible obstructions prior to the accident.

First, the NTSB's Factual Report concludes that the FAA had "no prior knowledge" of the utility poles as possible obstructions.' This is untrue. Specifically, the Factual Report states, "Georgia Power did not notify the FAA before constructing the utility poles in 1989; therefore, the FAA had no knowledge of the poles as potential obstructions." See Factual Report at Page 1e. However, the "fact" that the FAA had no prior knowledge of the subject pole and related wire span as potential obstructions is belied by the FAA's own Flight Inspection Reports prior to the accident. On July 6, 2011, the FAA issued a Flight Inspection Report for KHQU (Nondirectional Beacon Direction Finding, Visual Aids, Communications). See July 6, 2011 Flight Inspection Report for KHQU, attached hereto as Exhibit "A." The "Remarks" section of the FAA's July 2, 2011 Flight Inspection Report states as follows:

> SPECIAL# A-04-260-11 TO COMMISSION PAPI- 2L FOR RWY 28@ THOMSON-MCDUFFIE COUNTY AIRPORT, THOMSON, GA INCOMPLETE UNSAT, ANGLE IS SAT BUT OBSTRUCTION CLEARANCE UNSAT DUE TO POWER LINES ON SHORT FINAL. NOTIFIED AIRPORT MANAGER TO TURN PAPI OFF AND ISSUED ABOVE NOTAM. BOX 1 =3.65 BOX 2 = 2.40. OWNER IS THOMSON COUNTY [sic].

See Exhibit A at page 1 of 1, section 5 (emphasis added). Additionally, the NTSB Factual Report states that the Georgia Department of Transportation (GDOT) inspected KHQU biennially to ensure licensing compliance and for the FAA's Airport Safety Data Program. The Factual Report further states, "The 2012 inspection report for the runway 28 approach included an obstruction characterized as a power line, 66 ft high, and 2,200 ft from the displaced threshold, extending from the centerline to 400 ft right of centerline, which provided a 27:1 approach to 200 ft from the runway end and a 33:1 approach to the displaced threshold." Notab1y, GDOT sent a copy of its 2012 biennial inspection report to "Mr. Scott Seritt, FAA-Atlanta ADO." See 2012 GDOT inspection report for KHQU, attached hereto as Exhibit "B" at

[1] The FAA participated in the NTSB's accident investigation by and through Mr. David Keenan, FAA, Washington, DC. See NTSB Factual Report at Page 5.

p. 2; see also, June 7, 2012 email correspondence, attached hereto as Exhibit "C." The foregoing facts demonstrate that the FAA had prior knowledge of the utility poles as possible obstructions.

2. As a matter of fact, there were depictions of possible obstructions on aeronautical charts associated with KHQU.

Second, the NTSB's Factual Report states that, "there were no depictions or mention of possible obstructions on associated aeronautical charts." See Report at Page 1e. This statement is also not factually accurate. In fact, several of the instrument procedure charts issued by the FAA and included in the NTSB's Accident Docket clearly show a 613 foot obstruction at the immediate end of Runway 10, marked by the standard chevron and dot depiction. See NTSB's Accident Docket, ERA13MA139, Document 12, Attachment 9 - Charts at p. 6, attached hereto as Exhibit "D." This 613 foot chevron and dot at the immediate end of Runway 10 is a depiction of an obstruction and is shown on all KHQU instrument approach charts issued by the FAA. This 613 foot chevron and dot also demonstrates that the FAA had actual prior knowledge of possible obstructions before the accident.

3. The glideslope angle for the runway 28 PAPI was changed from 3.00 to 3.50 degrees *before* the accident.

Next, the NTSB's Factual Report states that the glideslope angle for the runway 28 PAPI was changed from 3.00 to 3.50 after the accident. Specifically, the NTSB Factual Report states, "following an aeronautical study after the accident, the FAA changed the glidepath angle for the runway 28 PAPI to 3.5 degrees." See NTSB Factual Report at Page 1c; see also, Page le ("Since the aeronautical studies were completed ...the FAA increased the glideslope angle for the runway 28 PAPI from 3.00 to 3.50 degrees"). However, this is incorrect. The facts demonstrate that the glideslope angle for the runway 28 PAPI was changed from 3.00 to 3.50 degrees before, rather than after the accident.

As discussed above, on July 6, 2011, the FAA issued a Flight Inspection Report for KHQU, which stated, "PAPI-2L FOR RWY 28@ THOMSON-MCDUFFIE COUNTY AIRPORT, THOMSON, GA INCOMPLETE UNSAT, ANGLE IS SAT BUT OBSTRUCTION CLEARANCE UNSAT DUE TO POWER LINES ON SHORT FINAL." See Exhibit A at page ·1 of 1, section 5, Remarks. Accordingly, the FAA recommended increasing the runway 28 PAPI angle from 3;00 to 3.50 degrees angle to specifically provide safe obstacle clearance over the pole and wire span east of Runway 28. On January 23, 2012, a corresponding Data Information For VGSI Facilities form was submitted to the FAA- including the 3.50 degree angle for the runway 28 PAPI. See January 23, 2012 Data Information For VGSI Facilities form, attached hereto as Exhibit "E." On or about January 24, 2012, the FAA received the January 23, 2012 Data Information For VGSI Facilities form and updated the Avnis Database. See January 24, 2012 email correspondence, attached hereto as Exhibit "F." Finally, on April27, 2012, the FAA issued another Flight Inspection Report (Nondirectional Beacon Direction Finding, Visual Aids, Communications) for KHQU. See April 27, 2012 Flight Inspection Report for KHQU, attached hereto as Exhibit "G." The "Remarks" section of the FAA's April 27, 2012 Flight Inspection

Report states, "SPECIAL# A-04-260-11 TO COMMISSION PAPI-2L FOR RWY 28 @ THOMPSON-MCDUFFIE COUNTY, THOMPSON [sic]. GA COMPLETED SAT. BOX 1 = 3.62 BOX 2 = 3.18. OWNER THOMPSON COUNTY [sic]." See April 27, 2012 Flight Inspection Report, at page 1 of 1, section 5. The foregoing facts demonstrate that the glideslope angle for the runway 28 PAPI was changed from 3.00 to 3.50 before rather than after the accident, and was done to raise the base/bottom of the glideslope to assure "obstacle clearance." The FAA found the results "SAT" (satisfactory).

4. The crew failed to coordinate on the use of required checklists.

Absent from the Report are any facts regarding the crew's failure to coordinate on the use of required checklists for the before landing, balked landing and go-around phases of the subject flight. The required use of cockpit checklists by flight crewmembers when operating the airplane is governed by FAR 91.503, which states in relevant part as follows:

> § 91.503 Flying equipment and operating information.
>
> (a) The pilot in command of an airplane shall ensure that the following flying equipment and aeronautical charts and data, in current and appropriate form, are accessible for each flight at the pilot station of the airplane:
>
> * * *
>
> (2) A cockpit checklist containing the procedures required by paragraph (b) ofthis section.
>
> * * *
>
> (b) Each cockpit checklist must contain the following procedures and shall be used by the flight crewmembers when operating the airplane:
>
> (1) Before starting engines.
> (2) Before takeoff.
> (3) Cruise.
> (4) Before landing.
> (5) After landing.
> (6) Stopping engines.
> (7) Emergencies.

See FAR 91.503 (emphasis added).

Here, a review of the Cockpit Voice Recorder (CVR) transcript reveals that there was no communication and essential coordination between the PIC and the rated pilot occupant of the right seat (the so-called "copilot") with respect to checklist usage during the critical phases of the

flight. Indeed, the CVR transcript reveals that there was no coordination on the use of a landing checklist; there was no "landing briefing" made; there were no "callouts" of critical checklist items during the critical approach phase, landing and "balked" landing or go-around phases of the flight; and there was no safety belt briefing given to the passengers as required by 14 CFR 91.107. In fact, the CVR transcript demonstrates the fact that there was no checklist coordination at all between the two ostensible crew members. One critical example of this fact is the Report's summary of the post-accident interview with the "copilot," which states:

> The copilot thought that the airplane touched down on runway 10 within 200 ft of the 1,000-ft runway marker. As he began to reference the after landing checklist, he heard the pilot announce a go-around, but the copilot did not know the reason for the go-around.

See Report, p. Ia (emphasis added). During this most critical phase of the flight, there was no coordination whatsoever between the two crew members.

5. Richard Trammell was **not the only operator of the accident aircraft** as a **matter of fact.**

The NTSB's Factual Report states that the captain of the subject flight, Richard Z. Trammell, was the "Operator of Aircraft." See Report at Page 2. However, the "fact" that Mr. Trammell was the sole "operator" of the accident aircraft (as opposed to the sole manipulator of the controls) is belied by the NTSB's own factual findings, as well as the governing FARs.

In the Group Chairman's Factual Report, the NTSB states, "The Captain [Richard Z. Trammell]…was hired by the Pavilion Group to provide private pilot services for their Premier and operate it under the provisions of 14 CFR Part 91. See NTSB's Accident Docket, ERA13MA139, Document 3, Group Chairman's Factual Report, attached hereto as Exhibit "H" at p. 8. This statement is followed by a reference to footnote 25, which states, "For additional information, see Section 13 Organizational and Management Information of this Factual Report." In the Organizational and Management Information section of the Group Chairman's Factual Report, the NTSB makes the following factual finding: "The Pavilion Group hired Executive Shuttle (owned by the accident captain) to provide pilot services for their airplane." See Group Chairman's Factual Report at Section 13.0, p. 31. Thus, the NTSB has made inconsistent factual findings regarding whether the Pavilion Group hired Mr. Trammell, individually, or whether it hired Mr. Trammell's company, Executive Shuttle, to provide pilot services for the Premier. Although Mr. Trammell owned Executive Shuttle, the individual and the company are two separate and distinct actors with separate and distinct duties under the FARs and other laws. Therefore, according to the NTSB's own inconsistent factual findings as set forth in the Group Chairman's Factual Report, Mr. Trammell cannot be identified as the sole "Operator of Aircraft."

In addition to the NTSB's own factual findings, the controlling FARs prohibit a finding that Mr. Trammell was the only operator of the accident aircraft. Section 1.1 of the FARs defines "operate" and "operational control" as follows:

> *Operate,* with respect to aircraft, means use, cause to use or authorize to use aircraft, for the purpose (except as provided in § 91.13 of this chapter) of air navigation including the piloting of aircraft, with or without the right of legal control (as owner, lessee, or otherwise).
>
> *Operational control,* with respect to a flight, means the exercise of authority over initiating, conducting or terminating a flight.

See 14 CFR Section 1.1.

> Here, as incorrectly noted in the Group Chairman's Report:
>
> [T]he Pavilion Group was a subsidiary established by the owners of The Vein Guys® to handle all business activities associated with the ownership and operation of its private airplane, which it used to shuttle doctors and staff between their offices in Georgia, Tennessee, and North Carolina. The doctors with The Vein Guys® also used the airplane for private flights to vacation destinations.
>
> The Pavilion Group hired Executive Shuttle (owned by the accident captain) to provide pilot services for their airplane and operated under the provisions of 14 CFR Part 91.[2] According to billing records, the Pavilion Group paid the captain $400/day for pilot services on the Premier, and for flights where the captain scheduled a co-pilot, $200/day was paid to the co-pilot. According to the accident captain, the Pavilion Group also paid for the captain's initial and recurrent Premier ground and simulator training at FlightSafety.

See Group Chairman's Factual Report, p. 31. Importantly, the NTSB is in error in identifying the Pavilion Group as a "subsidiary" of The Vein Guys®. In fact, the sole member of the Pavilion Group, LLC was Stephen Roth, M.D. individually and not The Vein Guys®. See the NTSB's Accident Docket, ERA13MA139, Document 8, attached hereto as Exhibit "I" at p. 9.

Based upon the facts adduced by the NTSB here, and the broad definitions of operators contained in the FARs, the "Operator of Aircraft" should include not only the PIC, Richard Trammell, but also: (1) Sky's the Limit d/b/a Executive Shuttle; (2) the Pavilion Group, LLC; (3) The Vein Guys®; (4) Jeremy Hayden (the "copilot"); and (5) Stephen Roth, M.D., who initiated the flight for his fellow employees of The Vein Guys®. Each of these entities and individuals "cause(d] to use or authorize[d] to use" the accident aircraft for purposes of the

[2] As discussed below in section 7 of this correspondence, the NTSB cannot properly conclude as a matter of fact that the accident flight was solely operated under the provisions of 14 CFR Part 91.

accident flight. Each also exercised "operational control" with respect to the accident flight. No one entity was the sole "operator."

6. The accident flight was not operated purely under 14 CFR Part 91 as a matter of fact.

The NTSB's Factual Report states that the subject flight was conducted under 14 CFR Part 91. See Report at Page 2. The source of this "fact" is revealed in the Group Chairman's Factual Report, which states in pertinent part as follows: "The captain stated in interviews that...all Premier flight Executive Shuttle operated for the Pavilion Group were conducted under 14 CFR 91 flight rules." See Group Chairman's Factual Report at section 13.0, p. 32. This statement is the only basis for the NTSB's finding of fact that the subject flight was conducted under 14 CFR Part 91. However, the captain's statement is not only subjective, it is also self-serving, conclusive and even deceptive, and therefore cannot form the basis for any factual finding.

The Report notes that a separate third-party company, the Pavilion Group, was formed to hold title to the aircraft. See Report at Page 1h. As noted above, however, neither The Vein Guys® nor their affiliates owned the Pavilion Group. Rather, the sole member of the Pavilion Group was Stephen Roth, M.D. Thus, contrary to the conclusion drawn in the NTSB Factual Report, the Pavilion Group could not legally act as a "flight department" for The Vein Guys® and its staff. See Report at Page 1h. The Pavilion Group had no business other than providing air transportation to The Vein Guys®. The Pavilion Group hired Mr. Trammell and/or Executive Shuttle for the services of flight crews. See Report at p. 1h. The FARs do not permit a single-purpose or "flight department" company to operate an aircraft for other "separate and discrete" corporate entities without a commercial operating certificate per 14 CFR Parts 119 and 135. See Exhibit "J", article authored by Alan Armstrong.

An aircraft "operator" (as defined in FAR 1.1), who carries passengers or property for compensation or hire, or who is otherwise defined to be a "commercial operator," is required to have the appropriate commercial operating certificate issued by the FAA. See 14 CFR 91.147, 119.1, 119.5 and 135.7. One of the FAA's principal safety policies is that a person who transports another for compensation or hire must maintain a high level of safety by obtaining and maintaining an appropriate FAA operating certificate. See FAA Legal Interpretation to Wendell Willkie (June 16, 1992), copy attached as Exhibit "K." FAR 1.1 defines a "commercial operator" as a "person who, for compensation or hire, engages in the carriage by aircraft in air commerce of persons or property." The regulation further states, "[w]here it is doubtful that an operation is for 'compensation or hire', the test applied is whether the carriage by air is *merely incidental to the person's other business* or is, in itself, a major enterprise for profit." See 14 CFR 1.1 (emphasis added).

Numerous FAA Interpretations have made clear that this definition prohibits a company whose only or primary business is air transportation from operating an aircraft without a commercial operating certificate from the FAA. See FAA Legal Interpretations to Kevin Jung

(March 6, 1996 and March 22, 1996); Legal Interpretation to Jackye Bertucci (February 22, 2010); FAA Legal Interpretation to Joseph Kirwan (May 27, 2005); FAA Legal Interpretation to Larry Richards (Feb. 20, 2013); FAA Legal Interpretation to Cliff Runge (May 20, 1993), attached hereto as group Exhibit "L." Further, the FAA construes the term "for compensation or hire" very broadly. It does not require a profit, a profit motive or the actual payment of funds. Instead, compensation under the FAA's view is the receipt of "anything of value." See FAA Legal Interpretation to Joseph Kirwan, May 27, 2005. That can include the mere logging of time to "build time," which is consideration and a benefit conferred. Jeremy Hayden, for example, was using the flight as an opportunity to build time as "Second in Command." See page 49 Interview Summaries attached hereto as Exhibit "M".

Here, the operational aspects of the accident flight raise considerable factual questions about whether the accident flight was in fact legitimately operated purely under 14 CFR Part 91. Part 91 applies to all flights, including Parts 121 and 135 flights. Indeed, given the facts set forth in the Group Chairman's Factual Report about the convoluted ownership and operation of the accident aircraft, it should be clear that the accident flight was being, or should have been, operated under 14 CFR Part 135. In coming to the conclusion that the accident flight was being operated purely under 14 CFR Part 91, the NTSB appears to rely exclusively on a statement to that effect by the accident pilot. See Group Chairman's Factual Report, p. 32. The totality of the operational characteristics of the accident flight here, however, belies that self-serving statement by the accident pilot.

Conclusion

Based upon all of the foregoing facts, we respectfully request that the NTSB correct and modify the Factual Report for this accident to state, at a minimum, that (1) although we do not currently have evidence that Georgia Power notified the FAA pursuant to 14 CFR Par 77 before constructing the utility poles in 1989, the FAA had prior knowledge of the pole struck and associated wire span as possible obstructions prior to the accident; (2) there were depictions of obstructions at the east end of Runway 10 on associated FAA aeronautical charts; (3) prior to the accident, the FAA had conducted actual flight tests of the airspace east of KHQU, took note of the subject pole and wire span, and consequently increased the glideslope angle for the runway 28 PAPI from 3.00 to 3.50 degrees; (4) the crew failed to coordinate on the use of required checklists for the approach, landing and balked landing phases of the flight; (5) Richard Z. Trammell was not the only "Operator of Aircraft" as a matter of fact; and (6) the subject flight was not operated solely under 14 CFR Part 91 as a matter of fact; rather, the flight was operated under 14 CFR Part 135.

Thank you for your attention to this matter. Should you have any questions, please do not hesitate to contact us.

Very truly yours,

HOFF LAW GROUP

[redacted]

John S. Hoff

Counsel for the City of Thomson, Georgia, and McDuffie County, Georgia