



U.S. Department
of Transportation
**Federal Aviation
Administration**

Aviation Safety

800 Independence Ave SW
Washington, DC 20591

April 7, 2026

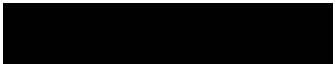
Mr. Mitchell Rasmussen
Investigator-in-Charge
National Transportation Safety Board
490 L'Enfant Plaza East, SW
Washington, DC 20594

Subject: FAA Party Submission for N633JH, MD500, Kekaha, Hawaii

Dear Mr. Rasmussen:

Enclosed, please find the FAA's party submission on the subject accident. This package is being sent to your attention via electronic mail.

Sincerely,



Charles "Andy" Olvis
Manager (A), Accident Investigation Branch

Enclosure: FAA Party Submission to NTSB for NTSB Case # ANC24LA017



**Federal Aviation Administration
Aviation Safety
Office of Accident Investigation & Prevention
Accident Investigation Division, AVP-110**

Party Submission to the National Transportation Safety Board

**Helicopter Accident
Jack Harter Helicopters
McDonnell Douglas Helicopter 369E (MD500E)
N633JH
Emergency Landing Following Engine Failure
Kekaha, HI, USA
February 27, 2024**

**FAA Case Number: 24-25
NTSB Case Number: ANC24LA017**

**Submitted
April 7, 2026**

Accident Summary

On February 27, 2024, at about 1330 Hawaii-Aleutian standard time, an MD Helicopter 369E, N633JH, was substantially damaged when it was involved in an accident on a remote beach about 14 miles north of Kekaha, Hawaii, on the island of Kauai. The helicopter was operated as a Title 14 Code of Federal Regulations Part 135 sightseeing flight.

While conducting a doors-off sightseeing flight near the northern shoreline of Kauai, the pilot detected smoke and immediately diverted the helicopter toward Kalalau Beach; the operator's pre-designated emergency landing site along the planned tour route. Shortly after, the pilot heard a loud "pop" accompanied by the engine-out aural warning. He immediately lowered the collective and entered autorotation, landing at the nearby Honopu Beach as an emergency landing site.

During the landing rollout on the sand-covered beach, the helicopter pitched forward, nosed into the sand, rolled onto its right side, and came to rest in that position. The accident caused substantial damage to the tail boom, fuselage, and main rotor system. The pilot and three passengers sustained minor injuries, and one passenger sustained serious injuries.

FAA Response

A Senior Air Accident Investigator from the Federal Aviation Administration's Office of Accident Investigation & Prevention was deployed to Hawaii to conduct the FAA's parallel safety investigation, and to support the NTSB's investigation as FAA Party Coordinator. Additionally, an engine and propulsion engineer from the FAA's Aircraft Certification Service traveled to support the investigation.

Party Status

The Federal Aviation Administration is granted party status to NTSB aircraft accident investigations by statute. As the regulator, the FAA is uniquely positioned to support an accident investigation as the authority on the aircraft's type design and certification, as well as oversight responsibility of the operator. If immediate safety concerns are discovered during an investigation, the FAA can quickly respond with the appropriate actions (Airworthiness Directives, for example).

Also supporting this investigation were party members from:

- MD Helicopters,
- Jack Harter Helicopters, and
- Rolls-Royce Corporation.

Investigation & Examination

Post-accident examination showed that the overrunning clutch and engine-to-transmission driveshaft were fractured. The main rotor blades were partially attached to the main rotor hub.

The overrunning clutch is designed to allow the output of the clutch to turn freely (freewheel) when the input to the clutch stops or rotates at a slower speed. This permits an helicopter to perform an “autorotation” landing by disconnecting the engine from the rotor head when the engine fails. Detailed examination showed that the overrunning clutch was fractured and thermally deformed at the inner race.

Airworthiness Directive (90-19-02) requires disassembly of the overrunning clutch at 300-hour intervals for inspection. The output bearing is required to be removed and repacked with new grease. Although the applicability of the specific clutch assembly part number is not entirely clear in the AD, the accident helicopter’s Aircraft Maintenance Manual (AMM) includes a requirement task to repack the bearing with new grease at 300-hour intervals. Interviews with maintenance personnel after the accident indicated that they had not removed the output bearing for greasing and that the greasing task was not a common practice for maintenance personnel at the operator.

Recorded Data

Per Title 14 Code of Federal Regulations Part 135, the accident helicopter was not required to be fitted with a flight data recorder (FDR). The accident helicopter was equipped with an AeroLink engine monitoring system for the Rolls-Royce 250 Series turboshaft engine. Data was downloaded on scene by the operator and the data provided to party members in an Excel CSV format.

The data captured 9 basic parameters, including Date & Time, Altitude (ft), Turbine Outlet Temperature (deg C), Torque (PSI), Outside Air Temperature (deg C), Bus Voltage (V), N1 (%), N2 (%), and NR (rpm). The FAA Accident Investigation Branch analyzed this data, which did not indicate any preexisting engine anomalies and did not provide enough parameters for detailed use in the investigation.

Findings

- The pilot was appropriately trained and qualified to operate the aircraft.
- When the pilot began to smell smoke, he immediately began flying towards Kalalau Beach in accordance with the operator’s predetermined emergency landing zone along the tour route.
- When the “pop” sound occurred and the aural “engine out” alarm sounded, the

pilot responded by lowering the collective and entered an autorotation to land at nearby Honopu Beach, recognizing the helicopter would not make it to Kalalau Beach.

- When the helicopter touched down, it nosed over in the sand and came to rest on its side resulting in substantial damage. The pilot's immediate response to the engine failure likely resulted in minimizing injuries to people on board.
- Examination of the wreckage revealed that the overrunning clutch and driveshaft were fractured.
- Evaluation of maintenance practices and interviews with mechanics at the operator revealed it is likely the output bearing of the overrunning clutch was not removed and repacked with grease at the required 300-hour intervals, per FAA Airworthiness Directive 90-19-02.

Conclusion

The FAA concludes that the accident resulted from engine failure, caused by fracture of engine-to-transmission driveshaft and overrunning clutch assembly due to lack of proper greasing of the output bearing. The overrunning clutch assembly was exposed to high heat which resulted in the failure of the output bearing outer race, rollers, and cage assembly.

Safety Recommendations

The FAA Investigator-in-Charge and NTSB Party Coordinator make the following safety recommendation to the Federal Aviation Administration:

- Prohibit "doors-off" helicopter air tour operations under Part 135. Although no persons were fatally injured in this accident, a serious injury did occur. Injury severity may have been mitigated if the helicopter was required to operate with doors installed which would have provided a protective barrier between the beach and the passenger cabin during the emergency autorotation landing. Additionally, items from within the passenger cabin may become unsecured during doors off flight and could reasonably be expected to impact critical components of the helicopter main rotor and tail rotor systems, resulting in accident scenarios.