



## RECORD OF CONVERSATION

**Timothy W. Monville**  
**Sr. Air Safety Investigator**  
**Eastern Region**

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**Date: March 19, 2020**  
**Person Contacted: Jenny R. Hawk**  
**NTSB Accident Number: ERA18LA010**

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### Narrative:

Ms. Jenny Hawk was contacted by phone on October 19, 2017, at 1506 EDT. Also on the call were FAA inspectors Timothy Hahn and David Hintz. The call was made to [REDACTED]

At the beginning of the phone call she was advised that the NTSB is a federal agency mandated by Congress to investigate aircraft accidents, and NTSB has no authority to take any action against any individual. She was also informed that the purpose of an NTSB investigation is for safety only, and any person NTSB talks with has the right to representation. She agreed to the interview without representation because she wants to assist with the investigation, but if she felt uncomfortable during the interview she would stop it.

She indicated that she is 61 inches tall and weighs 105 pounds. Her address is [REDACTED] Manns Harbor, NC [REDACTED] Her date of birth is [REDACTED] Her cell phone number is [REDACTED] but because she is busy flying, her assistant's work phone is [REDACTED] Her e-mail address is [REDACTED]

Her certificate number is [REDACTED] She holds a commercial pilot certificate with airplane single engine land and instrument airplane ratings. She also holds a flight instructor certificate with airplane single engine, and instrument airplane ratings, which she renewed in December 2016. She currently has a temporary 2<sup>nd</sup> class medical certificate issued August 25, 2017, with no limitations. Her total time is about 8,000 hours, of which 4,000 are as a flight instructor.

The operator of N400LE is OBX Airplanes LLC, whose address is [REDACTED] Manns Harbor, NC [REDACTED] They operate 10 aircraft. They have owned the airplane since January 2017, and since then have operated it for about 130 hours. Since owning the airplane, they have not had any electrical wiring issues. She did note during a recent flight to the Outer Banks while testing

of the gear lights, they would dim. Maintenance checked this and replaced a bulb. The airplane was only equipped with lapbelts; shoulder harnesses were not installed.

The pilot-rated student was either referred to her recently by a friend or an advertisement she placed in Barnstormers. She had taken him on as a student to finish his commercial pilot certificate. She indicated that all his hours were completed and he was signed off for his checkride. The day before he was to take his commercial check ride, the propeller governor started leaking. She would not allow the airplane to be flown until the governor was repaired or replaced. The airplane was down for about 3 weeks, during which time an annual inspection was performed (the maintenance records indicated it was signed off as being completed on October 6, 2017). She flew the airplane 1 or 2 days before the accident date and there were no issues. She indicated that she and the student flew together a good bit, reporting he was a really nice guy.

She provided the following timeline for October 18, 2017-

She was asked in advance of the flight whether there was any discussion between her and the student as to who would be pilot-in-command (PIC). She indicated that he was deemed PIC, reporting that he behaves mentally like he is PIC.

She was at the school early, and knew the student was coming. To prepare for the flight, she performed a preflight inspection of N400LE, and realized it needed fuel. Stephanie met the student to pull the airplane out of the hangar, and the fuel tanks were topped off. She (Jenny) visually checked each fuel tank after fueling and confirmed the tanks were full. The student who also performed a preflight inspection told her the engine oil quantity was 6.5 quarts. Because of this she had the student add 1 quart of oil. When the student was done with his preflight she followed behind him adding that there were 3 preflight inspections done to the airplane. She told the student he should fly solo and then she would fly with him, but he asked her to fly with him on his first flight that day. The student was in the left seat and she was in the right seat.

The student used all checklists, and after engine start, he performed a normal taxi, and back taxied to the active runway, where he performed an engine run-up with no issues noted. He initiated a no-flaps takeoff from runway 5, and when the airplane was about midpoint of the runway, at an unknown altitude, with the landing gear extended, there was smoke in the cockpit and wires on her side of the cockpit were on fire and had contacted her leg. She looked to check the position of the landing gear, and noted 3 green, then reported all lights went out. About the time of the start of the smoke/fire, the student screamed fire, fire, fire, which she agreed. She was later asked during the interview what she was wearing, and she indicated she could not recall. Immediately after the smoke and fire she indicated that all lights turned off, and wires were falling from under the panel and the cockpit was getting hot. Because they lost intercom, they resorted to talking loud to communicate to each other rather than through the noise cancelling headsets/intercom. She indicated that the student froze as he did not realize the extent of the issue, and he asked her whether he should secure the battery and alternator switches. She told him yes, and initially indicated he turned off the battery, then later indicated that he turned the master and alternator switches off. She mentioned that it happened quickly and there was no time to complete a checklist. She took the controls from the student (but did not verbalize that), and when near the VOR antenna, executed a 180-degree turn to return to the runway, but landed

hard. She helped the pilot-rated student from the airplane, and was delighted it did not catch fire on impact. She was asked if there was any preimpact failure or malfunction with the engine or flight controls. She said she did not think there was a problem with the engine, and did not recall an issue with the flight controls, but added she had a hard time recollecting the accident sequence. She offered that her husband observed the flight and he reported hearing the engine at full-power to impact, with no discrepancies reported.

Postaccident the pilot-rated student asked her if there was a fire, which she thought strange.

With respect to the smoke and fire, she indicated that the smoke filled the cockpit, and burning wires on her side of the cockpit were going across or falling on her legs, the fuel selector, and fuel lines. She reiterated the need/urgency to get the airplane on the ground.

She was asked by NTSB if they used Crew Resource Management (CRM) to deal with the issue. She indicated there was no time to use the checklist, and also indicated that the POH/AFM she has for the airplane does not have a checklist for electrical in-flight fire. She indicated that she had a copy of the POH/AFM (in pdf form) on her web site. I said we need to trust but verify, and asked the FAA inspectors to photograph the cover page, any revisions pages, and the emergency procedures section of the POH/AFM that was in the airplane and used for the accident flight. She was also asked if she heard the stall warning horn or if she felt airframe buffet at the later portion of the flight. She indicated that she did not feel airframe buffet and did not recall hearing the stall warning system, adding that it was tied to the electrical system that was deactivated; therefore, it would have been inoperative. She was also asked whether the pilot-rated student was fighting with her on the flight controls after she took over. She indicated that she did not know if he had his hands on the control yoke.

FAA inspector David Hintz (airworthiness) advised the group that he did see/find an electrical wire hanging down on the right side of the cockpit with the insulation melted. She indicated that she did not know where that wire went to. He asked her if anybody postaccident took anything from the airplane because a red truck was seen next to the airplane postaccident. She indicated that she asked Jessie to get the flight log, POH, and the student's flight bag.

FAA inspector Timothy Hahn (operations) asked her if she reduced power when turning to return, and what the power setting was set to when returning. She indicated she did not reduce power, and re-iterated that her husband heard the engine at full power, and as far as she knew, the airplane was on fire and she felt heat in the cockpit. She said they needed to land and wanted the airplane on the ground. She had experienced smoke in the cockpit before. The inspector also asked if she recalled the airplane's attitude when clearing the trees or did she remember flaring to land. She indicated she did not.

She indicated the emergency locator transmitter did not activate.

The airplane which was insured crashed on airport property; the insurance adjuster was Kaleb Gilmore.

She went to a hospital the same day for a cut on her elbow that required sutures. She also indicated that she is sore and sustained a burn on her right leg. She was not taking any medication for pain management.

She was asked if she or the student was recording video, audio, or had a GPS. She indicated that she was not recording, but was not sure if the student was. She indicated the student had a flight bag, and was not sure if he had a GPS in the bag. She indicated there was nothing plugged into any auxiliary port. All electrical equipment that was in use (2 radios, intercom, and transponder) were permanently installed in the airplane.

The digest was e-mailed to her for review on October 24, 2017, November 16, 2017, and again on November 20, 2017. She did not provide any comments to the digest.



## RECORD OF CONVERSATION

**Timothy W. Monville**  
**Sr. Air Safety Investigator**  
**Eastern Region**

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**Date: December 5, 2017**  
**Person Contacted: Balpreet Singh Chahal**  
**NTSB Accident Number: ERA18LA010**

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### Narrative:

On November 16, 2017, a conference call was held with Mr. Chahal, Mr. Jason W. Konvicka (his attorney), Mr. Timothy Hahn (FAA), Mr. David Hintz (FAA who joined the call later), Mr. Ricardo Asensio (Textron Aviation), and Mr. Timothy Monville (NTSB). The conference call which was made through the NTSB Response Operation Center (NTSB ROC) began at 1500 hours, and was made to [REDACTED] and passcode [REDACTED]

At the beginning of the phone call his attorney asked if it was OK for him to record it. He was told yes.

Mr. Chahal was advised that the NTSB is a federal agency mandated by Congress to investigate aircraft accidents, and NTSB has no authority to take any action against any individual. He was also informed that the purpose of an NTSB investigation is for safety only, and any person NTSB talks with has the right to representation; he was being represented by Mr. Konvicka.

He provided a home address of [REDACTED] Leesburg, VA [REDACTED] and a cell phone number of [REDACTED]. His date of birth is [REDACTED]. He indicated that he normally takes Ibuprofen twice a day, and because of his injury he was taking Oxycodone and a muscle relaxer. He last took the Oxycodone and muscle relaxer at 0100 hours on November 15, 2017. He was asked if he felt clear headed and he indicated, "I do." Prior to the accident, he did not have any back issues.

He was asked whether he had his pilot and medical certificates with him. He indicated he did not have them within reach, and could not recall his pilot certificate number. He estimated that at the time of the accident, he had 260 hours total time, and 10 to 12 hours in make and model. He has flown about 10 to 12 hours with the accident flight instructor over the course of 5 to 6 flights, but did not recall when his first flight with her was. He was asked if he was current at the time of the

accident. He indicated he was not current by a flight review, but he was by a (flight review equivalent) when he obtained his instrument rating in December 2016.

He indicated that the purpose of the accident flights was a refresher flight since he had not flown in the last 2 to 3 weeks. He had been previously signed off for a commercial pilot check ride, but the airplane went down for maintenance, thus the 2 to 3 week delay. He was scheduled for his checkride with a FAA Designated Pilot Examiner (DPE) Greg Hudson at 1400 hours the day of the accident, which his instructor arranged.

With respect to the accident flight, he arrived at the airport and met a colleague (Stephanie) of his flight instructor, who told him to preflight the airplane. He did so using the Flight Manual and noted it was OK, but that the engine oil quantity was at 6 quarts. He then met with his flight instructor and told her the airplane was OK, but the oil level was at 6 quarts. She had 1 quart of oil added. The fuel tanks were full.

Prior to flight, there was no discussion as to who would be the pilot-in-command (PIC). In fact, he indicated that in his previous flights with her it had never been discussed. He said that based on his flight instructor's prior experience, she would have been considered the PIC, and she had ultimate command authority.

He was seated in the left seat and was wearing a seatbelt; there wasn't any shoulder harness installed. He was wearing a headset that was plugged into the normal connection on the instrument panel. After engine start, he taxied to the run-up spot for runway 5, and reported there were no issues while taxiing. Since the engine oil was cold they waited for it to warm up then performed an engine run-up using the checklist. There was nothing abnormal noted. When the engine indications were in the green arc, and after an airplane had landed, he taxied onto the active runway and then onto the displaced threshold, where he turned around and began a no flap takeoff roll. He scanned the engine gauges and everything was normal. Between 85 and 90 mph, he rotated, and immediately (about 3 seconds) after rotation, he heard a "pop" sound from inside the airplane that was not over the intercom. The "pop" sound occurred before the landing gear was retracted, and he never touched the landing gear selector handle, so the landing gear remained extended.

He attributed the "pop" sound to be consistent with the tripping of a circuit breaker, though he did not look at the circuit breakers. He noticed a smell of smoke in the cockpit about 5 seconds after the "pop" sound. At the time of the "pop" sound, the airplane was about 1/2 way down the runway and no more than 10 to 15 ft above the runway. He continued flying the airplane and reported there was no discussion at that time between him and the flight instructor about landing straight ahead. He further indicated that based on the aircraft's location, and speed, it was not possible to safely land ahead on the remaining runway. At the time the airplane flight manual was on the floor between the seats and due to time constraints, it was not accessed. After the "pop" sound the intercom did not work. He was asked if he felt communication between him and the flight instructor was possible without the intercom, and he responded yes.

About 3 to 5 seconds later, he motioned to his flight instructor, and 5 seconds after smelling smoke, smoke became visible. He described the smoke as "heavy electrical, and thick" which

didn't take long to fill the cockpit. He also described it coming from the right side of the instrument panel, and was white/blue which did obscure their forward visibility. His instructor said she was "taking over", and put her hands on the control yoke. He then "backed off" the controls and let her have control of the airplane. He did not see any fire, though the flight instructor said there was fire at 1 point of the flight. That was about the time she took over the flight controls.

He then opened the storm window, but about 1 to 2 seconds later she told him to close it, which he did. He then motioned with his hand on the battery switch whether she wanted him to turn it off, but she did not respond. He repeated his motion 2 or 3 times, but because she did not reply, he did not move or change the switch position which remained on. He reported he did not ask her anymore. He also did not move or touch the battery, alternator, or avionics master switches, they remained on. The battery switch was in front of him on the bottom left, and would have been difficult for her to access.

The instructor, "idled the engine just prior to initiating the turn" and while at 500 ft mean sea level (msl), with the engine at idle, the instructor began a left turn estimated to be between 30 and 35° bank, and she reached over and touched the mixture control, but he did not recall where she placed it. He reported the propeller did not stop, and she lined up for a taxiway and grass. She had about 1.5 seconds before impact, and he noted the airplane was not rolled out of the turn at impact. He did not recall hearing a stall warning horn, nor did he feel any airframe buffet. The flight instructor did not arrest the rate of descent and impacted the ground while in a slight left wing and nose low attitude. The nose bounced, and he immediately felt a sharp pain in his back. The airplane slid an unknown distance, and came to rest. "She motioned for me to turn off the electrical system and master switches after the airplane came to rest and just prior to her evacuating the aircraft. At that time I did follow her instructions and turned off the electrical system." She told him to get out, but because of severe pain he initially couldn't. He then exited the airplane on his own, and crawled about 5 ft away on grass. She came over to him, and he met her father. Mr. Chahal told the flight instructor's father to pull him away from the wreckage, and his instructor came over and said she was trying to call 911, but she had no cell phone service. Postaccident, she did not make any comment to him about the accident sequence. He was asked if there was any consideration to continuing in the traffic pattern with engine power for a normal landing. He responded that the flight instructor was not responsive to his questions, and she wanted to get the airplane on the ground as soon as possible. He did not query her at that time of the flight.

He then heard sirens, and estimated about 5 to 8 minutes later first responders arrived. He was placed onto a stretcher, his back was protected, and he was taken by ground ambulance (15 minute ride) to The Outer Banks Hospital. While there, x-rays were taken and they found spinal trauma. He was then transported by ground ambulance (1.5 hour ride) to Norfolk General Hospital (Sentara Norfolk General Hospital). There he met the trauma surgeon, and had scans and CT scans done. At 2000 hours, it was decided he needed spinal fusion surgery for his L1 and L2 vertebra. The surgery was performed the following day at 1430 hours, and he awoke at 2100 hours. He was subsequently transferred to a 3<sup>rd</sup> hospital near his home.

His injuries, “per hospital documents show, ‘closed stable burst fracture of first lumbar vertebrae’ and corrective surgery of T12-L4 posterior lateral fusion, and L2 compressive laminectomy with the use of several implants including rods and screws.” He was asked if he would have any permanent disability as result of his injury sustained because of the accident. He indicated that his surgeon said he would not have any long-term issues, but that would be on a case by case basis.

He was asked if he prepared a written statement and he indicated he had not yet.

At the end his attorney was asked if there were any changes or omissions to what his client had previously told him. The attorney advised that his client’s story was consistent with what he had previously told him.

The digest was e-mailed to his attorney for review on November 17, 2017, at 1946 EST. The attorney replied on December 4, 2017, at 1940 EST, with comments that were incorporated into the narrative. The corrected digest was e-mailed to the attorney for review on December 5, 2017, at 0909 EST. He replied the same day at 1617 EST with, “Tim, These changes are acceptable. Thanks. Jason”. The final digest was e-mail to the attorney on December 5, 2017.