

National Transportation Safety Board

Office of Aviation Safety

Washington, DC 20594



ERA25MA171

OPERATIONS

Group Chair's Factual Report

January 9, 2026

TABLE OF CONTENTS

A	ACCIDENT.....	3
B	OPERATIONS GROUP	3
C	SUMMARY	3
D	DETAILS OF THE INVESTIGATION	3
E	FACTUAL INFORMATION.....	5
1.0	WITNESS AND VIDEO.....	7
2.0	FUELING	8
3.0	AIRPORT INFORMATION	9
4.0	PILOT INFORMATION	10
4.1	Pilot's Training	11
4.2	Pilot's Schedule	11
4.3	Pilot's Certification Record	11
4.4	Pilot Medical and Pathological Information	13
5.0	HELICOPTER.....	13
5.1	Cockpit Layout	14
5.2	Passenger Seating Arrangement.....	16
5.3	Weight and Balance	17
6.0	METEOROLOGICAL INFORMATION	18
7.0	FAA EMERGENCY ORDER	19
8.0	COMPANY OVERVIEW	19
8.1	Director of Operations Summary.....	21
8.2	Chief Pilot Interview Summary	23
8.3	Pilot Questionnaire Summary.....	24
8.4	FAA Records Review	25
9.0	EXAMINATION AND BIRD STRIKE FINDINGS.....	26
10.0	OPERATOR BIRD STRIKE MITIGATION	26
10.1	Survey of Helicopter Operators	26

A ACCIDENT

Location: Hudson River, Adjacent to Jersey City, NJ.

Date: April 10, 2025

Operator: New York Helicopter Charter, Inc. (NYHC)

Time: 1515 EDT

Helicopter: Bell 206-L4 N216MH, Serial #52296

B OPERATIONS GROUP

Group Chair Lawrence Aaron McCarter
Aviation Accident Investigator
National Transportation Safety Board
490 L'Enfant Plaza East, SW Washington,
DC 20594-2000

Group Member Matthew Rigsby
Member Senior Air Safety Investigator Office of Accident
Investigation and Prevention AVP-100
Federal Aviation Administration (FAA)
10101 Hillwood Parkway Fort Worth, Texas
76177

C SUMMARY

On April 10, 2025, about 1515 eastern daylight time, a Bell 206L-4 helicopter, N216MH, crashed into the Hudson River near Jersey City, New Jersey. The commercial pilot and five passengers were fatally injured. The helicopter departed the Downtown Manhattan/Wall Street Heliport (JRB), New York, New York, about 1450, for a Title 14 Code of Federal Regulations Part 91 air tour flight. The helicopter was owned by Meridian Helicopters, LLC and operated by New York Helicopter Charter, Inc.

D DETAILS OF THE INVESTIGATION

The National Transportation Safety Board (NTSB) investigators from the Operations Group traveled to Jersey City, New Jersey on Thursday, April 10, 2025. The group chairman was briefed by the Investigator in Charge (IIC) on the following

day's plan. The Operations Group was formed with a Senior Air Safety Investigator from the FAA's Office of Accident Investigation and Prevention (AVP-100).

On day Two (April 11, 2025); Members of the Operations Group convened at the accident site and staging area and oversaw the wreckage recovery with the New York Police Department (NYPD) and New Jersey Emergency Management officials. There was 1 recovery ship on site and 2 sets of NYPD divers searching the inlet area where the primary fuselage impacted the water adjacent to the pier and 1 set of divers searching the Hudson River open water about 150 yards east of the pier: specifically searching for the tail boom, tail rotor, and transmission/MRB assy.

On day Three (April 12, 2025) Members of the Operations Group convened at the command center; conducted a brief phone call with the Director of Operations, then proceeded to the accident site and staging area before proceeding to the operators' facility and held a formal meeting and interview with the President and General Manager (Owner), his spouse & Office Manager and the Chef Pilot where a review of operations, policy/procedures manuals, operations specifications and other details of their operation were conducted. The operator provided two exemplar helicopters that were on the NYHC certificate: N227MH and N232MH. In addition, the group was given a tour of the facility and their operations. The meeting lasted about 4 hours. (1100-1500)

On April 13-14, 2025) Members of the Operations Group convened at the NTSB command center collating factual information and talking with witnesses. From there the group convened at the Army Core of Engineers and observed and assisted with the wreckage examination.

On day six, April 15, 2025; Members of the Operations Group convened at the NTSB command center and drafted flight operation questions regarding operations, culture, maintenance, and safety with specific emphasis on N216MH; The group sent an introductory email with the questions to each current and former pilot provided by NYHC. Collated factual data and information and authored field notes.

Day seven, April 16, 2025, Members of the Operations Group convened at the NTSB command center, finalizing collated factual information and field notes. Subsequently terminated on site work.

On May 2, 2025, the NTSB chairman of the operations group conducted two separate interviews with the director of operations and the chief pilot.

E FACTUAL INFORMATION

The accident flight was the eighth tour flight of the day. The flight departed out of the JRB airport/helipad at 1458 eastern daylight time¹ (1858 UTC) with five passengers; two adults, three minor children and the pilot. The passengers paid for the "Charlie" package which would take them over to the statue of liberty, north to the George Washington bridge, then a south turn on the west side of the Hudson River southbound where it would land back at JRB, refuel and pick up the next passengers.

ADS-B data provided by the FAA (see figure 1) revealed the accident helicopter N216MH, departed JRB (Skyport Heliport) at 1458. The helicopter flew at a low altitude (~ 200 feet agl) on the south side of "Governors Island" and continued until it completed a teardrop pattern south of the Statue of Liberty, then proceeded north. The helicopter then proceeded up the east side of the Hudson River adjacent to Manhattan on a ground track of 025° at approximately 600 ft mean sea level (msl) /850 ft geometric altitude² and 109 kts groundspeed. The helicopter continued up the Hudson River to the George Washington Bridge and crossed over the bridge at 1,000 ft msl/1,275 ft geometric where the helicopter made a left 180° turn to the south (200°) on the west side of the Hudson River and crossed over the bridge again at 1,000 ft msl/1,275 ft geometric at 86 kts at 1509:08.

The helicopter continued south on a track of 210° over the Hudson River, crossing over the Lincoln Tunnel then continued on a stable track of 200°. The helicopter then passed abeam the Hoboken Waterfront before passing the "Ellipse at Newport" as it was flying at 350 ft msl/650 ft geometric and 93 kts at 1514:47.

As the helicopter approached the Holland Tunnel ventilation towers near Jersey City, New Jersey, it was at a geometric altitude between 625 and 650 ft. Then helicopter's altitude increased rapidly to 675 ft before it entered an uncontrolled descent. The data ended at 1514:54.5 and the helicopter's last observed altitude was 125 ft. (see figure 2). For reference, an FAA helicopter chart shows the Hudson River and airspace boundaries. (see figure 3)

¹ All times unless otherwise noted will be in a 24-hour clock format for eastern daylight time.

² Geometric altitude in ADS-B (Automatic Dependent Surveillance-Broadcast) is the vertical distance of an aircraft above the WGS84 reference ellipsoid, calculated via GNSS (GPS) sensors rather than air pressure. It acts as a highly accurate, non-pressure-dependent altitude source, providing a "true" height above the earth's surface to supplement or verify barometric pressure altitude.



Figure 1. ADS-B flight track overview of entire route of flight from takeoff through loss of signal near the accident location.

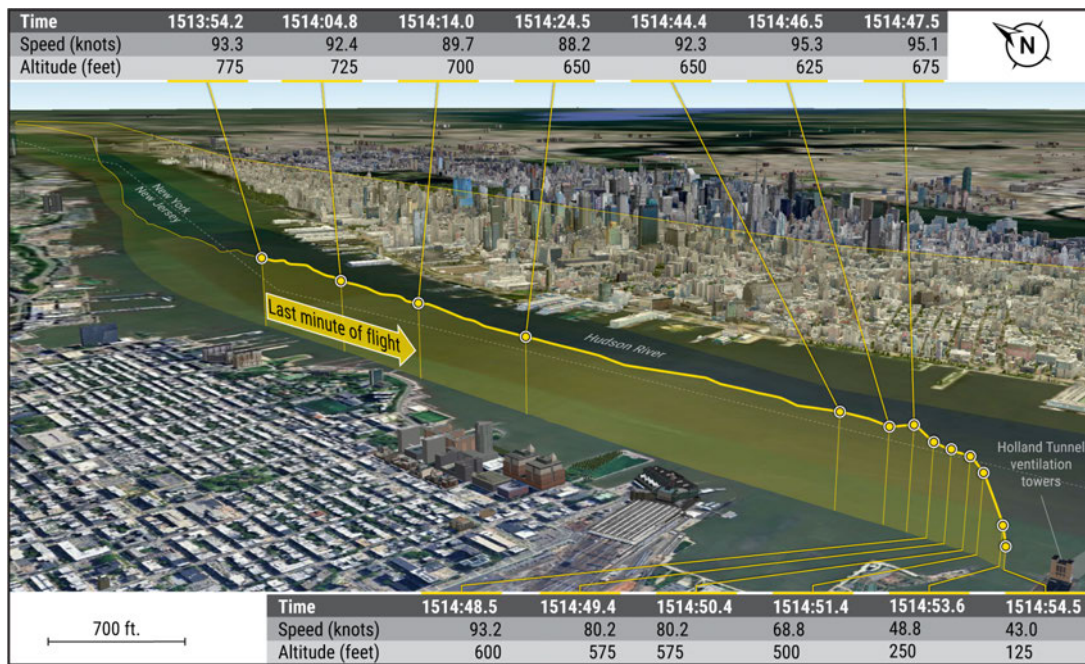


Figure 2. ADS-B flight track and geographic data highlighting the last minute of the flight through breakup, uncontrolled descent and loss of signal.

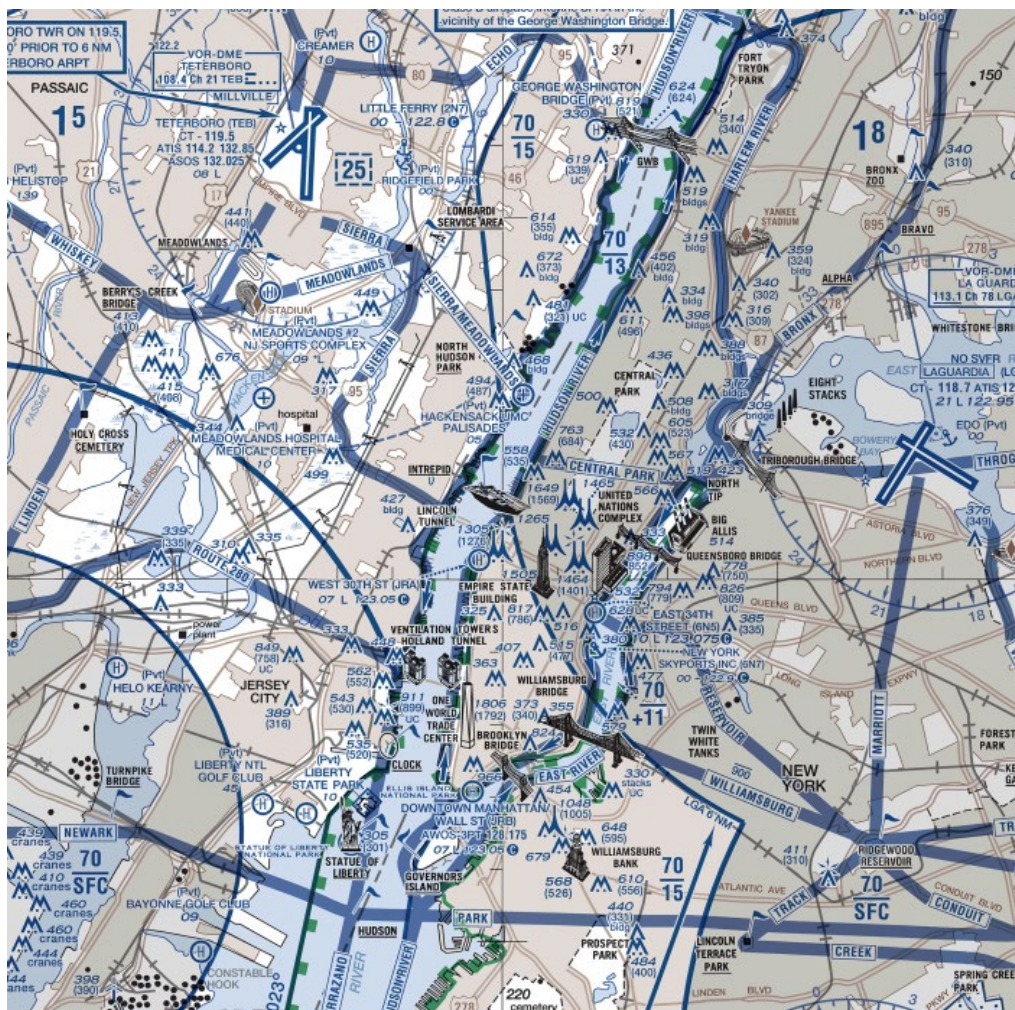


Figure 3. FAA Aeronautical Raster Chart excerpt for helicopters.

1.0 Witness and Video

Multiple witnesses described hearing several loud “bangs” & “pops” emanating from the helicopter before it broke up and descended into the river. Surveillance video (with accompanying audio) captured the helicopter traveling south before it suddenly separated into three major sections: fuselage (including the engine), main rotor system (including both main rotor blades, transmission, and roof-beam structure), and the tail boom (including the tail rotor) (see figure 4)

An additional witness reported that just minutes before the accident, she ran by the Newport lighthouse, and a large flock of geese took flight. “The geese were big and there were many of them. When the helicopter went bang, I immediately thought it was a Bird Strike.”

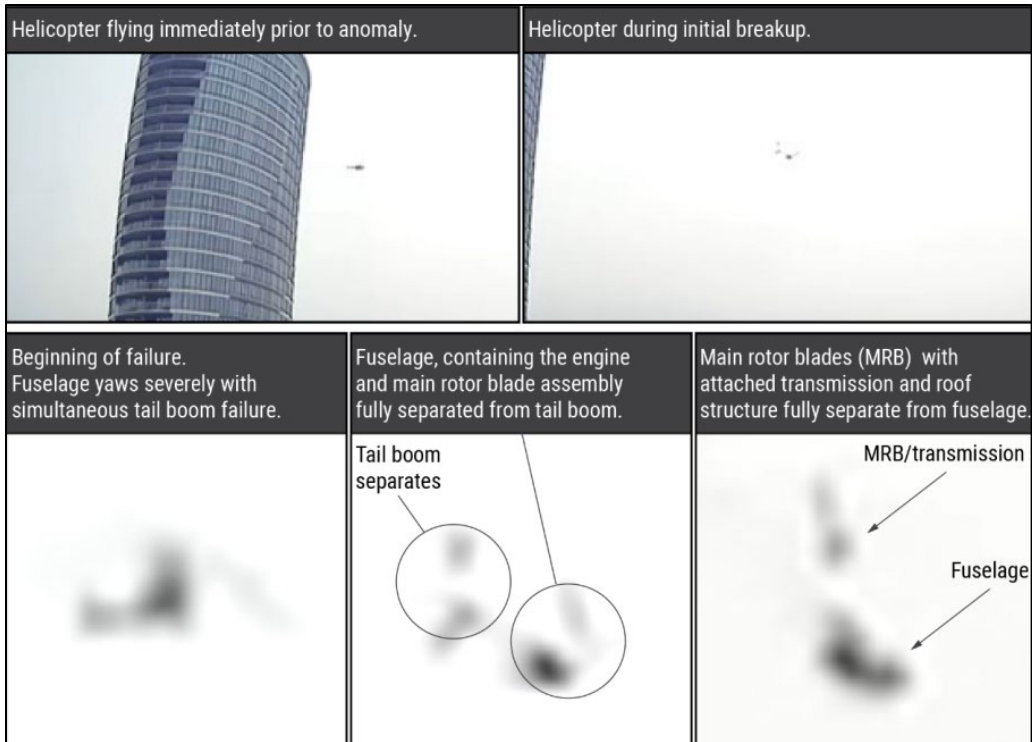


Figure 4. Enhanced surveillance video with sequential images depicting the helicopter's flight and breakup.

2.0 Fueling

The pilot, while on the return leg of the flight and prior to the accident, contacted operations at JRB requesting fuel per normal procedures and was not indicative of a fueling irregularity. The helicopter was refueled twice at JRB on the day of the accident; Once at 1041-1056 where it was fueled with 30.6 gallons and a following time at 1358-1413 where it was fueled with 40.8 gallons (see figure 5). The operator fueled the helicopter in between passenger/tour operations when required. A fuel calculation estimate was prepared after the accident based on the last fueling and length of the flight. The chief pilot concurred that there would have been about 28 gallons of fuel (~200 lbs) remaining at the time the pilot requested fuel.

NYH


Downtown Skyport

Date: 4/10/25 Weather: _____ Page: 1 of _____

No.	Acct. No.	Customer	Reg. No.	Pilot in Command	Time		Jet A Gallons	Passengers		Type A/C	Misc
					In	Out		Boarded	Disembarked		
1		NYH	216MH	SJ	1004	1015	0	6	0	LR	-
2		1	227MH	OK	1008	1012	0	4	0	LR	-
3			227MH	OK	1026	1029	0	0	4	LR	RTB
4		2	216MH	SJ	1041	1056	30.6	6	6	LR	-
5			216MH	SJ	1110	1122	0	3	6	LR	-
6		3	216MH	SJ	1136	1141	0	0	3	LR	RTB
7		4	216MH	SJ	1324	1331	0	6	0	LR	-
8		5	216MH	SJ	1353	1413	40.8	6	6	LR	-
9			216MH	SJ	1423	1436	0	6	6	LR	-
10		6	216MH	SJ	1450	1458	0	5	6	LR	-
11											
12											
13											
14											

Figure 5. Document showing number of flights, ship number, times, pilot and fueling on the day of the accident.

3.0 Airport Information

Downtown Manhattan/Wall Street Heliport (JRB) was a public-use heliport located approximately 3 miles southeast of downtown New York City, New York, at an estimated elevation of 7 feet mean sea level. The FAA identifier for the facility was JRB.

Primary communications include common traffic advisory frequency (CTAF) on 123.05 and weather information via an on-site AWOS-3PT, supplemented by nearby ASOS³ and AWOS⁴ stations at surrounding airports, including Newark, LaGuardia, Teterboro, and John F Kennedy International Airport (JFK) New York, New York.

The facility includes Helipad H1, which measured 62 by 62 feet and was constructed of concrete in good condition, with a single-wheel weight-bearing capacity of 50,000 pounds. The helipad was equipped with perimeter runway edge lighting, left traffic patterns, and basic markings described as being in fair condition. Helipad elevation was 7 feet, consistent with the overall heliport elevation. The JRB heliport had 14 parking spots for helicopters. Two primary spots for refueling were identified as spots 5 and 6 in the red outline of the photo. (see figure 6)

³ The Automated Surface Observing System (ASOS) is the primary 24/7, U.S.-based, automated weather station network. It provides continuous, real-time data on wind, temperature, dew point, pressure, visibility, and precipitation type/intensity,

⁴ AWOS stands for Automated Weather Observing System, a suite of sensors and computer technology installed at airports to provide real-time, minute-by-minute aviation weather data. These systems, regulated by the Federal Aviation Administration



Figure 6. JRB helipad

According to FAA records, the heliport was publicly owned by the New York City Economic Development Corporation, with management responsibilities assigned to Downtown Skyport LLC. The listed owner and manager offices are located in lower Manhattan, with contact information on file with the FAA.

According to FAA records, the heliport was publicly owned by the New York City Economic Development Corporation, with management responsibilities assigned to Downtown Skyport LLC. The listed owner and manager offices are located in lower Manhattan, with contact information on file with the FAA.

4.0 Pilot Information

The captain was 36 years old and resided in Elizabeth, NJ. His date of hire with NYHC was on March 1, 2025. Prior to NYHC he was a helicopter fire and survey pilot with operators in Montana and Utah. According to his resume, he had prior experience in the R44, CH47, Hiller UH-2, MD-500, and Bell 206.

The pilot received his rotorcraft helicopter license [REDACTED] on August 18, 2022. He received his instrument rating for rotorcraft on February 3, 2023, and his commercial on August 1, 2023.

At the time of the accident, the pilot held a commercial pilot certificate with ratings for rotorcraft-helicopter and instrument helicopter. As of March 29, 2025, he had logged about 790.2 total hours of flight experience, of which, 48.6 hours were in the same make and model as the accident helicopter. The pilot was issued a first-class medical certificate on September 20, 2024, with no limitations.

4.1 Pilot's Training

According to NYHC training records, the pilot passed all required modules, lessons, and examinations in accordance with the NYHC ground school training curriculum. Between March 1, 2025, and March 10, 2025, the pilot successfully completed 20 hours of ground school training and examination and 5 hours of helicopter specific (B206) flight training. The curriculum segments were completed and graded satisfactory on March 9, 2025, and signed off by the chief pilot.⁵

4.2 Pilot's Schedule

According to the chief pilot, the pilot worked a 10 days on/10 days off schedule, and the day of the accident flight was the pilot's first day back after having been off for 10 days. The pilot arrived about 0800 and began operations at 1000. According to the Downtown Skyport refueling and flight schedule log, the accident flight was the eighth tour flight of the day for the accident helicopter, and all of those flights were operated by the pilot.

4.3 Pilot's Certification Record

The PIC logged his flight time in a hard copy pilot logbook. Recovered pilot logbook records showed that the least entry was made on March 29, 2025. A review of the PIC's logbook revealed that he had logged 783.2 flight hours total time, 601.1 hours PIC, 262.4 hours night, and 45 hours in the B-206 of which 19 hours was in the accident helicopter N216MH. (see figure 7) ⁶

Total Time	783.2	Cross Country	199.6	12-Months	414.5
Rotorcraft	783.2	Total Night	262.4	Bell 206	45

⁵ See attachment 1: NYHC Personnel training records.

⁶ See attachment 2: Pilot logbook excerpts.

4.4 Pilot Medical and Pathological Information

An autopsy of the PIC was conducted by the State of New Jersey, Department of Health, Office of the Chief State medical Examiner, Newark, New Jersey. determined the cause of death to be blunt force injuries with terminal submersion in water and the manor of death was accident.

Toxicological testing of the PIC was conducted by the State of New Jersey, Department of Health, Office of the Chief State Medical Examiner, Toxicology Laboratory Newark, New Jersey, and the results yielded negative findings. In addition, the FAA Forensic Sciences Laboratory tested post-mortem specimens of the pilot. No tested-for substances were identified.

5.0 Helicopter

The accident helicopter, a Bell 206L-4 Long Ranger IV (registration N216MH, serial No. 52296) was built in 2004 and issued its most recent airworthiness certificate on February 11, 2005. (see figure 8) The 206L-4 had a two-blade semi-rigid (teetering) main rotor system that provides helicopter lift and thrust. A two-blade teetering tail rotor system provided thrust for helicopter directional control. A Rolls-Royce 250-C30P turboshaft engine was installed on the accident helicopter. The helicopter was equipped with light weight pneumatic floats, Van Horne composite main and tail rotor blades, and a Precise Flight Pulselite⁷ system.

The helicopter was not equipped with a cockpit voice recorder or flight data recorder, nor was it required to be.

Photos of the pilot taken just before the helicopter departed indicated that the pilot was wearing computer-augmented sunglasses, which had video and audio recording capability. The sunglasses were not recovered, and no data could be accessed.⁸

The last helicopter maintenance record was dated April 9, 2025. As of the end of the day of April 9, 2025, the aircraft total time (ATT) was 13,021.8 hrs. and the engine total time (ETT) was 23,351.8 hrs. The last maintenance action performed was the removal of snow baffles on April 7, 2025, at an ATT of 13,013.1 hrs. and an ETT of 23,343.1 hrs. On March 27, 2025, at an ATT of 12,991.3 hours, the swashplate and support assembly was removed and replaced with swashplate and support assembly with a mast nut retorque due in 1-5 hours. On March 27, 2025, the operator

⁷ The Pulselite® System from Precise Flight Inc. is an FAA-certified, electrical system modification designed to increase aircraft visibility and reduce bird strikes. It works by pulsing existing landing and auxiliary lights at a specific frequency and pattern.

⁸ The glasses featured a built-in display with a camera and audio recording capability.

accomplished a main rotor mast nut retorque at an ATT of 12,992.4 hrs. The reason for the swashplate and support assembly replacement was not listed.⁹



Figure 8. Photograph of helicopter prior to the accident. Photo by Dan Smith

5.1 Cockpit Layout

The cockpit flight control system was composed of cyclic, collective, and directional (pedal) controls. The helicopter was configured for the pilot to fly in the right seat and for single-pilot operations. The instrument position on the right forward seat was equipped with a HSI (Horizontal Situation Indicator), airspeed, attitude, vertical speed indicator, and altimeter as the primary instrumentation. (See figure 9) Above the flight instruments, below the glareshield contained the panel with caution and warning indications. (see figure 10)

Above the pilot, on the overhead panel (see figure 11) which was damaged, circuit breakers and toggle switches for the avionics, air conditioning, position, strobes and anticollision lights were located. An open receptacle was discovered that was labeled "PULSE LIGHT" but the toggle switch was missing and not recovered. The Pulselite system was designed to flash the existing lights, in this case, the landing light for the Bell 206 accident helicopter. The system served two purposes - to reduce bird strikes and to increase aircraft recognition for collision avoidance with other aircraft. Video evidence provided to the NTSB shows a previous (not accident) flight, with the Pulselite system activated and "pulsating" during a pre takeoff flight condition. (see figure 12)

⁹ See the Airworthiness Group Chair Factual Report.



Figure 9. N216MH post-accident view of cockpit instrument panel.



Figure 10. Exemplar (N227MH) instrument panel with caution and warning panel.



Figure 11. The accident helicopter overhead panel containing the circuit breakers and light switches, including the missing Pulselite switch on the lower left.



Figure 12. Sequential screen captures of video showing the Pulselite flashing. Full video in the docket shows the helicopter tail wag as reported by witnesses and pilots is listed as Attachment 10.¹⁰

5.2 Passenger Seating Arrangement

The pilot and passengers were seated as follows: (see figure 13) An adult female passenger occupied the aft left, forward-facing seat. A minor child was seated

¹⁰ Video was from a previous flight and not the accident flight.

in the aft middle seat between the two adult passengers, and an adult male occupied the aft right, forward-facing seat. In the middle row, which consisted of two rear-facing seats, a minor child occupied the right seat, and the left seat was unoccupied. In the forward section of the helicopter, a minor child occupied the left front seat in the cockpit area, and the pilot occupied the pilot's seat on the right.

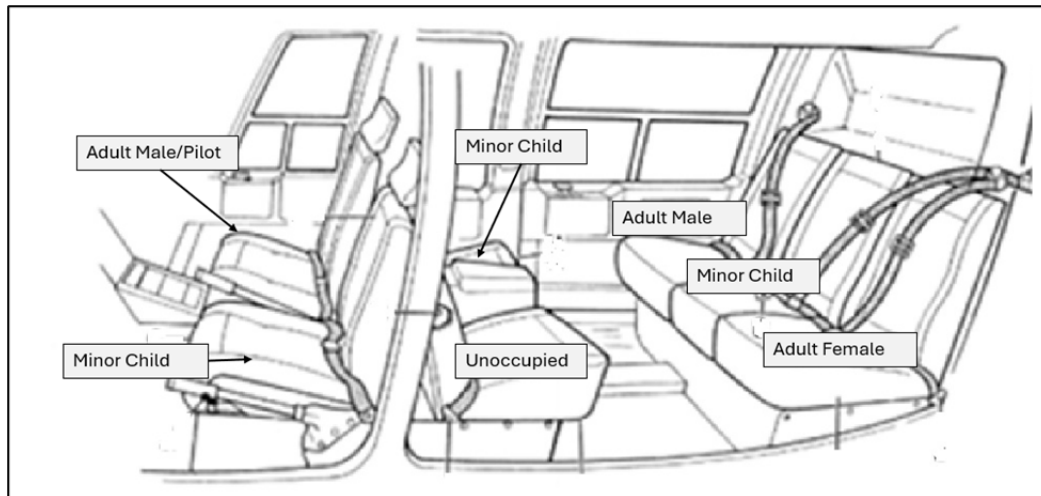


Figure 13. Seating configuration of pilot and passengers.¹¹

5.3 Weight and Balance

A review of the weight and balance data provided by NYHC and Meridan Helicopters showed that the helicopter was within its weight and balance limitations for the flight.¹² (see table and figure 14)

W&B			
Bell 206 L (N216MH)	LBS	ARM	Moment (IN. LB.)
EMPTY	2800.7	128.7	360488.60
OIL	13	205.0	2665.00
REMOVED CONTROL STICK	-3.4	60.9	-207.10
Dual Control Covers	0.9	39.5	35.60
Pilot	220	65.0	14300.00
Forward PAX	75	65.0	4875.00
Right Mid PAX	75	91.0	6825.00
Left Aft PAX	167	129.0	21543.00
Center Aft PAX	45	129.0	5805.00
Right aft PAX	220	129.0	28380.00
Fuel	187	129.2	24160.40
TOTALS	3800.2	123.4	468870.50

¹¹ Seating diagram/configuration courtesy of Bell Textron Inc.

¹² Attachment 3: Weight & Balance charts.

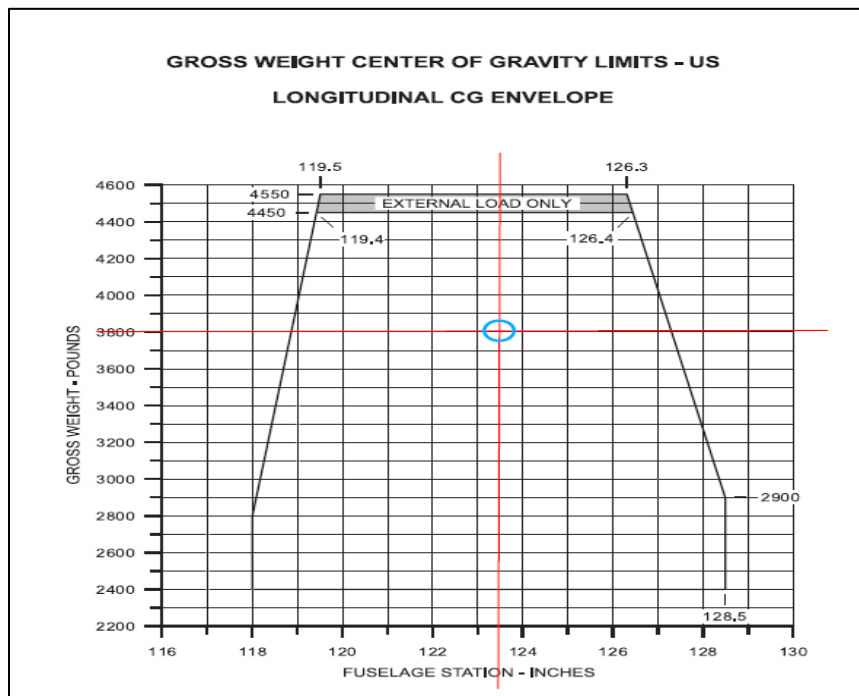


Figure 14. Weight & Balance CG envelope.

6.0 Meteorological Information¹³

The closest official weather reporting location was the departure heliport at the Downtown Manhattan/Wall Street Heliport (KJRB), New York, NY, located about 2 miles south of the accident site at an elevation of 7 ft.

The following conditions were reported from the time of departure through the accident. KJRB weather at 1456 EDT, automated, wind from 150° at 10 knots gusting to 18 knots, wind 120° variable 190°, visibility 10 miles or more, ceiling broken at 7,500 ft agl, temperature 8°C (46°F), dew point temperature -2°C (29°F), altimeter setting 30.34 inches of mercury (inHg). Remarks: automated station with a precipitation discriminator, peak wind from 260° at 36 knots reported at 1423 EST, sea-level pressure 1027.4-hPa, temperature 7.8°C, dew point -1.7°C,

A review of the 5-minute AWOS observations for KJBR for 1515 EDT indicated the wind was from 150° at 8 knots, visibility 10 miles or more, ceiling overcast at 7,000 ft agl, temperature 46.4°F, dew point 26.6°F, relative humidity 46%, altimeter setting 30.34 inHg. Remarks; wind from 110° variable 170°.

¹³ See the Meteorology Group Chair Factual Report.

7.0 FAA Emergency Order

On April 14, 2025, the FAA Acting Administrator issued an Emergency Order¹⁴ suspending the air-carrier certificate of New York Helicopter Charter Inc. after determining that its continued operations posed an unacceptable risk to aviation safety following the accident. Immediately after the accident, the company's Director of Operations agreed with the FAA to cease operations pending completion of an investigation.

Minutes later, the company's CEO terminated the Director of Operations and rescinded the decision to halt flights, leaving the company without required qualified management personnel. The FAA found this action raised serious safety concerns and violated 14 C.F.R. § 119.69(a), creating reasonable doubt as to the company's qualifications to hold an air-carrier certificate. The FAA therefore suspended the certificate effective immediately (April 14, 2025) and ordered its surrender until the company's qualifications could be reestablished.

Shortly after the order was received NYHC elected to cease all operations and subsequently closed the business.

8.0 Company Overview

New York Helicopter Charter, Inc. (NYHC) conducted helicopter operations under Title 14 Code of Federal Regulations (CFR) Parts 91 and 135, providing passenger air tour and charter services in and around New York City and surrounding landmarks, including the boroughs of New York City, the Hudson River, major bridges, waterfront areas, skylines, and the Statue of Liberty. The company's principal operations and maintenance base was located in a shared hangar facility in Kearny, New Jersey, which was utilized by four other unrelated operators. NYHC was owned and managed by its President and General Manager, who reported more than 40 years of experience in aviation. At the time of the accident, NYHC employed approximately 35 personnel, including 7 pilots. According to NYHC operations, the estimated total number of passengers flown in 2024: was 20,413 passengers.

NYHC operated three helicopters—N216MH (the accident aircraft), N227MH, and N232MH—all of which were leased from Meridian Helicopters, LLC, Broussard, Louisiana. FAA records indicated that NYHC held Air Carrier Certificate No. NY9A9001, authorizing operations under 14 CFR Part 135. The FAA Farmington Flight Standards District Office oversaw the operator. Under its FAA-issued

¹⁴ Attachment 4: FAA Order, Emergency Order of Suspension

Operations Specifications^{15, 16} and applicable Letters of Authorization (LOA)¹⁷ NYHC was authorized to conduct single-engine helicopter on-demand operations, including day and night visual flight rules (VFR) passenger and cargo operations for up to nine occupants within the contiguous United States. NYHC was also authorized through a Letter of Authorization from the FAA to conduct commercial air tour operations under 14 CFR § 91.147¹⁸, subject to applicable limitations, provisions, and airspace requirements.

As a commercial air tour operator defined under 14 CFR § 91.147 Key FAA Requirements for the 91.147 LOA included the following as referenced in the LOA:

- Application Submission: Written request to the local FSDO providing operator name, address, d/b/a, and responsible management personnel (business and maintenance).
- Aircraft Listing: Specific identification of aircraft by make/model/series and registration number.
- Drug & Alcohol Program: Registration with the FAA Drug Abatement Division for an Anti-drug and Alcohol Misuse Prevention Program.
- Safety Management System (SMS): New applicants must develop and implement an SMS per Part 5, while those with existing LOAs (as of May 28, 2024) have until May 28, 2027, to implement.¹⁹
- Operator Compliance: The operator must ensure all safety-sensitive employees (pilots, maintenance) are covered by the drug testing program.
- Operational Scope: Limited to non-stop commercial sightseeing flights within a 25-statute-mile radius of the departure airport.

At the time of the accident, the organizational structure (see figure 15) and assignment of responsibilities were defined in the company's General Operations Manual (GOM). The owner served as President and General Manager and retained overall responsibility for operational control and regulatory compliance. The director of operations was responsible for the supervision of day-to-day flight operations,

¹⁵ Attachment 5-Operations Specifications

¹⁶ FAA-approved documents that detail the specific operating authorizations, limitations, and procedures under which they must conduct business, usually attached to an Air Operator Certificate (AOC). They define the exact rules—such as weather minimums, authorized routes, and specific landing sites—that the company must follow to comply with federal regulations.

¹⁷ A Letter of Authorization (LOA) is an official document issued by the Federal Aviation Administration (FAA) that grants an operator permission to conduct specific flight operations or utilize particular equipment. LOAs are commonly required for operations that exceed standard regulatory allowances, such as advanced navigation capabilities, use of special airspace, or safety exemptions.

¹⁸ FAR Part 91.147 pertains to passenger-carrying flights conducted for compensation or hire under 14 CFR Part 91, specifically addressing operations that fall under certain exemptions, like sightseeing flights or limited commercial operations for compensation and hire.

¹⁹ NYHC had a framework in development for the future implementation of an SMS, but it was not fully developed, nor was it required to be.

flight scheduling, dispatch, and training. The chief pilot was responsible for pilot supervision, training, standardization, and ensuring compliance with FAA-approved manuals and procedures. as the director of maintenance (DM) and was responsible for maintenance oversight, aircraft airworthiness, compliance with FAA maintenance regulations, and maintenance recordkeeping. All aircraft operated by NYHC were owned by Meridian Helicopters, LLC.

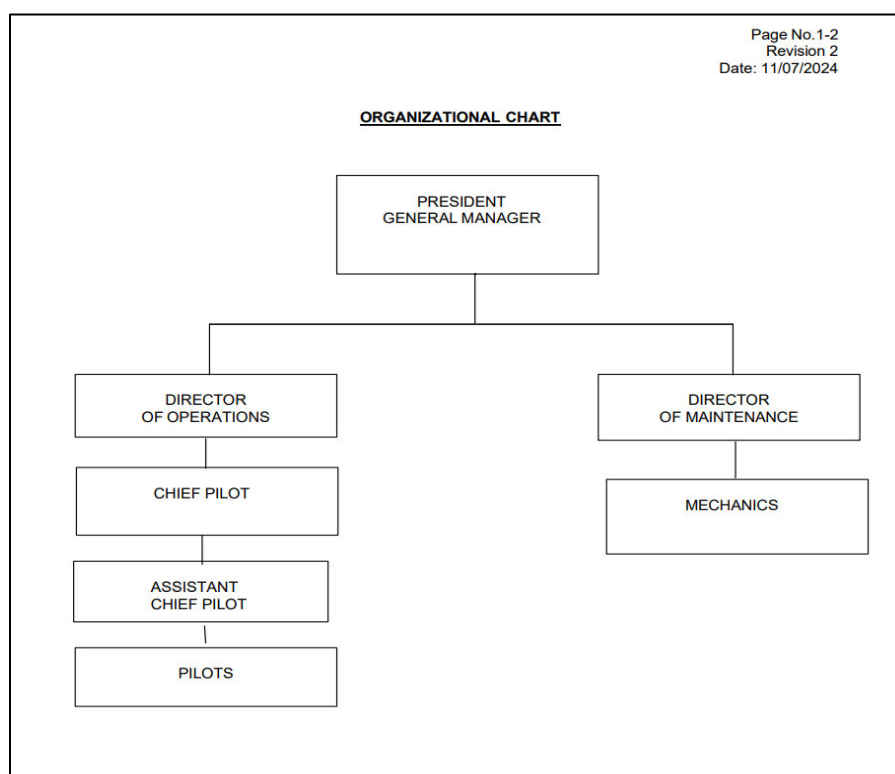


Figure 15. NYHC Organizational Chart per the GOM.

8.1 Director of Operations Summary

The director of operations stated that immediately after the accident, he strongly recommended that they suspend operations, and do a "safety standdown," until they had some factual information; According to the director of operations he did it for safety reasons; the situation was fluid and he thought it best to be proactive. He called the owner and informed him of the suspension. The owner "strongly" disagreed and informed the director of operations that he was fired.

After the FAA requested a stoppage of the operation, the owner responded to the FAA and informed them that the director of operations was no longer employed

and that he did not want to shut down the business. He also informed the FAA that that he had 30 days to replace the director of operations.

A formal interview with the director of operations was conducted on May 2, 2025.²⁰ He stated that his responsibilities included ensuring aircraft availability, coordinating maintenance activities, conducting required pilot check rides, and serving as the primary liaison with the Federal Aviation Administration (FAA). He reported having a working relationship with the FAA Principal Operations Inspector (POI) and stated that he had more than 11,000 hours of helicopter flight experience. He had been employed by New York Helicopter Charter (NYHC) for approximately seven years, including prior service as Chief Pilot.

The director of operations stated that pilots were hired based on prior experience and compliance with 14 CFR Part 135 minimum requirements, and that NYHC required a minimum of five hours of training before pilots were authorized to conduct revenue flights. He stated that the company offered three sightseeing tour options—Alpha, Bravo, and Charlie—with approximate durations of 15, 20, and 25 minutes, respectively. He reported that the company was adequately staffed with pilots and mechanics at the time of the accident, although one mechanic had recently died and had not yet been replaced.

Regarding helicopter N216MH, the director of operations stated that he was aware of pilot reports describing a “hop,” which he indicated was addressed through track-and-balance procedures and remained within acceptable limits. He stated that he did not personally experience the condition and was unable to determine whether it was related to collective input or airframe characteristics. He reported that the condition was limited to N216MH and stated that he was not aware of any unresolved mechanical discrepancies or reports of ground vibration conditions communicated to maintenance personnel.

The director of operations stated that he did not meet the accident pilot in person but had communicated with him and expressed no concerns regarding the pilot’s conduct. From a safety culture perspective, he stated that pilots were not pressured to conduct flights if they were uncomfortable and were not subject to punitive action for declining flights. Maintenance discrepancies were reported through electronic messaging applications and maintenance irregularity sheets carried onboard the aircraft. He stated that maintenance issues were addressed by the maintenance department and that he had no concerns regarding maintenance performance.

²⁰ Attachment 6: Director of Operations Interview.

The director of operations stated that both the director of operations and director of maintenance positions were part-time, and that following the cessation of operations, he no longer had access to company files or the internal network.

8.2 Chief Pilot Interview Summary

The chief pilot was interviewed on May 2, 2025.²¹ He stated that newly hired pilots at New York Helicopter Charter (NYHC) were required to complete approximately 20 hours of online ground school training and were trained to 14 CFR Part 135 standards, although most operations were conducted under Part 91. Flight training consisted of approximately five hours of dual instruction, including tour route familiarization, radio communications, and altitude procedures. He stated that hiring decisions were based on Part 135 minimums, pilot experience, and suitability for the operation, and that he conducted pilot training and familiarization. He reported that the company was adequately staffed at the time of the accident.

Regarding helicopter N216MH, the chief pilot stated that he was not aware of any mechanical irregularities. He reported that the helicopter exhibited a vibration during ground operations, which he described as consistent with other helicopters he had observed. He stated that the vibration was reported to maintenance personnel, a track-and-balance procedure was performed, and the condition was deemed acceptable, and that the helicopter operated normally in flight. Maintenance discrepancies were recorded in a binder kept onboard in a waterproof bag, which also served as a backup for flight manifests and weight-and-balance documentation in the event of electronic failure.

The chief pilot stated that pilots were responsible for conducting weight-and-balance calculations prior to flight using passenger counts and weights provided by operations. He stated that safety concerns could be reported directly to him or to the aviation safety officer and elevated to the director of operations if necessary, and that safety reporting procedures were informal and not documented. He stated that pilots had final authority to decline a flight if they were uncomfortable and that no punitive action resulted from such decisions, although this policy was not formally documented.

The chief pilot stated that pilot duty days typically began with a report time of approximately 0800, with the first flight around 1000, and that tour operations generally concluded around 1900 during the summer season. He stated that company weather minimums included ceilings of 800 feet, visibility of three statute miles, and wind limitations of 35 knots sustained, or a 15-knot gust spread. He stated that he did not have significant safety concerns regarding the operation and that the

²¹ Attachment 6: Chief Pilot Interview

company had a Safety Management System under development by a former pilot on a contract basis.

Regarding the fuel load on the accident flight, the chief pilot stated that fuel calculations based on the previous refueling and the length of flight were estimated to be about 28 gallons (~ 200 pounds) of fuel remaining at the time the pilot radioed in and requested fuel upon landing; it was consistent with expected fuel consumption. He stated that due to the cessation of operations at the time of the interview, he no longer had access to company electronic records or internal systems.

8.3 Pilot Questionnaire Summary

Multiple current and former pilots voluntarily provided responses to a questionnaire regarding training, staffing, operations, safety culture, maintenance, and aircraft performance at NYHC. All statements were based on personal observations during employment.²²

Respondents reported total helicopter flight experience ranging from approximately 750 to more than 1,500 hours. Most held commercial pilot certificates with instrument ratings, and several held flight instructor certificates as well. Employment duration typically ranged from several months to approximately one year. Pilot turnover was described as historically frequent, with some improvement noted in the year preceding the accident.

Respondents reported receiving FAA Part 135 ground and flight training, including online coursework, followed by a Part 135 check ride conducted by the director of operations, chief pilot, or designated training captain. Additional training included tour route familiarization, practice approaches, and supervised ride-alongs. Training was generally described as structured, thorough, and adequate, with emphasis on aircraft-specific procedures and emergency operations.

Pilots reported operating along published FAA helicopter routes and standard Hudson River Letter of Authorization (LOA) tour routes ("A" and "B" tours), typically at 1,500 feet AGL when assigned by air traffic control. The "Bridge" and "Castle" routes were commonly used for transitions between Kearny and the Hudson River. Within the Hudson River Exclusion, enroute altitudes of approximately 900 to 1,000 feet were commonly used, except during takeoff and landing. Airspeeds were governed by aircraft performance, passenger loading, and air traffic control constraints.

Typical staffing levels were reported as 4 to 6 pilots, supported by 8 to 15 ground personnel. Respondents stated that NYHC employed three mechanics until

²² Attachment 7: Pilot questionnaire and responses.

December 2024, when the lead mechanic passed away; operations thereafter continued with two mechanics.

Several respondents reported flying with or observing the accident pilot. He was described as competent, cautious, and methodical, particularly for a pilot new to the Bell 206 and the New York operating environment. Respondents stated that he was evaluated by senior pilots or the chief pilot before being released for solo tour operations.

Multiple pilots reported that helicopter N216MH exhibited vibration during ground operations at flight idle compared to other fleet aircraft. Respondents stated that the vibration resolved with throttle application and was not observed in flight. Pilots reported that maintenance personnel were notified and that multiple track-and-balance checks were conducted without identifying any adverse findings.

Respondents stated that maintenance discrepancies were generally addressed promptly. Squawks were communicated through maintenance logs, verbal communication, messaging applications, or the company Safety Management System (SMS).²³ Most pilots expressed confidence in maintenance personnel. Some respondents expressed concern following the loss of the lead mechanic and questioned whether staffing and financial resources were sufficient thereafter.

Most respondents stated they were not pressured to operate outside company or personal minimums. One respondent reported verbal pressure related to weather decisions but stated that they declined and did not operate outside minimums. Respondents stated that pilots retained final authority to decline flights.

Several respondents expressed concern regarding the company's financial stability, citing aircraft repossession and payment issues. Respondents generally did not identify direct safety impacts associated with these concerns during their employment.

8.4 FAA Records Review

The Safety Assurance Systems (SAS) was a risk-based, data-supported oversight system utilized by the FAA for 14 CFR Part 135 operators. SAS provides data collection tools to help the principal inspectors assess the certificate holder's performance. For certificate holders, SAS encompasses certification, surveillance, and certificate management processes. SAS assesses the safety of the certificate holder

²³ In aviation maintenance, a squawk is a reported issue, defect, or malfunction with an aircraft that requires investigation and repair. Pilots document these discrepancies in a "squawk list" or maintenance logbook after a flight—such.

using system safety principles, safety attributes, risk management, and structured system engineer practices.

The operations group reviewed various part 135 and any writeups for the part 91 LOA. SAS data for NYHC. During the year prior to the date of the accident, no issues of concern were found in the SAS data for NYHC, the accident helicopter, and the accident pilot. No deficiencies were noted with the FAA's oversight of NYHC prior to the accident.

The operations group requested NYHC bird strike reports submitted to the Farmingdale FSDO between 2021 and 2025. There was 1 report filed on January 5, 2022; As reported to AFG100EA11:

"12/31/2021 @ 1400 EST During descending checkout out of KEWR airspace using the bridge routing, a medium sized seagull busted through the pilots windshield. No one was injured apart from a few scratches on pilots face and hands. Pilot immediately slowed down and continued the approach into Kearny Heliport K65NJ. Helicopter landed safely and passengers disembarked the aircraft before the aircraft got pulled back inside the hangar. Damage reported by director of operations is to the LH forward canopy which has a hole caused by the bird strike. Helicopter will need canopy replaced prior to return to service."

9.0 Examination and Bird Strike Findings

During examination of the fuselage and rotor blades, main rotor blade foam core pieces and a severed bird wing were discovered on the ground and on roof tops about 2,000 feet northwest of the wreckage recovery site, a specialist from the Smithsonian Institution's Feather Identification Lab (National Museum of Natural History) was invited by the NTSB to conduct sampling of the wreckage to identify potential bird remains. Additional sampling of the main rotor blades was conducted by the Feather Identification Lab at the NTSB Materials Laboratory. Bird remains were discovered.²⁴

10.0 Operator Bird Strike Mitigation

10.1 Survey of Helicopter Operators

The Operations Group attempted to contact 16 helicopter operators nationwide, including tour operations, powerline, utility and charter, regarding bird strike mitigation and awareness practices; six operators responded.²⁵ A review of the

²⁴ See Airworthiness report in the docket.

²⁵ Attachment 8: Operator survey responses.

responses indicated limited awareness of the Rotorcraft Bird Strike Working Group (RBSWG), associated ARAC guidance, and National Transportation Safety Board (NTSB) Safety Recommendations A-10-136 through A-10-147.²⁶ Most operators reported being unaware of, or only vaguely familiar with, the working group and recommendations, and formal dissemination of this information within organizations appeared inconsistent.

Bird strike data collection and reporting practices varied widely. A minority of operators reported having formal reporting procedures, typically integrated into an existing Safety Management System (SMS), with events documented using standardized reporting forms. Most operators indicated that reporting was informal, relying on verbal notifications, institutional knowledge, or air traffic control notification rather than structured data collection.

Formal bird strike mitigation policies were generally absent. Most operators reported that they did not have documented bird strike mitigation procedures in company manuals, with mitigation instead addressed through training discussions or operational awareness. Some operators indicated that formal policies may be incorporated as their SMS programs mature.

Airspeed and altitude management practices were largely driven by operational constraints. Operators reported tour airspeeds typically ranging from 70 to 85 knots, increasing during transit segments. While some acknowledged that higher airspeeds increase bird strike risk, few reported formal training addressing the relationship between airspeeds above 80 knots and increased strike likelihood. Tour altitudes were commonly constrained by airspace and route requirements, with most operations conducted below 1,500 feet above ground level.

Use of personal protective equipment (PPE) for bird strike mitigation was uncommon. Most operators reported that helmets and visors were not used by flight crews, citing operational norms or passenger considerations, with only a limited number reporting mandatory helmet use. Use of aircraft lighting as a mitigation measure was also inconsistent; some operators reported using pulsed or continuous lighting systems with perceived effectiveness, while most relied solely on standard strobe and landing lights without specific bird strike procedures.

Operators with more mature SMS programs reported greater awareness of bird strike hazards, more consistent reporting practices, and inclusion of bird strike topics in training. Overall, responses reflected a reliance on informal practices, pilot experience, and situational awareness rather than standardized, documented bird

²⁶ Bird Strike Working Group, ARAC guidance and NTSB Safety Recommendations, A-10-136 to 147

strike mitigation programs aligned with existing industry guidance and NTSB recommendations.

10.2 Chief Pilot and Director of Operations (Bird Strike Mitigation)²⁷

A subsequent communication with the former chief pilot revealed that that use of the Pulselite system was voluntary and varied by pilot. While mandatory for nighttime operations, it was not required during the day and was not documented in company manuals or checklists, although he reported routinely using it based on perceived bird strike reduction benefits.²⁸

In addition, according to the chief pilot, bird strikes were not a frequent occurrence for their operation. Pilots were briefed and routinely discussed bird activity, as birds were a known environmental factor encountered along established flight routes, particularly during dusk hours. Mitigation methods employed included the use of non-aggressive evasive maneuvers and avoidance of flight beneath birds, based on the understanding that birds may dive or lose altitude when an aircraft approaches.

In the event of a bird strike, both Operations and Maintenance personnel were notified. A visual inspection of the aircraft was conducted by either the flight crew or maintenance personnel. The Director of Operations reported all bird strike events to Mark Burnett of the Farmingdale Flight Standards District Office (FSDO).

With respect to airspeeds used to mitigate bird strike risk, the operator noted that this subject was difficult to quantify precisely. Bird avoidance typically occurred at lower altitudes rather than at cruise or tour altitudes. Bird activity was primarily a consideration during takeoff and landing phases of flight, during which pilots exercised increased caution. The term "issue" was used to describe bird presence, although the operator emphasized that few bird strikes occurred during the chief pilot's tenure. Tour flights were generally conducted at airspeeds between approximately 90 and 100 knots, with little to no difference between tour airspeeds and transit airspeeds.

They were not familiar with or aware of the Rotorcraft Bird Strike Working Group (RBSWG) or the referenced National Transportation Safety Board (NTSB) Safety Recommendations, and as a result, that information was not disseminated to flight crews. Despite this, pilots actively avoided birds to the best of their ability during flight operations.

²⁷ See Attachment 9: Director of Operations and Chief Pilot Memorandum of Record

LIST OF ATTACHMENTS

Attachment 1: Training Records
Attachment 2: Pilot Logbook
Attachment 3: Weight & Balance
Attachment 4: FAA Order of Suspension
Attachment 5: Ops Specs
Attachment 6: Director of Operations and Chief Pilot Interview
Attachment 7: NYHC Pilot Q&A
Attachment 8: Operators' Bird Strike Survey
Attachment 9: Director of operations and Chief Pilot Memo for Record.
Attachment 10: Video of Pulselite and Tail Wag

Submitted by:

Aaron McCarter
Aviation Accident Investigator-Operations Chair