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Eastern Region

Date: December 8, 2025

Subject: ERA26LA065 Flight Instructor Interview

Contact: [REDACTED]

Mr. [REDACTED] was contacted via telephone to discuss the accident of N95KC. The following is a summary of that conversation from December 8, 2025.

Mr. [REDACTED] stated that the pilot had a checkride tomorrow and that the purpose of this flight was to perform a mock checkride in preparation. They were coming into land at Merrit Island and were on the RNAV for Runway 11 when they experienced a dual engine failure. He immediately took controls of the airplane from the pilot. He noted that the fuel tanks were reading $\frac{1}{4}$ and the electronic fuel gauge was reading 20 gallons. He then noted that he could see Interstate 95 and decided that would be the best option for landing and that he would land with the traffic flow.

He was asked at what altitude the engine's lost power, and he replied that they were at the final approach fix point, about 7-8 miles from the airport.

-End of conversation

Mr. [REDACTED] was contacted via telephone on December 9, 2025, for additional information. The following is a summary of that conversation.

Mr. [REDACTED] was asked to start from the preflight and explain the flight through the accident events. He stated that he arrived at the Merrit Island airport where the airplane was because the pilot had a checkride scheduled for the next day (12/9). He evaluated the pilot's logbooks and noted that he had the proper endorsements. He then commented that he does not have much time in this airplane but felt comfortable performing the mock checkride with the pilot. The pilot did the preflight planning and inspection of the airplane. Mr. [REDACTED] commented that he believed that

they had 65 gallons of fuel onboard prior to departing. Shortly after takeoff, he initiated a simulated engine out for the pilot to navigate through. The pilot successfully returned the airplane back to the departing airport where they departed again to perform additional maneuvers and emergency scenarios. They then began to head back to the departing airport. As they approached, he recalled that the fuel gauges showed $\frac{1}{4}$ of fuel. They contacted the approach controller. They broke out of the clouds and had the airport in sight, so they told the approach controller they would like to cancel and to go VFR. They began to descend from 2000 ft to 1600 ft. He recalled that the pilot was supposed to maintain 1600 but they were getting a little low. At 1400 ft, Mr. [REDACTED] advanced the throttle in an attempt to correct the altitude discrepancy, but the engines did not respond. He took the controls of the airplane and established best glide. He began to scan around him for a suitable landing location but only noted trees and houses, so the highway was his best option. While navigating towards the highway, the pilot performed the emergency checklist and attempted to troubleshoot the engines. With the limited altitude, Mr. [REDACTED] focused on landing the airplane and attempted to aim for a gap in the highway without vehicles. He believes that they landed around 100mph when they quickly caught up to the vehicle in front of them. They contacted the vehicle and were spun into the center median of the highway.

Mr. [REDACTED] was asked if he and the pilot discussed a route or plan prior to the departure. He replied that he told the pilot what they would anticipate for the checkride and that the flight was going to be local. He then commented that the owner of the airplane noted that the airplane had enough fuel for the mock checkride. Mr. [REDACTED] was asked if there was discussion about the length of the flight, to which he replied "no" and that they "needed to hit the points". When asked how long a checkride takes, Mr. [REDACTED] replied that it is about 1.3 to 1.4 (hours).

Mr. [REDACTED] was asked if he watched the pilot perform a preflight of the airplane. He replied "yes" and that he saw him walk around the airplane. He also commented that he walked around the airplane as well. When asked if either of them checked the fuel inside of the fuel tanks, he replied that he was unsure if the pilot looked in the tanks or if he measured the fuel level. Mr. [REDACTED] said that he himself looked into the tanks, saw fuel, but did not measure the quantity.

He was asked how long the flight duration was and he replied that they were in the air about 1 hour and 16 minutes. Mr. [REDACTED] was asked what the fuel consumption of the airplane was and he replied that it is about 30 gallons per hour normally, maybe a little less but that varies with takeoff and landing.

The IIC asked him how much fuel was onboard prior to departing. He replied that they had about 65 gallons onboard the airplane. He recalled taking "a quick peak" at the fuel indicators prior to departing and the "middle" was closer to $\frac{3}{4}$ but the needle was "wobbly". He described it as a range. He commented that the airplane has 2 main fuel gauges and 1 gauge for the auxiliary fuel tanks and that the auxiliary fuel tank gauge was to the far left in front of the pilot. He believed that the airplane had 2 main fuel tanks and 2 auxiliary fuel tanks and commented that the auxiliary tanks were on one gauge, but he was not entirely sure of that. Mr. [REDACTED] was asked which fuel tanks they were on when the engines stopped producing power. He replied that he believes the pilot switched the fuel tanks, but he was not sure and commented that he thinks that they needed to be on the main fuel tanks during landing, according to the POH. The pilot was manipulating the fuel selector.

Mr. [REDACTED] was asked if anything was leaking from the airplane once they came to a stop on the highway. He replied that there was some fuel leaking and that the first responders put a white powder on it to clean it up. He could not tell where the fuel was leaking from.

Mr. [REDACTED] was asked if it is possible that they ran out of fuel, leading to the engines losing power. He replied "honestly, yeah". He commented that the fuel gauges were old. He also commented that he "should have done better" and put trust into the pilot and owner's comments.

He provided an email address of [REDACTED]

He was asked if he spoke to the pilot since the accident. He replied that he did. He wished that he did things differently and that he assumed the pilot knew the airplane better.

The NTSB 6120 form was discussed with the pilot.

-End of conversation

An email was sent by the IIC to the instructor on December 29, 2025, stating:

"Can you confirm that what I have typed in this document is accurate? Your personal information will be redacted from the public docket.

Also, to verify, were there any mechanical malfunctions or failures with the airplane? Or would you agree that this is a fuel mismanagement event?"

The flight instructor responded later the same day stating:

"Thank you for following up and for the opportunity to review the summary. I wanted to provide a few brief clarifications to ensure the record accurately reflects my recollection and intent.

Regarding fuel selector positioning, I did not observe a definitive selector change prior to the loss of power. It is possible the selectors were not repositioned as intended; however, I did not observe this at the time and cannot state that with certainty. Any references to this possibility were reflective of my thought process after the event, not a conclusion about what occurred. During the event, my focus was on aircraft control and identifying a safe landing option while the pilot conducted trouble shoot emergency checklist.

Fuel verification using engine indications did not occur during the initial descent, as that phase was brief and priority was placed on aircraft control, energy management, and situational awareness. Fuel indications were reviewed shortly afterward during a standard training maneuver conducted as part of the ACS while setting up to return for the RNAV approach. That maneuver was not related to the engine issue and was part of the planned training profile.

When referencing the approach phase and checklist usage, including GUMPS, my comments were intended to describe a standard configuration flow commonly used during approach. They were not meant to imply that a specific step was missed or that any individual action caused the event. It was a reflection and possibility after the accident based on adrenaline and pilot comments.

I had prior experience in this make and model totaling approximately 14 hours; however, only about 1.8 hours of that time was recent and occurred earlier in the same month. I had not flown the aircraft regularly in the months prior. Any comments regarding fuel quantity were based on cockpit indications and general observation rather than direct measurement. This was my first time flying with this pilot, and the flight was conducted in preparation for an upcoming checkride the following day based on appropriate endorsements and expectations of an examiner. .

I do not have enough information to determine whether this event resulted from a mechanical malfunction or a procedural issue, and I did not observe a mechanical failure. While there may have been differences in understanding or expectations during the flight, I cannot conclusively determine the cause of the event based on observations alone. Determine the cause would require additional technical evaluation and without complete information, any conclusions on my part would be speculative.

My intent in providing these clarifications is simply to ensure accuracy and context, not to speculate or assign fault. I appreciate the opportunity to review the summary and am happy to provide any additional clarification needed. The information I provided, along with the included safety considerations is intended to support continued learning and help reduce the likelihood of similar events in the future."