DCA22MA193

OPERATIONAL FACTORS

Group Chair's Factual Report - Attachment 2 Interview Summaries - POI and Previous POI March 15, 2023 **Interviewee:** Inspector Robert Dean Shaffer

Representative: Cristina Zambrana - FAA Office or Chief Counsel

Date/Time: October 27, 2022 / 1023 PDT

Location: FAA Office - 5th Floor conference room - Des Moines, WA **Present:** James VanDerKamp - NTSB, Shawn Etcher - NTSB, Matthew

Rigsby - FAA, Shane Carlson - West Isle Air, Mark Tomicich - FAA

During the interview Inspector Shaffer stated the following:

He was assigned as a frontline manager (FLM) with the FAA in June 2021.

He started flight school in 2000 through a local technical college and received his single-engine land rating private, commercial, instructor, instrument ratings and instrument instructor rating. He taught locally and initially flew with a student pilot. He worked at Boeing Field in downtown Seattle in an instructing facility and taught there for five years from 2004 to 2009 and conducted Part135 operations.

During flight school he received Bachelor of Arts degrees in Professional Piloting (2003) and Dispatching Management and Air Traffic Control (2006). Then he completed his Bachelor of Science degree at Embry-Riddle Aeronautical University with two minors: Professional Aeronautics and Aviation Safety (2009).

While working as a CFI¹ received his AMEL² and ATP³ certificate and completed his MEI⁴ certificate as well. All was complete by 2008. His goal was to be a corporate pilot. He had several coworkers encourage him to apply at the FAA, but he deferred that while he was working on his degree in night school.

He joined the FAA June 29, 2009. His first day of work was July 14, 2009. He was assigned to the Anchorage, AK FSDO⁵. In Anchorage he was an aviation safety inspector. About a year into the job, he was given a POI⁶ position which included 29 operators – a lot of single pilot operators with tundra tires, skis and floats. At a minimum, he did 29 proficiency checks a year. He gained experience in Anchorage and did some sea plane training while there. He eventually received an ASES⁷ certificate. He did about 19 hours of training, more than normal because he wanted to learn everything he could. Six of his 29 operators were seaplane. On his initial training he received about 10 hours of Beaver training. Some of the planes for his operators were Cessna products and at least three operators operated Beavers.

¹ Certified Flight Instructor

² Airplane Multi-Engine Land

³ Airline Transport Pilot

⁴ Multi-Engine Instructor

⁵ Flight Standards District Office

⁶ Principal Operations Inspector

⁷ Airplane Single Engine Sea

He was in Anchorage for almost three years and found a job in the Seattle FSDO working policy in order to move back to Seattle. Policy was dealing with coordinating questions and answers. And there was always program work there as well. He was also managing reports coming in, ensuring they got in on time. If he had all the facts, he could also QA, but mostly he dealt with the matrix to make sure the program was healthy. He worked that post for about three years. After that, he took a job in the FSDO and applied for and received a POI position in December 2014. He could not recall how many operators he had at the time. He was in that position for six and a half years. He took whatever he was assigned as long as he felt it was within his knowledge and training.

The dynamics of the group changed whenever veteran POIs took another position and a new inspector would come in. He had air carrier operators and flight schools in the area. He estimated there were 12 flight schools in the geographical area. He emphasized that at "no time I was bored." He did not do any float plane work when he started. He was first assigned flight schools because he had experience managing in a flight school and was a chief instructor in a 141 school.

He was assigned to West Isle Air in April of 2020. It had its challenges due to the pandemic. He was assigned to their certificate for about 15 months until he was assigned as an FLM in June of 2021. He assumed his FLM position on June 5, 2021, and at that time they had only one fully qualified inspector for the office. During that transition there was no one assigned to West Isle Air, but if the operator called with a request or questions he would assist. When the current POI was assigned, he briefed him and considered him sharp, but he wasn't sure when that happened. He felt that the current POI was hard working, fact-based, and would get it done correctly the first time and that it was "easy for him to pick it up."

As West Isle Air's POI, he would go there a minimum of at least once a year for proficiency checks and a lot of times during the check they would try and check the pilot records. They would go whenever the surveillance would require it. They use SAS⁸ as a tool to make their assessment. The POI would use the DCT9 to collect the data and update the SAS as appropriate and that would dictate priorities. The ops inspector could modify the priority if needed. The plan was a matrix and "simple square" of operators and inspection and then a series of tools that were nuanced and record the answers.

While at West Isle Air, he interacted with the chief pilot and one thing he found remarkable was that the chief pilot was articulate and detailed-oriented. He felt that the chief pilot came well prepared with good ideas about solutions. He was well informed before he talked to the POI. He felt the chief pilot was knowledgeable. He did not

⁸ Safety Assurance System

⁹ Data Collection Tool

observe the pilot training firsthand because he never sat on a check ride. His interaction with the program was just reviewing the program itself and he did not observe any ground training. He basically looked at their program, including the training manual, which included details of the curriculum, how it was to be recorded and who would provide the training. He also looked through their GOM¹⁰.

The chief pilot was planning to add a new aircraft to the certificate, and he went through both manuals to add the new aircraft. The POI gave the manuals a thorough review at that time. The airplane that was to be added was the Otter. If an operator had a training manual and an ops manual in place, he would compare the older manuals with the new modifications to ensure they were accurate.

He thought West Isle Air had only two initial aircraft and the chief pilot was going to limit the piloting of the Otter to just himself and one other pilot to build up their experience. The POI only reviewed and accepted/approved the manuals. The instruction and proficiency check were done by someone else because he was no longer in that position at the time of the checks. They "accept" GOMs and "approve" training manuals.

He did not recall how many pilots they had because it was a seasonal operation. He thought the majority of West Isle Air's training was conducted by the chief pilot. He did not recall how many instructors and check pilots they had at the time.

When asked about the structure of the West Isle Air's operation he stated that he would classify it as a "relatively small operation - it was a limited number of folks there". There was someone at the desk taking calls and working with the passenger. Sometimes it was the chief pilot himself.

He could not recall the weather briefing requirements and resources but knew it was in their OpSpecs¹¹. He did not approve or visit any of the docks they used. He knew there were cameras in some of the areas where they land because the chief pilot informed them of that. The Alaska weather program was an "excellent" program.

When asked, the inspector stated that he had about 2,500 hours total flight time. FSDO staffing depended on the year and the office. Sometimes there were not enough people to do the important work. They had no throttle on the work that needed to be done. The Seattle FSDO had a maximum of 8 inspectors and of those, 2 were in training. He felt they had adequate inspectors. He was recently assigned 4 ops inspectors to oversee. Their scope covered schools, examiners, helicopters, agricultural, and air carrier/operator and all of the Part 91.

¹⁰ General Operations Manual

¹¹ Operations Specifications

They did not approve an operator's schedule but approved the airports because there was a policy and process for that. The operator would look at the policy and send in an application. The inspector would send to an environmental group for an assessment. Once he received that back, if it had a successful environmental assessment, the inspector would add the airport to their OpSpecs C070. The inspector had a lot of responsibility to read and understand the policy and they had the authorization to make that determination. If there were questions, the inspector could go to the FLM¹² or anyone within the FAA.

He could not recall if he added airports for other operators in the past, but the process was simple.

He was not sure how many certificates the office oversaw.

He did not have an assistant. The POI did sometimes work with the PMI¹³, but they did not assign the PMI, the PAI¹⁴ and the POI together as a group. If there was a problem, they talked amongst themselves to work out the issue. He felt they were independent and interdependent when they work together. The POI and PMI did not necessarily go together to visit an operator.

They had a national program to share inspectors among other FSDOs.

They used authorized weather that they approved in their GOM. They could use what they wanted to use as long as the underlying data was from NOAA¹⁵. It depended on what worked best for the operator. Most seaplane operators also used dock camera information because most weather data was available for airports but not at seaplane bases.

He thought that he was the most recent approver of West Isle Air's manuals.

There was no preliminary process when an operator wanted to revise a manual. They would tell him that they wanted to make a change, so it was voluntary. He then would send the policy to the operator and tell them to follow the policy for efficiency. The operator would make the changes and send them to the inspector. The inspector would then evaluate the document. He would suggest any required changes and send them to the operator. At the end of the policy there were outcomes... either approved or disapproved. In practice, they communicated well. They could reject because of one error, but if the manual looked good except for a technical issue, they could reach out to the operator to explain the required changes and they could fix it quickly. If they rejected it, they had to send it back and could take a month or more to get the changes

¹² Front Line Manager

¹³ Principal Maintenance Inspector

¹⁴ Principal Avionics Inspector

¹⁵ National Oceanic and Atmospheric Administration

back. The fastest a major alteration would take could be five to six months. The longest he had taken was "never".

They had no control over complexity of revisions with a certificate. You can't always get it all done. They would do the highest safety risk items first. Air carrier items had the highest priority. The management team assigned and spread-out work. The inspectors could ask for help within the office. They have good relationships with other FSDOs and could also ask them to assist. As an FLM, he would not touch certificate management.

When asked to describe a typical day for a FLM at the Seattle FSDO, he stated: At 0800 they had a meeting with all the management team for about an hour every day. They had other weekly and biweekly regular staff meetings. They met with the inspectors to assist them. Every two weeks they had a flight standards leadership meeting. He usually attended the meetings and then looked at emails. He tried to get the actionable items' responses out of the way first. He also talked to the employees during the day. There was an operational "churn" as a manger.

The inspectors rotated an on-call duty to answer phone calls in order to address accidents and various questions. FLMs were also assigned an on-call duty for a month at a time, which was additional duty. He didn't think that his inspectors did a lot of overtime. If they asked for overtime, it needed to be for a safety function and not just for administrative duties in order for it to be approved.

He felt they had very good report in the office, and he was proactive to build good relationships. Building professional relationships was key to having a healthy organization.

The operational size of the company depended on the pilot cadre. West Isle Air was not the smallest operator they had, but they had bigger operations, the biggest of which was about 35 pilots. So, West Isle Air was more on the small sized. The outlier they had was an aeromedical operator which has 800 pilots.

When he got his promotion to front line manager, he no longer acted as the POI for West Isle Air. He had already been working with West Isle Air to bring on the additional aircraft but did not want to hinder West Isle in getting the required checks. The rule required adequate current and qualified instructors for an airplane and that was why they brought down an inspector from Alaska. He did not think it delayed the process.

He found the chief pilot to be very forward thinking. He felt the chief pilot did a thoughtful objective preparation for what needed to be done on the proficiency check. The inspector debriefed him on Friday afternoon saying that he was able to accomplish everything by the end of the week plus 10 hours of operational experience, which he

felt was a lot to get accomplished. He classified it as a safety sensitive event, but West Isle always took their safety seriously. They would consider it safety from a support role, and it definitely would be a higher priority.

West Isle Air is day/ VFR restricted but they still have a PAI assigned because that would be the normal course of work. He did not know the PAI's name. He was not certain the exact number of PAIs but thought that the total of PMIs and PAIs in the office equaled 16 total.

When asked about flight-following, he stated: The operator can file a flight plan with the FAA or use an internal flight plan. It should be in accordance with their manual but there was no regulatory requirement to monitor it a certain amount of time.

An inspector could be assigned to an operator for a short period of time or a long period, it all depended on the needs. There was no prescribed time period.

When they built professional relationships with operators, he had not seen their work with an operator dimmish. If there was a single pilot operation he was not going to reach out during the off season. Objectively they would go with what the data collection tool asked of them, as well as to ask them to make sure they know how to use the manuals properly.

When asked what type of risk assessment matrix they use, he answered: He would use SAS to do a risk assessment on the operators. That would help him find where the issues were. If there were no issues, they would follow a "normal" surveillance and go once a year to do a records inspection. It was mandatory that the assessment be done at a minimum of once a year.

They normally encouraged operators to follow an SMS. They highly encouraged them, but they are not required for part 135. Most lessons came from experience. Small operators found things that had happened to their colleagues or to themselves. He was not certain of any operators with an SMS. A major maintenance provider might have an SMS, but small operators probably would not.

Geographically, the office covered the from the Canadian border in the north to Toledo in the south (down near Portland), and they cover everything on west of the Cascades mountains.

The Seattle FSDO maintained an air safety hotline system which includes "whistleblower complaints" that could be used to report anything. Once received by the office, hotline calls were assigned to investigators. He estimated that they received about 8 a month, however, some may not have been valid because there was no way to investigate it, possibly due to a lack of contact information. An investigation could take up to 8 hours of work but could be more, even up to 140 hours or more. He felt it

was lower in priority than an air carrier surveillance. If it was a hotline call on a carrier, whether the investigation was assigned to that carrier's POI would depend upon the POI, but the FLM would make the decision. At a minimum they would advise the POI of the event. There was no prohibition for the POI to do the work.

He was not aware of any complaints with West Isle Air.

There was no limit on time doing Aviation Safety Hotline complaint. During an investigation, they had to prove what the complaint was and determine its validity. He classified it was very technical.

They did use a risk matrix with their operators and if they saw something of concern, they ran it through their matrix. It looked "just like an SMS matrix."

His professional opinion was that West Isle Air was run in a professional way and that the chief pilot's communication was very knowledgeable. He felt that the current POI showed great concern for his work. He had a high-level confidence in the POI's work.

Interview concluded at 1244 PDT

Interviewee: Inspector Lawrence Tolentino

Representative: Cristina Zambrana - FAA Office of Chief Counsel **Date/Time:** October 26, 2022 / 1018 Pacific daylight time

Location: FAA Office - 5th Floor conference room - Des Moines WA

Present: James VanDerKamp, Shawn Etcher - NTSB, Matthew Rigsby - FAA,

Shane Carlson - West Isle Air

During the interview Inspector Tolentino stated the following:

He started his career in the Philippines where he earned a commercial pilot license and worked as an avionics engineer, serving Beechcraft and Dornier Jets. He moved to the U.S. in 2000 and earned his U.S. licenses beginning as a student pilot up to ATP¹⁶ and CFI¹⁷. He worked as a Part 141 chief instructor and a chief pilot for the same Part 135 company before joining the FAA. He had approximately 6,000 total flight hours and was assigned to oversee and conduct various FAA checks on 6 different category/type aircraft: single engine, multi-engine, King Air, seaplane, tailwheel and Honda Jet.

He joined the FAA in 2015 starting at the Seattle Flight Standard District Office (FSDO) and had been there ever since, except for a 6-month temporary assignment with the San Jose FSDO.

He was assigned to the West Isle Air POI¹⁸ position in December 2021. He received a briefing from the previous POI which included three or four projects. He further provided examples of the projects which included the chief pilot's check pilot letter needed to be updated to include the DHC-3. All the checks had been completed, and just needed to update the letter. In addition, other airports were being added to the list of approved airports in their Operation Specifications (OpSpecs)¹⁹.

When asked about the oversight of approved airports/docks, he said that they don't necessarily need to go to all of them. It depended upon where the operator wanted to go, such as a new facility. Only those airports/docks that were on the Part 135 commuter flight schedule were required to be in their OpSpecs. They were not required to approve the Part 135 on-demand destinations.

Following West Isle Air adding the Otter to their OpSpecs, they had to have an inspector come down from Alaska to certify them but that was under a different POI. Mr. Tolentino can complete their check rides going forward. He was able to provide the required checks to West Isle Air after completing the FAA required training and

¹⁷ Certificated Flight Instructor.

¹⁶ Airline Transport Pilot.

¹⁸ Principal Operations Inspector.

¹⁹ Operation Specifications were a contract between the FAA and the Carrier. It granted permission for the carrier to operate and contains the permissions for several parts of the operation.

EBC qualified. If an inspector was qualified in category and class, he was able to give the check ride, e.g., airplane single engine sea, not necessarily Otter qualified.

He had oversight of 6 different "types" of airplanes: single engine land, single engine sea, multi-engine land, tailwheel, King Air, Honda Jet. He was required to maintain currency in every quarter. When asked if he had trouble keeping up with all the different planes, he stated that it's busy to stay current and qualified, but he was able to do so. He stated that being current, kept him safe in case he needed to take the plane from the pilot, and that he wanted more time, but he was so busy.

He stated that he had been out to see West Isle Air twice since taking over as POI, once in May and again in June. The May visit was to inspect pilot records and he gave the chief pilot a check ride in June. He had never flown with the accident pilot and was unsure about how many pilots they had because it tends to fluctuate by the season, but he thought it was between 12 and 15 pilots.

He provided a high-level overview of the operational structure by saying its main facility was in Renton, a few yards from the city dock. Pilots preflight the airplane while it was on land then use the tug to put it in the water. While conducting that inspection, he observed the chief pilot place one of the Beaver airplanes on a tug and started the engine. He stated that he had never seen that before and thought it was unusual.

He had not met the director of operations. He could not remember the director of maintenance's name. The only person he had met as far as Part 119 personnel was the chief pilot. The chief pilot was their only instructor and check airman.

All the pilots work for West Isle after Northwest Seaplanes dissolved a couple months ago. He had nothing to do with the maintenance oversight of West Isle Air and was unable to recall the name of the director of maintenance; however, was not sure he had ever met him.

All West Isle Air's training was done internal. The chief pilot conducted all the training and check rides. He was their only instructor/check airman. At the time of the accident, West Isle Air had submitted a letter to the FAA requesting the accident pilot to be added to their certificate as a check pilot. There was a process to add someone to their certificate, which was on-going at the time of the accident.

When asked about his visits to West Isle Air, he responded that the only discrepancy was that they were keeping electronic records instead of actual paper records and they were not approved to use electronic records. The chief pilot printed out the electronic record so that they had the required paper copy. The result was a corrective action by counseling and will be addressed during the next inspection. He was currently discussing the process as to how to change record-keeping to electronic format with West Isle Air.

The pilots can see the maintenance status of the airplane by looking at tracking sheets whether it's a day or a flight time limit when dispatching.

When asked what he knew about the accident, he stated that he had not sought out information about it, but he knew if he wanted to, he had the ability to reach out to other departments at the FAA to obtain the information.

If West Isle Air wanted to approve other docks/seaplane bases to land at, they did not need approval for on-demand operations, but for scheduled commuter operations they do. There was a process within the guidance that says they have to send a request to include the name of airport, what type of aircraft, how often they will be landing during day and night, and any additional equipment they will be using. Then he would submit that information to AFS to have an environmental assessment conducted. Once he received approval about the environmental study and if there is a facility there, he was required to go inspect the facility and look at what type of equipment was available. After a successful inspection, he would add it to their OpSpecs C070 which listed the operator's approved airports, but only within the U.S. Outside of the U.S., they followed the same process, but there was no environmental assessment.

He confirmed that West Isle Air was authorized to conduct Day/VFR operations only.

He has not had to conduct any seaplane facilities inspections so far since he took over as POI of West Isle Air. There was a risk assessment checklist that he used for land airports. There was a similar checklist for seaplane facilities. When asked to provide an example of what he would look for when conducting a risk assessment, he stated were... "Were there procedures that kept the passengers safe going to and from the airplane? Were they protected from the propeller? Was that area cordoned off?

He stated that he only recently got his seaplane rating in a Super Cub and had approximately 40 to 60 hours in single engine seaplanes. Of those hours, approximately 8 to 10 hours were in a Beaver and he had not yet flown the Otter.

West Isle Air was not his only operator. At the time of the accident, he oversaw 24 certificated operators and did not know how many were Part 91 operators. The certificated operators were operated under Part 133/137/141/135. The FSDO was currently in the process of redistributing the Part 91 operators assigned; however, he stated that it has ranged from 10 to 40. Of the 24 he oversaw, 15 of the certificated operators are part 135, with West Isle Air being one of them.

In response to a question regarding geographical distance of his territory, he offered that the furthest to the south was Olympia, the furthest north was Bellingham,

the furthest northwest was Friday Harbor. He lived north of Seattle and most of his operators were in the north. He uses his own private vehicle to visit those operators as he did not need to go to the office to pick up a government car. If he was travelling south, he stopped at the office to use a government vehicle. He used ferries to get to the islands.

In August of 2021, he was realigned with Seattle (from his temporary duty in San Jose). The operator assignments were "very dynamic." Management realigned the operators among the inspectors in the office, the most recent realignment occurred last April, and they were currently in the process of removing some from him and assigning them to another inspector. Based on the meeting with his manager, the more complex operations, bigger operators, and commuters will remain with him and the smaller ones like single pilot Part 135 operations will be removed from his list and reassigned to a new inspector.

A complex operator would be one with jet aircraft. There were different Part 135s: single pilot, single PIC²⁰, basic and full 135, and commuter. He'll still be assigned with full 135, some basic and commuter, as well as bigger operators. When asked if this realignment would be beneficial to him, he stated that it would be a reduction of the operators he will see and would reduce his workload.

When asked how he gets it all done he replied: "It's not humanly possible." He further explained that that's what his manager told him. They assess the risk and what type of surveillance that they would provide. He stated that there were three different types that the system assigns to them. They were classified as low, medium, and high. If it was low, because of the number of operators assigned to them by the office, they mark them as Resource Not Available (RNA). They then delay their oversight until the next quarter and only do the medium and high-risk surveillance items. They have to assess what type of surveillance they can do, if there's any risk involved, such as check rides - those were the highest priority. That's how they would assess the pilots and said those were continuous operational safety. If they were unable to conduct those check rides, which he stated was typical now because of limited resources in the office. They would let their manager know and the manager would list them as RNA.

When asked how the pandemic affected their oversight, he stated that it did because some inspectors in the office weren't able to complete surveillance or check rides during a regular schedule because of health concerns. They had to reach out to other FSDOs. Some operators, because they hadn't been there for a while, had some issues that developed that they weren't able to observe during the pandemic. So, when they started going into the operators, they found issues that increased the risk and increased the workload. There were some issues that needed to be addressed before they could conduct regular surveillance.

²⁰ Pilot-in-Command.

When asked how often he gets to each operator, he replied: at least once a quarter, if not every other quarter. He stated that he has a good rapport with his operators and that it's easy to get overtime to spend time with the operators assigned to him. His frontline manager would approve his overtime request.

When asked about staffing, he stated that the current staffing number showed they have eight inspectors. However, of those eight only "two and a half" were qualified. The other six were in training. They used to have eight POIs. The "half" qualified inspector could be assigned because the outstanding training tasks were not the core part of his training. Trainees were assigned to a trainer. He had only one trainee assigned to him, but he also conducted training for other trainees. When teaching trainees, it took more time on a surveillance because he had to explain during the surveillance rather than teaching in a classroom.

When asked if he had observed any of West Isle Air's training, he stated that he had not witnessed any of the training at West Isle Air, but he reviewed the training when he was there in May. He just verified that it was current and approved. He had not conducted any enroute observations on any of his operators but included it in the proficiency or competency checks.

When asked how he could ensure that pilots were not getting lax on their procedures, he stated he treated proficiency and competency checks like line flights and made them do everything the same as an actual line flight, which included asking passengers' weights and weighing bags. He does not complete proficiency or competency checks on a revenue flight. Instructors and check airmen were welcome to observe any checks he would conduct on the operator's pilots.

When asked if he had had pilots not have a successful check, he stated he had had pilots fail check rides. Examples being if they did not meet the standards or if he had to take the controls from the pilot. He estimated it had happened about seven or eight times in a year out of 15 to 20 in a quarter. He further clarified that it was 15 to 20 line checks a quarter not pilots. Proficiency (instrument), competency and line checks were all different checks, and could be accomplished during the same flight. A pilot can pass two and fail one but only fail the one. At West Isle Air he only did line checks and competency checks. The instrument check (inadvertent IMC) was checked under emergency procedures. West Isle Air did not do proficiency checks because it specifically listed that a pilot must do two non-precision and one precision approaches, and they were authorized to operate Day/VFR²¹ only.

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²¹ Visual flight rules.

When asked what ratings he had, he stated: ATP airplane single-engine, multiengine, single-engine sea, instructor airplane, instructor instrument, and single-engine multiengine ATP, as well as a type rating in the Honda Jet HA420.

His duties and responsibilities as a POI or inspector were categorized in four major groups: certification, surveillance, investigation, and enforcement. He also had phone duty, which he categorizes under investigation, during which he would receive part 61 and part 91 calls. They were doing that four times per month per inspector. During that time the inspector typically would be assigned an accident if they were on duty when the call came in unless that inspector was a principal of that operator and then they may not be assigned it. Additionally, an inspector might be assigned an accident by a manager, even if not on phone duty.

When asked how he found out about the West Isle Air accident, he stated that he found out about it from his manager who learned about it from the frontline manager.

He was not the approving manager on the current West Isle Air General Operations Manual (GOM).

He last visited West Isle Air in June 2022, which was to conduct the chief pilot's PIC check ride.

When asked if he had to document any time he took control of an aircraft during a check ride, he stated that he would document it as unsatisfactory in SAS²² (electronic record keeping within the FAA) and also a paper form that would remain in their binder in the office.

He looked at the West Isle Air training manual in June during surveillance.

West Isle Air was a Part 135 on-demand and commuter.

When asked if on-demand and commuter could be conducted on one flight, he stated that no it could not as it had to be determined before the flight if it was going to be on-demand or a commuter operation. However, he was not certain and wanted to research that question and ask within the office if his understanding was accurate.

When asked if he still had any obligations for the San Jose FSDO, he stated he did not.

When they conducted an inspection at an operator, part of that inspection was to verify that they were using the approved or accepted manuals with the current

²² Safety Assurance System.

revision with the accepted or approved stamp. He would also verify the log of revisions and make sure that all the parts of the manual were there.

In general, when conducting a check, if they find a discrepancy at an intermediate stop, then he would expect the pilot to go to the GOM to see what it required. If they don't go to the GOM, it was generally because they already knew, and the pilot would write it down and call maintenance. He has had it happen on check rides where they said I'll take care of that when I get back to the base. But those were not a part 135 operator but a part 141.

When asked if he expected the same thing on a revenue flight, he stated he did.

When asked if West Isle Air had an MEL²³, he stated he did not know.

When asked how he perceived the experience level of pilots and operators, he stated under Part 135, there were some that needed one or two more pilots but nothing that hindered their operation and that he does not see a pilot shortage. Additionally, he stated that their experience was a mix. He clarified that it was not necessarily less experienced, but higher risk. He has had some instances where the pilot had more experience but made mistakes. He reiterated it was a mix of experience.

When asked if he had ever had a pilot reach out to him about an operator, he stated that not directly to him. However, if there was a safety hotline complaint, an inspector would investigate it but that's all he would know about it. He has not had any complaints about West Isle Air. He further stated he had an open line and gave pilots his contact information which included both his phone number and email address.

When asked if he would investigate a hotline complaint about one of his operators that he provides oversight on, he stated that would be having to go through his manager.

When asked if an operator had an event would he expect them to reach out to him, he stated that it would depend upon the event, if it was an immediate notification or if notification was required, then he expected it. Otherwise, notification was not required.

When asked if there was something that needed to be asked but wasn't, he stated that there was not.

Interview concluded at 1156 PDT

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²³ Minimum equipment list.