

December 23, 2019

Bettina Von Brentano


Mt. Pleasant, SC 29466

NTSB Chairman
NTSB Headquarters
490 L'Enfant Plaza SW
Washington, D.C. 20594

Dear Sir or Mdm.;

This is a Petition for Reconsideration filed under chapter 49 Code of Federal Regulations (C FR) section 845.32 in connection with NTSB Aviation Accident Factual/Final reports; G A A 17 C A 191, for which I was the Pilot In Command.

Attached please find a copy of my investigative file (pages 1 – 18 Untitled) and its' supporting Appendix of Enclosures (items 1– 22).

Also attached are copies of my three letters 1. (Dated 05/17/2018) to the Office of Inspector General (OIG) Department of Transportation (DOT); 2. (Dated 10/02/2018) to Director of Audit and Evaluation (AAE), Federal Aviation Administration (FAA) and 3. (dated 11/28/2018) to H. Clayton Foushee, Director AAE/FAA.

In addition, attached are copies of Mr.Foushee's letter of 11/13/2018 to Congressman Mark Sanford as well as copies of several e mails between myself and Mr. Scott Harding of the DOT/IG's office.

Finally, I have attached a copy of the "Specific Changes Requested" by me concerning the above cited NTSB Aviation Accident Factual and Final Reports.

Although I have previously attached the cited attachments and enclosures to written communications directed to the FAA, NTSB and DOT/IG, I have not previously petitioned the Board. These items are again enclosed as a convenience to assist you in your review of my petition.

In accordance with the requirements of the cited regulation set forth on your website, I would submit that the Board's findings regarding this accident's "probable cause", as set out in the referenced NTSB reports, are erroneous, based as they are upon the clearly erroneous underlying FAA EIR.

While a read through of the enclosed letters and e mails provides a working background of the basis for my petition, as is often the case, the "devil is in the details". Therefore, I would particularly draw the attention of the Board to pages 10 through 17 of my attached investigative report (untitled) in the subsection labeled "Specific Challenges to the EIR".

As noted in FAA Order 2150.3B (in force at the time of this event) under Chapter 2, paragraph a. "The FAA's central mission is to promote safety in civil aeronautics". In section 3 of the same chapter (entitled "Compliance and Enforcement Philosophy") it notes "FAA investigative personnel must conduct investigations promptly. They must gather, and accurately and completely report all facts, and conduct their investigation in an unbiased and focused manner. A violation report without all the facts only leads to delays that compromise the objectives of fair and responsive enforcement. An incomplete or inaccurate enforcement investigative report can mislead reviewing officials and FAA legal counsel and result in wrong or inappropriate actions being taken."

I have previously directed a copy of this Petition and supporting documentation to the FAA and have attached a copy of said service, documenting same, to this petition.

I further request that I be afforded the opportunity to personally present this matter to the Board. I believe it is only via first hand, direct testimony that a true appreciation of the facts and circumstances leading to this accident can be understood and similar future outcomes be avoided. Such an appearance will also afford the members of the Board the opportunity to ask me questions concerning these events in order to clarify any unresolved questions which my submission or statements may have raised.

Best Regards,



Bettina A. Von Brentano





From: Harding, Scott V.

Sent: Tuesday, October 2, 2018 5:37 AM

To: 'Bettina'

Subject: RE: Complaint of Bettina von Brentano ; dated 05-17-2018 ; regarding the conduct of FAA Accident Investigation GAA17CA191.

Ms. Brentano:

Thank you for your follow-up correspondence regarding your concerns. As previously stated to the office of Congressman Mark Sanford, based on our review of the material provided, we have determined that we do not have primary oversight over your concerns and the appropriate venue is the Federal Aviation Administration (FAA). You may submit your concerns to the FAA Administrator's Hotline via telephone at 1-866-835-5322 (option 9) or 202-267-3935. The hot-line operates from 8 a.m. to 4 p.m. Eastern Time, Monday through Friday, except holidays. In addition, you can contact FAA's Director of the Office of Audit and Evaluation via email at FAAHotline@faa.gov or mail at:

Director, Audit and Evaluation (AAE-1)

FAA National Headquarters

800 Independence Ave., SW

Washington, DC 20591

We anticipate no further action from our office regarding this matter and thank you for bringing this information to our attention.

Sincerely,

Scott Harding

Chief, Complaint Center Operations

US DOT/OIG

This e-mail is from the U.S. Department of Transportation, Office of Inspector General, and may contain information that is "Law Enforcement Sensitive" (LES) or "For Official Use Only" (FOUO) or otherwise subject to the Privacy Act and/or other privileges that restrict release without appropriate legal authority.

From: Bettina [mailto:████████████████████]

Sent: Monday, October 01, 2018 1:26 PM

To: Harding, Scott V.

Subject: Complaint of Bettina von Brentano ; dated 05-17-2018 ; regarding the conduct of FAA Accident Investigation GAA17CA191.

Dear Mr. Harding,

I am writing today in an effort to determine the status of the above matter. After confirming DOT's receipt of my Fedex package on 05-24-2018, I waited approximately 6 weeks before inquiring by

telephone as to the status of this matter and was told that I would eventually receive a mailing which would include a complaint # which would allow me to follow up.

This has not occurred. After waiting until now, I reached out by telephone to the office of Deputy Assistant Max Smith, which referred me to you.

I would sincerely appreciate a response to this inquiry and stand ready to provide additional pertinent information concerning this matter.

Best Regards, Bettina von Brentano [REDACTED]

[REDACTED]
Sent from [Mail](#) for Windows 10

This e-mail is from the U.S. Department of Transportation, Office of Inspector General, and may contain information that is "Law Enforcement Sensitive" (LES) or "For Official Use Only" (FOUO) or otherwise subject to the Privacy Act and/or other privileges that restrict release without appropriate legal authority.

From: Bettina [REDACTED]
Sent: Tuesday, October 02, 2018 12:08 PM
To: Harding, Scott V.
Subject: RE: Complaint of Bettina von Brentano ; dated 05-17-2018 ; regarding the conduct of FAA Accident Investigation GAA17CA191.

Dear Sir;

I am in receipt of your e mail response to my inquiry of 10/01/2018, regarding the status of my complaint. Therein you state, in part, that "...based upon our review of the material provided, we have determined that we do not have primary oversight over your concerns and the appropriate venue is the FAA", thereafter referring me to an FAA "hotline" and/or the FAA's office of Audit and Evaluation.

Strangely enough, repeated multiple web browser searches for an FAA IG office all direct the searcher to the US DOT IG website.

Clicking on the navigation bar item entitled "Investigations", one reads that the DOT office of Investigations "is comprised of criminal and general investigators that are responsible for conducting criminal, civil and administrative investigations of fraud and a variety of other allegations affecting DOT, its operating administrations, programs and grantees" (see attached)

In fact, the DOT Home/Investigations webpage(s) contain numerous examples of investigations and prosecutions for which DOT IG takes partial credit. These listings contain multiple examples of investigations of FAA related matters ranging from lying or making false statements to FAA representatives to bribery and aircraft parts fraud.(see attached example)

It is therefore surprising to me that you state that you do not have "...primary oversight over (my) concerns" and thereafter refer me to the FAAs office of Audit and Evaluation.

In fact, my complaint sets forth with great particularity, multiple examples of unethical, improper and/or arguably criminal conduct by those identified therein and provides detailed documentary evidence thereof.

I am left wondering if your claim of lacking primary oversight in this instance is supported by the circumstances.

I invite your response to assist me in further understanding your position in this matter.

Best Regards, Bettina

Sent from Mail for Windows 10

From: Harding, Scott V.
Sent: Tuesday, October 2, 2018 5:37 AM
To: 'Bettina'

From: Harding, Scott V.

Sent: Tuesday, October 2, 2018 12:38 PM

To: 'Bettina'

Subject: RE: Complaint of Bettina von Brentano ; dated 05-17-2018 ; regarding the conduct of FAA Accident Investigation GAA17CA191.

Ms. Brentano:

The FAA does not have an IG so all related web browser searches for an FAA IG office will direct the searcher to the US DOT IG website. Whereas, a web browser searches for FAA AAE will provide the following:

FAA AAE

All Videos News Images Shopping More Settings Tools

About 843,000 results (0.33 seconds)

Office of Audit and Evaluation - Federal Aviation Administration
https://www.faa.gov/about/office_org/headquarters_offices/aae/
Mar 7, 2018 - The Office of Audit and Evaluation (AAE) is a staff office that reports directly to the FAA Administrator and provides an independent venue for ...

Whistleblower Protection for ...
Whistleblower Protection for FAA Employees. Share; Print.

FAA Hotline
The FAA Hotline does not accept certain types of reports.

Key Officials
... Offices > Office of Audit and Evaluation > Key Officials

That said, the OIG exercises independent judgment in determining the best use of available resources to meet our responsibilities under the Inspector General Act. We have reviewed the material you provided, determined that your concerns do not warrant a formal OIG Investigation/Inquiry and the appropriate venue is FAA AAE. Our file is now closed and we are unable to reply to further communications regarding this matter.

Sincerely,

Scott Harding
Chief, Complaint Center Operations
US DOT/OIG

From: Bettina

Sent: Tuesday, October 2, 2018 12:53 PM

To: Harding, Scott V.

Subject: RE: Complaint of Bettina von Brentano ; dated 05-17-2018;regardingthe conduct of FAA Accident Investigation GAA17CA191.

Scott; Thank you for your timely and detailed response. While I disagree with your analysis of the validity of my complaint, I do appreciate your clarification of DOT's official position. Best regards, Bettina

Sent from Mail for Windows 10

From: Harding, Scott V.

Sent: Tuesday, October 2, 2018 12:38 PM

To: 'Bettina'

Subject: RE: Complaint of Bettina von Brentano ; dated 05-17-2018 ;regardingthe conduct of FAA Accident Investigation GAA17CA191.

Ms. Brentano:

The FAA does not have an IG so all related web browser searches for an FAA IG office will direct the searcher to the US DOT IG website. Whereas, a web browser searches for FAA AAE will provide the following:

 Loading...

From: Bettina

Sent: Monday, October 1, 2018 1:26 PM

To: scott.v.harding@oig.dot.gov

Subject: Complaint of Bettina von Brentano ; dated 05-17-2018 ; regarding the conduct of FAA Accident Investigation GAA17CA191.

Dear Mr. Harding,

I am writing today in an effort to determine the status of the above matter. After confirming DOT's receipt of my Fedex package on 05-24-2018, I waited approximately 6 weeks before inquiring by telephone as to the status of this matter and was told that I would eventually receive a mailing which would include a complaint # which would allow me to follow up.

This has not occurred. After waiting until now, I reached out by telephone to the office of Deputy Assistant Max Smith, which referred me to you.

I would sincerely appreciate a response to this inquiry and stand ready to provide additional pertinent information concerning this matter.

Best Regards, Bettina von Brentano [REDACTED]

[REDACTED]

Sent from Mail for Windows 10

NTSB Aviation Accident Final Report GAA17CA191

Specific Changes Requested

1. Amendment to the wording of the "Analysis" Section, to wit: Removal of the words "As the pilot descended through 150 feet above ground..." to be replaced by "As the pilot entered the transition to land, otherwise termed the "round out" or "flare" to land..."
2. Further on in the same paragraph, add "...and the feathered propeller", to the sentence beginning "The airplane sustained substantial damage to the right side fuselage (and the), right wing..."
3. Removal of the entire fourth paragraph, beginning with "Examination of the accident airplane by FAA ASI determined that there were no pre-impact mechanical anomalies with the airplane that would have prevented normal operation".* (Please note that the language of this sentence was changed from that of the interim NTSB Aviation Accident Factual Report, which used the wording of "...that would have prevented normal flight operation". I suspect that this was done in order to avoid an obvious conflict with the Notice of Proposed Certificate Action, since dismissed, which had been based upon a theory of careless and reckless operation due to an allegation of a non functioning seatbelt. Results of multiple FOIA requests filed with the FAA, NTSB and NPS indicate that no technical examinations of the accident aircraft were conducted, despite my documented and timely requests for such exams.
4. Amendments to the wording of the Probable Cause Section, to wit; the addition of "... and turned, facing the accident aircraft, with its' propeller turning, still being on the runway, resulting in a hard landing and ground loop" to the single sentence currently in this section.
5. In addition, include the following language in the same section; "No technical examinations were conducted of the Beta arm reversing lever, carbon block assembly, propeller control linkage, propeller governor and/or power plant or their related components or assemblies as described in the NTSB's own Safety Recommendation Report, dated December 5, 2016. This report is entitled "Preventing the Incorrect Installation of the Beta Arm in P&W PT-6A Engines". Therefore, no determination could be made regarding the role which an incorrect beta arm installation or an associated un-commanded prop feathering may have played in this event ".

6. The addition of the statement "A review of the accident pilot's company training records and personal logbook fail to evidence that the accident pilot was properly trained in emergency actions, particularly "go-arounds" involving heavily loaded aircraft.
7. Correction of the Pilot Information Section to reflect that "Toxicology" was, in fact, performed.* (This aspect of this very public record has fueled speculation that I was inebriated or using drugs. I believe that this "error" was an intentional act which has caused me further harm.)
8. Correction of the "Aircraft...Information Section" to reflect that a C-208 is a single engine turbo prop (not a "2 turbo prop").

May 17, 2018

Bettina Von Brentano

[REDACTED]

Mt. Pleasant, S.C. 29466

Office of Inspector General
U S Department of Transportation
Office of Investigations
1200 New Jersey Ave., South East
Washington DC 20590

Dear Sir or Mdm.;

On February 27, 2018, I appeared with my attorney at an "informal conference" at the FAA offices in Washington, D.C. I did so in connection with an FAA Enforcement Action suggesting that I had acted in a "careless or reckless" manner in violation of Federal Aviation Regulations (FARs) by operating an aircraft in violation of FARs 14 C.F.R. 91.7(a) and (b) (relating to airworthiness); 14 C.F.R. 91.13(a), (relating to the operation of an aircraft in a careless or reckless manner); and 14 C.F.R. 135.65(b) (dealing with the entering of mechanical irregularities in the aircraft log). These alleged violations were contained in a Notice of Proposed Certificate Action dated June 30, 2017. (see attached 1).

In brief, the basis of these allegations were that I had failed to report seatbelt related maintenance issues concerning the functionality of a particular seatbelt in my aircraft to proper maintenance personnel prior to flight. This enforcement action was instituted as a result of my "ground looping" a Cessna Caravan aircraft (N865MA) at a remote runway on the island Molokai (Kalaupapa Airport) on March 11, 2017. At the time of the accident, I was operating this aircraft as a part 135 Scheduled Commuter Flight. This event was triggered by the runway incursion of another aircraft and my resulting attempt to complete a "go around" maneuver. Most fortunately, there were only a very few minor injuries reported among the nine passengers.

As a result of this hearing, I was notified by letter dated March 14, 2018 that the FAA had withdrawn this Notice of Proposed Certificate Action. (see attached 2). My attempts to determine what led to this decision through the FOIA were blocked via the appropriate exceptions to that law. (see attached 3).

While all of this is certainly a welcome development and has gone a long way toward restoring my faith in the good people at the FAA, a number of disturbing issues have come to light.

During my attempts to understand the circumstances leading to these events and the FAA'S subsequent investigation thereof, it became clear to me that the actions and inactions of those FAA personnel charged with the duty of conducting the related investigation raised significant concerns regarding their actions and motivations.

I have, therefore, attached a copy of my informal investigative report which was compiled over time, as what little information I was able to review became available. I hasten to make this point, as I started this report with questions concerning the actions of investigators in contrast to the information I was belatedly provided concerning the Pilots Bill of Rights (PBR). While troubling, this issue does not form the core of my complaints. My chief concerns are set forth in the attached document in extensive detail, raising a number of significant questions which are supported by various cited enclosures.

While any one of these concerns might be easily explained away as being the result of mere oversight, ineptitude, incompetence, or unintended mistake, when taken together, I believe they indicate an intentional pattern of behavior designed to shield those parties most responsible from any form of punitive regulatory action. This pattern of behavior represents a serious abrogation of the FAA'S mandate to ensure the safety of the traveling public.

In my opinion, the facts detailed here can only be viewed as an intentional and interrelated attempt to place responsibility for these events solely upon the pilot. In fact, the FAA report of investigation (ROI) relied almost completely upon an "investigation" conducted by the air carrier and its principal and 100% owner, who had the most to gain by deflecting any further inquiry away from the maintenance or pilot training practices of Makana Kai Airlines (MKA) or it's owner.

While the FAA has some discretion in how it conducts investigations, this represents a complete denial of its sworn duty to "ensure the safety of the traveling public". Furthermore, the actions of the investigators in this instance "fly in the face" of section 9 (a) of the order entitled "Aircraft Accident and Incident Notification, Investigation and Reporting" (8020.11C) which states' in part, that FAA responsibilities regarding an accident investigation are, among others, to "make sure that all the facts, conditions and circumstances leading to an accident are recorded and evaluated, and action taken to prevent similar accidents". It goes without saying that virtually none of the guidance set forth in Chapter 4 of the same order was followed. (see attached 4).

This accident involved a publicly available, revenue producing airline flight, operating under a contract with the Department of Transportation in the Essential Air Service Program (EAS). Yet only the most cursory of investigations was conducted, involving no on scene participation by FAA or NTSB personnel, relying almost solely on "investigation" conducted by the airline owner and his own maintenance person, each of whom had faced an investigation and official criticism for another crash at the same airfield which involved faulty maintenance issues, a loss of life and ensuing legal action only three years before. All this despite a specific and timely request that certain independent technical examinations be conducted and supervised by the NTSB of the power plant and propeller systems of the accident aircraft (see attachment 5).

This becomes more troubling in light of the joint NTSB and FAA recent "Safety Recommendation Report" adopted on December 5, 2016, approximately three months before the accident, entitled "Preventing Incorrect Installation of the Beta Arm in Pratt and Whitney Canada PT6 A Engines". This report recommended the issuance of special airworthiness information bulletins directing maintenance personnel conducting routine maintenance on aircraft equipped with PT6A engines and related propeller installations to be alert for improperly installed propeller reversing levers. In the words of that report, "The NTSB is concerned that any propeller on any PT6A engine that has undergone improper maintenance to the beta valve assembly can travel un commanded to the feather position during any phase of flight". (see attached 6). I believe that the circumstances of this accident suggest that this was a real possibility and should have been appropriately addressed.

It would appear from the results of the multiple FOIA requests filed in connection with this accident that the technical examinations of power plant and propeller systems requested in the previously referenced March 29, 2017 email to the NTSB were not conducted or documented. This is in spite of what I must therefore characterize as intentionally misleading statements to the contrary contained in the NTSB Factual and Final Reports of GAA17CA191 (see attached 7)) as well as other inaccurate statements within the FAA ROI dated April 11, 2017 (and apparently passed on to the NTSB). A review of the FAA Accident/Incident Report dated 4/11/17 and the FAA Oklahoma provided ATQA Report # AWP1317010 show that each make misleading inferences concerning the propeller's configuration at the time of the accident and neither indicates that any technical examinations or independent on scene investigation was conducted to support the statements in the NTSB reports to the contrary. A comparative review to the NTSB/ FAA investigations completed in connection with the above cited Safety Report, particularly IAD01LA048 (see attached 8) make this all the more clear.

Most simply put, I believe that FAA's attempted enforcement action, based upon the seatbelt and maintenance log allegations, represented a poor attempt to brand me as a "careless and reckless"

aviator. The occasionally self-serving statements contained in the two letters, (each written more than two or three weeks later) and relied upon by investigators to form the basis of their case, were filled with direct contradictions, either of one another, or contradictory to the statements made by investigators in their reports. (see attached 9). It's very clear that the EIR in this matter accepted a theory of events first, and then "cherry picked" those parts of the witness statements which would support this theory, while ignoring direct contradictory evidence, even from the same sources.

By extension, this approach tarnished investigators' actions (and lack of actions) as applied to the entire accident investigation (ROI). They ignored clear indications of power related issues (" I couldn't keep up the RPMs", echoed in both my own and various witness statements, as well as the NTSB's own recent Safety Recommendation Report which officially raised concerns applicable to these circumstances and was therefore clearly on point. They also ignored direct requests for NTSB supervised technical examinations of the propeller, propeller control unit and power plant. To top it off, they made conclusory statements in the record inferring that these and other examinations were in fact done, when the record fails to support this.

Based on the foregoing, I can only conclude that investigators reached their conclusions based upon the information provided to them by Schuman and MKA. As part of the FOIA data released to me, I have examined three CDs containing numerous photographs of the accident aircraft and the runway environment. Most of these were taken post accident by Schuman and his associates. Others were taken before, during and after the event by passengers.

Of all these photos, only two depict propeller strikes on the runway. The first series of strikes appear to occur only one to two hundred feet before the last (which trail off the pavement at the point of the ground loop on the adjacent grass). I can discern no appreciable difference in the nature or quality of these marks which would support the investigator's apparent theory of an initial low pitch strike followed by "mismanaged controls" and a subsequent feathered prop. As I stated previously, and as I believe the passenger pictures reveal, in the immediate aftermath of the accident, the prop lever was forward until I acted to shut down power. Furthermore, as noted elsewhere, the scimitar like deformation of the prop leaves little doubt as to its condition at the time of first impact.

In fact, none of the investigation was based upon any actual on scene investigation conducted by the FAA or NTSB. Instead, investigators accepted an investigation and theory of events handed to them by the very parties with the most to gain by deflecting further examination of their maintenance or training practices.

Based on the preceding, I believe that there is ample evidence to suggest that one or more individuals charged with the responsibility to conduct this investigation knowingly and willfully made false official statements to federal officials at the NTSB. I therefore am requesting that the Inspector General's Office at the Department of Transportation conduct an investigation of the facts and circumstances

surrounding this investigation. In addition, these circumstances contain clear violations of the FAA "Standards of Conduct" as set forth in the FAA HRP Sections 6, 7 (h), (i) as well as Part 2635 of the Standards For Ethical Conduct For Employees of the Executive Branch; Sections 101 (8) and 102 (v) (attached 10).

While I don't expect that the injustice which I feel I have experienced should garner much attention, I would hope that the inept, improper or illegal actions of those charged with the responsibility of conducting fair and complete investigations in an effort to ensure the safety of the traveling public would.

In addition, please note that some of the concerns outlined in the attached report relate to matters involving ongoing security concerns at PHNL (Honolulu International) and, as such, please feel empowered to act on them as you deem appropriate. I have left this aspect up to your discretion to address any issues of coordination between agencies which may or may not be an issue.

While other avenues exist to obtain a forum for a redress of such grievances, I am placing my faith in the good offices of your institution to conduct a fair and complete review of this matter. Please keep me as aware as your regulations may allow concerning your efforts in this regard.

I recognize that coming to terms with the factual details of this matter will be a time consuming endeavor. I have therefore attempted to put my concerns in as logical an order as possible in the hopes that it will make a disagreeable task a bit easier. Please be assured that I sincerely appreciate your efforts in this regard.

Incorporated by reference and attached to this letter is my own report of my investigation, as well as an appendix containing a variety of referenced documents.

I stand ready to cooperate with your efforts and may be reached via my cell phone [REDACTED] (voice or text) or by e mail at [REDACTED]

Best Regards,

[REDACTED]
Bettina Von Brentano

October 2nd, 2018

Bettina Von Brentano

[REDACTED]
Mount Pleasant, SC
29466

Director, Audit and Evaluation (AAE - 1)
FAA National Headquarters
800 Independence Avenue, SW
Washington, DC 20591

Dear Sir or Madam;

Attached please find a copy of my complaint, dated May 17th, 2018 which had originally been directed to the Department of Transportation's Inspector General's office. By way of an email which I received today, the Inspector General's office advised me that they do not have "primary oversight" over my concerns and suggested that I direct my complaint to the FAA Director of Audit and Evaluation(AAE-1).

In brief, my complaint centers upon the conduct of, and the conclusions reached by FAA investigators assigned to investigate an airline accident wherein I was the pilot in command of a Cessna Caravan landing at Kalaupapa Airport on the island of Molokai, Hawaii on March 11th 2017. Faced with a runway incursion by a privately owned aircraft, I ended up "ground looping" the Caravan without serious injury to any of my 9 passengers.

I believe that the enclosed documentation very strongly demonstrates that this investigation was intentionally conducted in a flawed manner, designed to avoid placing any responsibility for these events on the airline, it's owner, or the incurring pilot. As evidence thereof, I would briefly note the dismissal of an attempted administrative suspension action against my commercial pilot's license, after I requested and appeared at an informal hearing in Washington, DC earlier this year.

To further make this point, I have attached copies of the only two photographs of the accident aircraft and scene which were attached to the NTSB aviation accident final report. A third photograph, which apparently was not provided to the NTSB, is also attached, which depicts the aircraft post-accident propeller blades.

It should be noted that the FAA theory of events and accident investigation report states that the aircraft propeller initially struck the runway in a low pitch configuration. I believe that it is abundantly clear at first glance that the aircraft propeller was in a feathered position upon initial impact.

I have therefore attached a copy of my original letter of complaint, along with my own review of the facts and a listing of documentary enclosures which I believe clearly supports my position. I stand ready to assist you in further understanding this matter.

Best Regards



Bettina Von Brentano

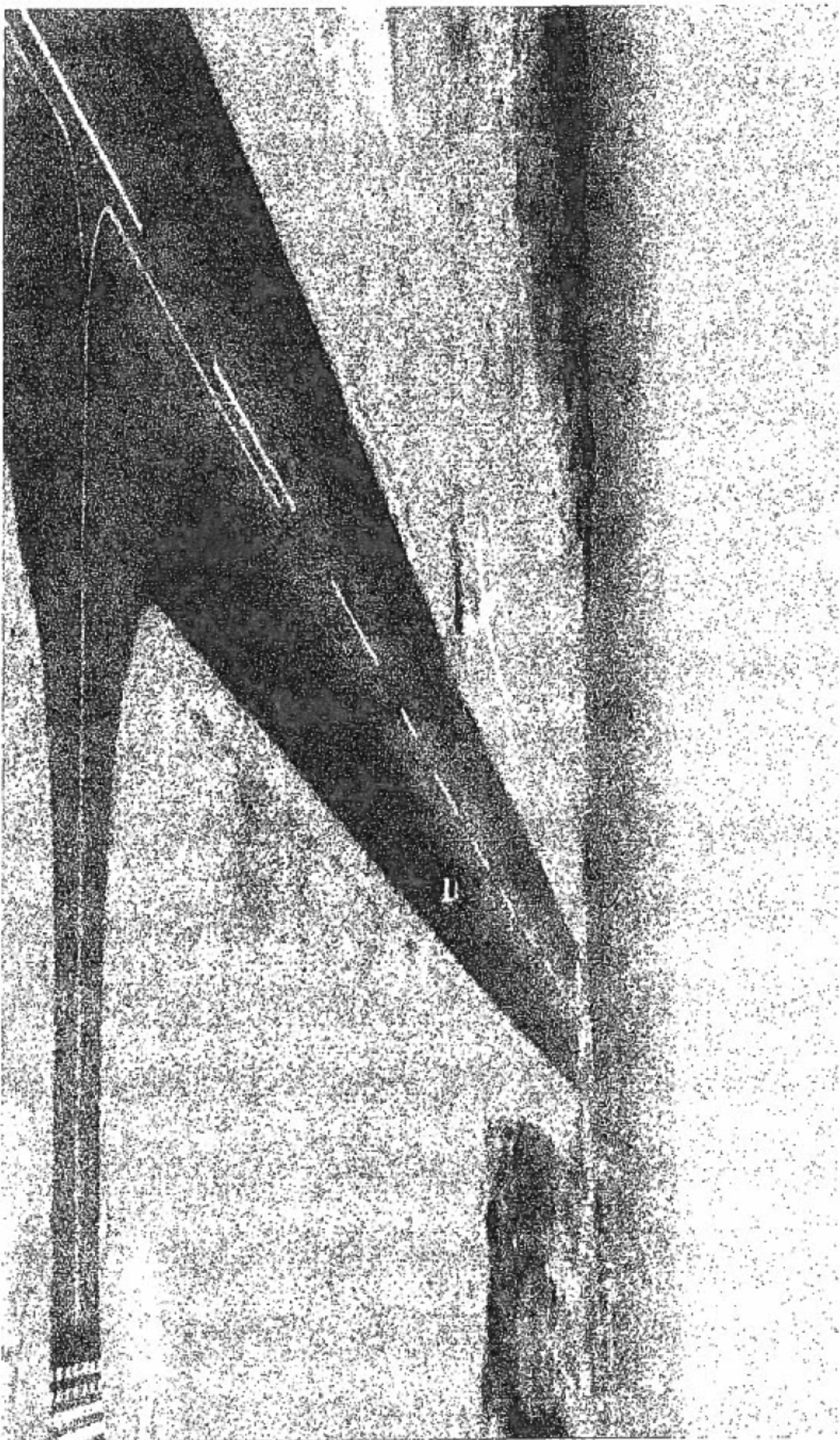



Photo 1 – View of airplane after ground loop (Courtesy of FAA)

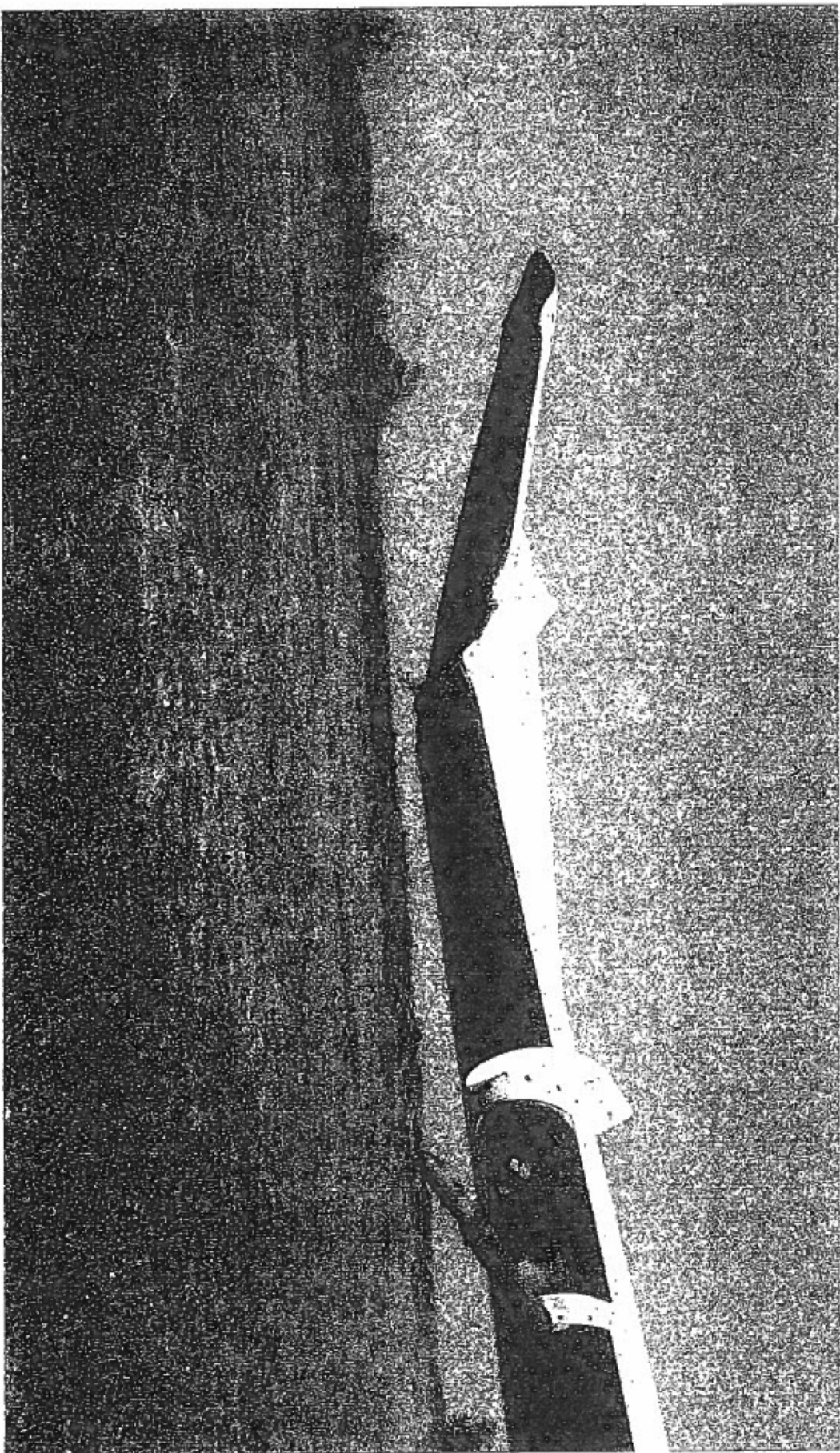


Photo 2 – View of damage to right wing (Courtesy of FAA)

November 28, 2018

Bettina von Brentano

[REDACTED]
Mt. Pleasant, SC 29466

H. Clayton Foushee

Director, AAE/FAA

800 Independence Ave., SW

WDC, 20591

Dear Sir;

I write in response to your letter of 11/13/2018 to Congressman Mark Sanford regarding my complaints surrounding the conduct of the FAA Accident investigation done in connection with GAA17CA191. I have enclosed a copy of that correspondence, forwarded on to me by the Congressman's office, for your convenience.

While I welcome your planned review of this matter, I disagree with the limited manner with which you catalog my complaints.

Nevertheless, I would like to provide you with some greater understanding of those issues you have chosen to highlight in your attached response. In responding, I have followed the format which you have adopted.

1. In your paragraph entitled "1. Enforcement Action (EIR)" "Response", you state that "FAA legal enforcement actions contain checks and balances to protect any certificate holder's due process rights."

Please be aware that there is a very significant human, personal and financial cost behind any individual's effort to actuate those "checks and balances". ...In my families' case, this situation involved the loss of a job (and its' attendant income) for which I had trained many years and invested several tens of thousands of dollars in so doing. The loss of income and related damage to my hard earned professional reputation was also a large factor in our decision to leave Hawaii and to accept both the financial costs thereof, as well as the emotional strain placed upon my husband, children and elderly mother by such a move. But we realized that we would need greater proximity to Washington DC if we were to obtain a "redress of grievances".

Despite my efforts under the FOIA, FAA Counsel's thought process regarding his deliberations related to the Informal Hearing which I elected to participate in during February of this year were not shared with me, due to attendant Privacy Act exclusions. Nevertheless, I welcomed his dismissal of the Notice of Proposed Certificate Action.

I suspect that his decision to dismiss the matter was a pragmatic one, balancing the investigation's many shortcomings against the risk of potentially creating greater legal restrictions in the future, (along the lines of the often expressed idea that "bad cases make bad law").

While you may term this "...a normal exercise of prosecutorial discretion", it may interest you to note that the FAA Counsel in your Western District that prepared this enforcement action remarked that she had been requested to keep the matter "in house" and not allow it to be removed to WDC (when we actually made that request). To her credit, she then granted our request anyway, in accordance with the stated policy.

2. While you are correct in pointing out that the NTSB is an independent Executive Branch agency and therefore not under DOT or FAA control, nonetheless their report in this instance is based solely upon the underlying FAA investigation. Therefore, any flaws in the FAA's investigation are simply compounded and potentially magnified as a result. In simple terms, this type of setting has been commonly referred to as a "Catch 22". Therefore, the circular logic presented in a claim of "no authority to question their conclusions or to request changes to their report(s)" falls short of the mark. While the FAA may lack authority to do so directly, it has both the power and duty to correct the EIR upon which the NTSB report is based.
3. Though encouraged by your decision "...to assign this matter for review by an experienced Accident...Investigator", I would like to try to understand the standard which you appear to set forth in "3. Response b." Therein you state; "If the investigation was deficient, was it so extreme as to exhibit potential employee misconduct...?. On its' face, this infers that you may not consider that various forms of negligence, including gross negligence, would rise to the level of misconduct. Would you please assist me in understanding this standard by defining it further or citing me to examples where your office has made such determinations and applied them in the past (respecting, of course, any privacy or identity issues contained therein)?
4. In addition, would you kindly elaborate as to the standards to be applied by your office "...to ensure both the adequacy of the investigation and the appropriateness of their conclusions". While I presume that you are referring to the directed "review" when using the term "investigation", please feel free to correct me on this point as necessary.
5. Speaking plainly, my goal has always been to restore my reputation and thereby my ability to earn a decent living by correcting the official record of this accident. I believe that I have the

right to demand that I be treated in a fundamentally fair and transparent manner. To date, this has not been the case.

6. As you are undoubtedly aware, the PRIA synopsis of any accident, along with the follow up Privacy Act Releases normally requested by a prospective employer, can have a very serious impact on a pilot's employment options for at least the five years following such an event. It is therefore of the utmost importance that at least reasonable efforts be undertaken to ensure the accuracy and completeness of such investigations.

In addition, the underlying purpose of any such investigation, is rather succinctly stated in Section 16 of Chapter 1 of FAA order 8020.11C (controlling at the time of the accident)... "The main purpose of accident and incident investigation is prevention". In essence, safety.

The failure to conduct an investigation in a manner even remotely in compliance with the pertinent regulations of Chapter 4 of the above cited document represents a complete abrogation of sworn duties of those individuals assigned to participate in this matter.

7. Under the fact pattern applicable to this instance, I have arrived at the conclusion that most, if not all, of the ordinary jurisdictional defenses to lawsuit traditionally available to federal agencies and their employees under the FTCA are likely to fail.

Nonetheless, my intent has always been to avoid the delay and expense of litigation, particularly since my goal is merely to be treated fairly and to restore my reputation via a complete and fair review of the facts associated with this accident and its' ensuing report.

I am therefore attaching a copy of my document entitled "Specific Changes Requested", not because I expect anyone at the FAA to dictate changes to the NTSB, but because I believe that a fair review of the facts will bring about changes to the underlying FAA report(s). This would be a necessary first step prior to petitioning the NTSB to review its' findings.

Of course, time is of the essence. Should litigation be required, the two year statute of limitations is not too far off.

After conducting the aforementioned review, should you be willing to negotiate my proposed changes to the underlying report, I expect that I would be willing to forego litigation in this matter. I urge you to become personally familiar with the details of my complaint, as I believe that my requests are well grounded in both fact and law.

Best Regards

Bettina von Brentano





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

Office of Audit and Evaluation (AAE)

800 Independence Avenue, SW
Washington, DC 20591
202-267-9000

November 13, 2018

The Honorable Mark Sanford
Member, United States House of Representatives
530 Johnnie Dodds Blvd., Suite 201
Mount Pleasant, SC 29464

Dear Congressman Sanford:

Thank you for your October 30 inquiry on behalf of your constituent Ms. Bettina Von Brentano. Ms. Brentano alleges inadequate Federal Aviation Administration (FAA) and National Transportation Safety Board (NTSB) investigation regarding an emergency landing/accident at Kalaupapa Airport.

My office has completed an initial assessment of Ms. Brentano's concerns, which consisted of three separate components, and we provide the following feedback and information:

1. Enforcement Action (EIR): Ms. Brentano alleges that the FAA reached a conclusion about her being "careless and reckless", and then cherry-picked facts to support that conclusion.

Response: FAA legal enforcement actions contain checks and balances to protect any certificate holder's due process rights. In this case, the evidence was reviewed by FAA legal counsel prior to issuing a Notice of Proposed Certificate Action (NPCA), and counsel found enough evidence to proceed with enforcement. Ms. Brentano exercised her right to request an informal conference. Following this conference, FAA counsel decided to withdraw the NPCA. This is consistent with FAA policy and procedures, and is a normal exercise of prosecutorial discretion in regulatory cases.

2. NTSB accident investigation: Ms. Brentano requests specific changes to the NTSB accident report.

Response: The NTSB is an independent Executive Branch agency and is not under the purview of the Department of Transportation or the FAA. We have no authority to question their conclusions or to request changes to their report(s).

3. FAA accident investigation: Ms. Brentano alleges deficiencies in the FAA accident investigation, including that it was conducted almost exclusively by parties who could not be impartial.

Response: My office will direct the Associate Administrator for Aviation Safety (AVS) to assign this matter for review by an experienced Accident and Investigation and Prevention (AVP) Air Safety (accident) Investigator. The AVP investigator will review the actions of the Honolulu FSDO investigation team, and determine:

- a. Whether the original accident investigation followed the procedures and met the requirements of FAA Order 8020.11; and
- b. If the investigations was deficient, was it so extreme as to exhibit potential employee misconduct by the FAA team?

Due to breadth of the concerns raised, this review could take some time. When AVP has completed their review, my office will complete a sufficiency review to ensure both the adequacy of the investigation and the appropriateness of their conclusions. We will also notify Ms. Brentano of our results, to the extent allowed by both the Freedom of Information Act and the Privacy Act.

Sincerely,



H. Clayton Foushee
Director

Enclosure
Transmitted Correspondence
cc: Washington Office

Appendix of Enclosures: Letter of Request/Report In Support

1. Notice of Proposed Certificate Action
2. Withdrawal of Notice
3. FAA FOIA Office of Chief Counsel; Letter of Denial
4. 8020.11C Ch.4; Accident Investigation...
5. E Mail of 03-29-2017 to Michael Hicks, NTSB
6. Safety Recommendation Report-NTSB; 12/05/2016 ASR-16-007
7. NTSB Aviation Accident Factual/ Final/ FAA Reports; GAA17CA191
8. NTSB Aviation Accident Final Report; IAD01LA048
9. Letters of Adam Jansen and Lisa Gollin; GAA17CA191
10. Elements; 18 U.S.C. 1001/ FAA HRPM Standards of Conduct 6, 7 (h), (i) and 5 CFR 2635.101 (b) (8) and 102 (v).
11. Pilot's Handwritten Statement at Scene 03/11/2017.
12. FAA Directive to Investigators N 8900.230 7,12 and 14.
13. Typed Pilot Statement of 03/12/2017
14. Attorney Requested "Prior Contacts Memo" 03/29/2017
15. MKA Website FAQs/ Safety Claims/ Newspaper Report of 12/14/2013
16. Treatment Letter/Kalaupapa Care Home
17. Michael Hicks; Memorandum For Record
18. Handwritten Statement of Incurring Pilot
19. KITV4 News Article 03-13-2017
20. FAA "709" Letter of 04/03/2017 and Notice of Successful Examination.
21. E Mail of 4-10-2017 to G.Rezzonico/C.Howard
22. L.O.I. Written Response 4-11-2017



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

Office of the Chief Counsel
Enforcement Division

800 Independence Ave. SW
Washington, DC 20591

**U.S. CERTIFIED MAIL – RETURN RECEIPT REQUESTED
and E-MAIL**

March 14, 2018

Bettina Anne Von Brentano
c/o Kathleen A. Yodice, Esq.
Law Offices of Yodice Associates
12505 Park Potomac Avenue, 6th Floor
Frederick, MD 20854
Kathy.yodice@yodice.com

RE: *Bettina Anne Von Brentano*, Case No. 2017WP130015

WITHDRAWAL OF NOTICE OF PROPOSED CERTIFICATE ACTION

The Acting Administrator of the Federal Aviation Administration hereby withdraws his Notice of Proposed Certificate Action issued on June 30, 2017 in the above-referenced case.

Naomi Tsuda
Assistant Chief Counsel
for Enforcement

By:

John C. Stuart, Jr.
Attorney
Enforcement Division, AGC-300
Office of the Chief Counsel
Email: mike.stuart@faa.gov
Telephone: (202) 267-9958
Fax: (202) 267-5106

A-2 (1)



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

Office of the Chief Counsel

800 Independence Ave., SW.
Washington, DC 20591

April 23, 2018

Ms. Bettina A. Von Brentano
[REDACTED]
Mount Pleasant, SC 29466

Re: Freedom of Information Act (FOIA) request (2018-005490)

Dear Ms. Von Brentano:

This letter responds to the portion of your March 17, 2018, Freedom of Information Act (FOIA) request regarding "any available releasable documents concerning my informal hearing with FAA Attorney Mike Stuart on 02-27-2018 at WDC, to include any releasable analysis or conclusions reached in connection therewith."

We performed a search within the FAA's Office of the Chief Counsel and found only two documents that are responsive to the request. These documents are being withheld in total under Exemption 5 of the FOIA. Exemption 5 of the FOIA protects information that pertains to "inter-agency or intra-agency memorandums or letters that would not be available by law to a party other than an agency in litigation with the agency, provided that the deliberative process privilege shall not apply to records created 25 years or more before the date on which the records were requested." 5 U.S.C. § 552(b)(5). In this case, these documents constitute attorney work product and therefore are being withheld under Exemption 5.

There are no fees associated with this request.

The undersigned is responsible for this denial. You may request reconsideration of this determination by writing the Assistant Administrator for Finance and Management (AFN-140), Federal Aviation Administration, 800 Independence Avenue, SW, Washington, DC 20591 or through electronic mail at: FOIA-Appeals@faa.gov. Your request for reconsideration must be made in writing within 45 days from the date that the initial determination was made, and must include all information and arguments relied upon. Your appeal must also state that it is an "appeal" from the above-described denial of a request made under the FOIA and include your assigned FOIA control number. The envelope containing the appeal should be marked "FOIA."

Sincerely,

CYNTHIA A
DOMINIK

Digitally signed by
CYNTHIA A DOMINIK
Date: 2018.04.23
12:54:19 -04'00'

Cynthia A. Dominik
Deputy Assistant Chief Counsel for
Enforcement

A-3-(1)

1 FAA Inspector Gino Rezzonico, knowingly and intentionally violated my rights under the Pilot's Bill of Rights (PBR) by taking or participating in the following actions: (Please note that where the contents of verbal conversations are related within quotation marks, this represents my best recollection of these conversations which I either personally witnessed or directly participated in. In other instances herein where documents are referenced, those areas in quotation marks are taken directly from the reference document). This report contains information which I have been able to obtain and assemble from publically available sources or upon my own experience, information and belief.

- A. Richard Schuman, sole owner and operator of Makana Kai Airlines, handed me the airport telephone at the aircraft accident scene on March 11, 2017 and simply said "talk to Gino", which I did, answering his (Rezzonico's) questions without any provided 'rights warnings'. That this was, in fact the case, is echoed in at least two separate synopses of this conversation with Inspector Rezzonico which were prepared by him. (see attached item 7 -Narrative))
- B. Richard Schuman directed me at the accident scene to prepare a written statement concerning the accident. (see attached 11)
- C. Schuman, an individual personally involved in multiple prior aircraft accidents, license suspensions and other violations (and therefore well-versed in such matters), then passed this written statement on to Inspector Rezzonico without my knowledge or permission.
- D. These actions and others as set forth below, represent significant and unwarranted departures from the guidance provided to FAA Inspectors concerning the Pilots Bill of Rights (PBR) and the conduct of investigatory interviews as set forth in paragraphs seven, twelve and fourteen of FAA order # N8900.230, dated 08/05/2013.(see attached 12).
- E. Nevertheless, I immediately began cooperating on the date of the accident, continued that cooperation as set forth both above and throughout this document and by returning to Oahu to submit to alcohol and drug testing later that day.
- F. On the following day, I attended a meeting with Schuman, MKA Director of Operations Bruce Mayes and two insurance company representatives. I answered the insurance company's questions and prepared another written statement for them per the request of Bruce Mayes. At that time, an insurance company representative (Mr. Perry) noted that MKA would probably get a new airplane within 2 months. Shortly thereafter, Schumann noted to Mr. Perry that they (NTSB) will take "Travis" (MKA's head of maintenance) opinion on any technical aspects concerning the aircraft because he is "the Caravan expert on the Islands".
- G. In a meeting that occurred immediately following the departure of the insurance company representatives, Schuman stated that he had used "bad judgment in hiring" me and that I was "a bad pilot", "that (your) personality caused this" and that "You will probably never fly again" and that inspector Rezzonico would likely "shred me". Schuman also stated at this time that he had spoken to the other pilot (the pilot of the incurring aircraft) and had decided to believe that the other pilot was not a factor!) He then stated that the accident was my fault and suggested that I see the movie "Sully" and ended asking in a sarcastic manner "You're not going to kill yourself, are you?" During this conversation, Bruce Mayes was present. I found this statement interesting, because only a few minutes before, Mr. Schuman had told the insurance company

representatives that he did not know who the other pilot(s) were. During this conversation, Schuman displayed various photographs of the accident aircraft, to include at least one showing the scimitar like bending and twisting of at least one of the propeller blades. At that point, Bruce Mayes stood up out of his chair and exclaimed that the propeller must have been feathered prior to impact. Schuman immediately rebuked him and insisted that the feathering of the prop was caused by the impact, and not before. Mr. Schuman then cautioned me to avoid bringing up "control issues" regarding the aircraft in order to lessen the likelihood of involving the NTSB.

- H. During this same conversation, I had asked Mr. Schuman for a copy of the handwritten statement I had provided at the scene to him the day before. He refused to provide it but noted "oh yes we got it, miss college graduate". He then advised me that Inspector Rezzonico was on the way over to MKA's offices to interview me. Schuman then advised that he intended to be present at this interview and instructed me to just answer any questions with a "yes or no" response, as I "talk too much". I then indicated to both Schuman and Mayes that I might seek the advice of an attorney before such an interview and left Schuman's office.
- I. That night or on the following day, Mr. Mayes contacted me by telephone requesting that I return to MKA to review and initial training records. I responded that while I was willing to meet, I did not want to go into the MKA's office and could meet elsewhere. This offer to meet elsewhere was not responded to.
- J. It should also be noted that Bruce Mayes had scheduled another FAA meeting for me to attend for an interview with Gino Rezzonico, which he had set for 11 AM on Monday, March 13, to be conducted at MKA (Schuman Aviation). I then had to call Inspectors Rezzonico and/or Chris Howard and advise them that I would not be attending an interview until I spoke to counsel.
- K. Continuing to cooperate, on March 15, 2017, I contacted Inspector Howard, obtained his fax number and forwarded my more formalized written statement concerning the accident related events. (see attached 13)
- L. Later that day, I was telephonically re-contacted by Inspectors Rezzonico and Howard. They were on speaker phone and confirmed receipt of my fax. They wanted my e mail address in order to send me a pamphlet concerning the PBR, which I provided. Speaking with my husband, they asked him if he was representing me "legally". He responded "No, just as (my) her husband" and explained our recent efforts to find an attorney. As Inspector Rezzonico continued to press us to set a date "in the very near future", we explained that we felt a need to talk with an attorney first. Inspector Rezzonico then inferred that a poor attitude toward cooperating could affect the outcome. My husband then advised Inspector Rezzonico of his own investigative background and suggested that comment had been "inappropriate". We then stressed the need for a professional and cordial relationship and advised we would attempt to expedite an attorney contact and would reach out by the following Monday with a view to setting an interview date.
- M. During the next few days, I made multiple attempts to locate a qualified attorney through references provided by AOPA and contacts within the local chapter of the "99's" organization. After being able to identify only three "aviation attorneys" in the Honolulu area, I determined by contacting them that one (attorney Chris Ferrara) was on retainer to Schuman Aviation and the next (attorney Don Machado) had been involved, over time, in numerous aircraft related business

dealings with Schuman and did not want to "run crosswise with Richard Schuman". I learned soon thereafter that MKA's attorney, Chris Ferrara, had been previously disbarred in California and Hawaii after pleading guilty to a federal money laundering charge in a DEA drug smuggling investigation wherein he was arranging the purchase and/or sale of real properties through the use of a Hong Kong money laundering front for an Oregon based drug organization.

- N. This left one individual, a retired attorney who operates out of his hangar at Honolulu, David Betancourt. He agreed to represent me for the purpose of the FAA interview and directed me to prepare a more formal written response. He also asked for a document outlining my prior contacts with Schuman, which I provided to him as well (see attached 14). I then prepared the documents and forwarded them to attorney Betancourt who directed me to send the formal statement document to the FAA which I did on March 15 (see above).
- O. After coordinating the availability of the FAA and my attorney, an interview was set up for 10 AM on March 21 at the Honolulu FSDO. Upon attending, I was surprised to find that Inspector Rezzonico was not present. I was also surprised that the questions I was asked focused almost exclusively on the training that I had received at Schuman Aviation and any records that I kept or recognized concerning this aspect of the investigation. No discussion of what the examination of the aircraft or the accident scene had suggested or revealed was entered into by the FAA investigators and any questions that I raised along these lines were resisted or disregarded. It should be noted that I was shown a copy of a document that I was told was a portion of my MKA training record and which supposedly contained my initials on it. When asked by one of the two inspectors present (Chris Howard and Kyle Bartler) if the initials were mine, I immediately told them they were not and the inspectors appeared to agree with me. No mention of this was made in Inspector Howard's synopsis of this interview obtained later under the FOIA.
- P. When I subsequently received my LOI on April 10, I sent Inspector Rezzonico an email requesting greater detail, as by then, I had read the Pilots Bill of Rights and was very much interested in "productively participating" in this investigation in an effort to understand why and how this accident had happened. (see attached 21).
- Q. Following up this email with several phone calls, I finally spoke with Inspector Rezzonico in a joint phone call with my husband. We requested greater specificity concerning those areas set forth in the LOI so that I could intelligently respond. Inspector Rezzonico's response was that "You know what you did" and he refused greater information. During the following hour, I re called the inspector on my own and essentially begged him for some greater information. After telling me that bringing up my rights and using legal terms and/or involving my husband wasn't helping me, he repeated "you know what you did". Responding that "no, I don't" (in reference to whatever it was he was suggesting), he stated "try to think what you might have done". He then asked me "were you in a rush"? I responded "no" to which he stated "well, we have the passenger statements and you know what you did". Following up, I then mentioned seatbelts and I told him about my efforts with the older medically challenged male patient whom I spent considerable time transferring from his wheelchair and making sure that he was properly seat belted. After I indicated that I had spent some time untangling the seatbelt, the inspector stated "you're not a mechanic, you have no business fixing a seatbelt". I responded that the belt had just been tangled, not broken. He never mentioned a separate female passenger who had claimed to have seatbelt issues.
- R. He then told me "your husband is not helping the situation. If he continues, it's actually going to hurt you" I responded by saying that my husband is my only real advocate. And I told him that I have lawyer Bettencourt who I had heard had ended up talking about me with "Makana Kai" airlines and everyone else. He responded "Yes, that's true. But there's nothing you can do about

it. What's done is done, there's nothing you can do about it. The investigation is done and remember, we have the passenger statements, remember that". He also continued by saying "there are a lot of things you did post accident, too". I responded that I had hit my head in the accident but I reacted and went back and helped the wheelchair-bound passenger. I asked him if he had been aware of my attorney's lack of discretion, shouldn't he have said something. He ignored this and once again repeated "You know what you did." The conversation then ended.

- S. In spite of a lack of sufficient information, on April 11th, 2017, I prepared and submitted a written statement in response to the LOI in which I was left to guess at those topics that I needed to respond to. (see attached 22).

CHARACTERIZATION OF MY ACTIONS AS CARELESS AND RECKLESS

T. Since this "Notice of Proposed Certificate Action" had raised the issues of "actions" (which) "were careless and reckless so as to endanger the life or property of another"(14C.F.R.91.13 (a), consider these facts concerning the actions of MKA; (the "Owner") and Inspector Rezzonico:

U. At all times during my association with MKA and its principal, Richard Schuman, Inspector Rezzonico was the FAA's Principal Operations Inspector for MKA. MKA is a "for profit business" operating in the Hawaiian Islands. Its' operations are based at Honolulu (now Daniel K. Inouye Airport). It serves the nearby islands of Molokai and Maui with both scheduled and chartered fixed wing airline service under the "Essential Air Service Program" as well as operating a large scale scenic and commercial helicopter flight service. As a "for-profit business" it advertises its services via a company website and has done so since at least 2011.

V. Contained in MKA web site under the section entitled "Frequently Asked Questions" are the following Questions and Answers (quoted here in pertinent part only) concerning passenger flights on MKA:

Q: "Will I have to go through TSA screening"?

A: "NO... There are no lines, no one with a wand and no one will open your suitcase".

Q: "how about carry- on items such as purses, backpacks etc."?

A: "for our regularly scheduled service, passengers are allowed to bring on one (carry-on)... Up to the size of a small back pack."

Q: "How many people can fit in the airplane"?

A: " Both the Cessna Grand Caravan and the Piper Chieftain..." (See Attached 15).

The stated mission of the FAA is to provide the safest, most efficient aerospace system in the world. Among its stated responsibilities is the protection of the public's interest and investment by

ensuring sponsor compliance with federal regulations and the protection of airspace on and immediately adjacent to an airport.

- W. In addition, this MKA company policy, which I had personally observed, is confirmed with only a few minutes review on the MKA website. Whether or not such policies are technically "legal" is unknown to me. But I would be surprised if it would relieve Schuman Aviation or the FAA's responsibility to operate safely. This complete lack of safety screening of passengers boarding MKA's aircraft leaves one to wonder how difficult it could possibly be for a suicidal individual bent on inflicting tremendous harm on the people and economy of Hawaii to concoct and act on a dangerous plan of destruction. That this policy is openly advertised and apparently well-known in local circles, suggests a failure on the part of the FAA's POI to suggest a more reasonable policy. Add to this the fact that Caravans and Chieftains provide no separation between flight crew and passengers and that on some flights, passengers are allowed to sit in the copilot seat with direct access to the controls, and the danger is all the more evident.
 - X. Based upon the foregoing, it seems patently obvious that, in the age of terror, MKA has conducted and continues to conduct its business activities in a "careless and reckless" manner with complete disregard for the safety of the traveling public. Added to this is the fact that over the past eight years, the President of the United States and other high officials regularly traveled to this major class B airport
 - Y. While I will leave it up to others to wonder as to why MKA might openly advertise the services of this "for profit" air transportation company as one in which passengers and their bags are not subject to screening, there is presumably a profit related motive.
2. In the company website "About Us" section, M K A notes that "We conduct our business as an FAA part 135 air carrier and have not had a charter safety incident or accident since we began flying in 1988". This is, at best, intentionally misleading to the flying public. As set forth in a Honolulu star advertiser article dated 14 December 2013 and entitled "Company had five incidents in past, FAA records show", a sixth nationally publicized accident was described. The accident in which I was involved brings the total to at least seven based upon my Google-based research.(see attached 15).
- Z. ..In his proposals to provide Essential Air Service to both Kalaupapa and Kamuela, Hawaii, Richard Schuman makes a great deal about his local ties and genuine concern for the people of Hawaii. He does not attempt in any way to disguise his company's lack of passenger or baggage screening. Instead, he highlights this as a selling point, stating in his proposal under "Ease of Use" that "our \$4 million passenger terminal obviates the need for TSA security screening". Given the suicidal nature of attacks worldwide, how is this so?

BB. Interestingly, MKAs chief competitor, Mokulele Air Lines, also has submitted proposals to fly many of these same EAS routes. MAL flies with two pilots as they do not possess the approval somehow obtained by MKA to operate with "autopilot in lieu of a second in command". Nevertheless, in his letter of support to his company proposal to fly the Kalaupapa route, the CEO of MAL makes no mention of a willingness to forgo common sense security measures, choosing instead to cite his airline's reliance on two pilot crews in the conduct of every passenger flight under IFR flight rules, which is another of two practices not adhered to by MKA.

CC. In its' order # 2014-6-12, served on June 19, 2014 concerning "Essential Air Service" at Kalaupapa, Hawaii, the Department Of Transportation (DOT) selected Schuman Aviation Company, dba MKA to provide service at Kalaupapa. In doing so, Susan Kurland ,the Assistant Sec. for Aviation (international affairs) stated that in arriving at her decision, she had considered "five factors" in accordance with 49 USC 41733 (C) (1). None of these factors as set forth in her footnotes directly mentions safety. The deciding factor cited was (D) "community views giving substantial weight to the views of elected officials representing the users". Oddly enough, they then ignored the letters of support filed in support of the Mokulele Airlines competing bid, written by the Speaker of the House for the State House of Representatives and by the Mayor of Maui and cited instead "community comments received from Kalaupapa residents".

DD .Furthermore, Ms. Kurland notes that in accordance with the requirements of 49 USC 41737 (b) and 41738, the air carrier must be found " fit, willing and able to provide reliable service "and no information has come to our attention that would cause us to question MKA's fitness at this time. We have contacted the FAA and it has raised no concerns that would negatively affect our fitness finding". Section 41738, dealing with "fitness of air carriers" requires, among other items, that "operations related to the service or transportation conform to the safety standards prescribed by the administrator of the federal aviation administration".

EE. I would be surprised if the FAA's Administrator would approve of flights exempted from any form of security screening being allowed to arrive at or depart from a major Class B airport in a state whose economy is substantially based upon tourism. I would also suspect America's partners in the worldwide struggle against terror might find this troubling.

FF. While lowering the payroll by operating with only one pilot and allowing a passenger to sit at the controls to add a little more revenue may make good "business sense" to MKA and give it a competitive edge in its EAS proposals, openly advertising that it conducts no security screenings as a promotional strategy in the age of terror seems "careless and reckless" within the meaning of 14 CFR 91.13 (a).

GG .By failing to report or correct this conduct, the FAA's POI appears to be adopting an attitude more consistent with the pre "Valu Jet" 1996 official FAA policy of "promote and regulate" instead of one consistent with the currently expressed policy focused on safety.

HH. Furthermore, this failure to report this practice has been compounded by the DOT's reliance upon this lack of information. In reaching its' decision to either award or continue EAS contracts with MKA, DOT officials specifically state that they contacted the FAA and were not made aware of any information which would negatively affect their "fitness" determination concerning MKA.

II. These same inactions have conceivably penalized competitors in the same bidding process due to their own reasonable compliance with the requirements of 49 USC 41738's safety regulations.

JJ. A recent (7/9/17) FBI terror related arrest of a service member at Hawaii who had expressed a willingness to "kill many people" and news reports of the resurgence of ISIS activity in the Philippines highlight this danger.

KK. In addition, a recent article written by Andrew Gomes in the Honolulu Star Advertiser on November 17, 2017 which described events related to the actions of an escaped mental patient who utilized a charter airline flight to travel to the Big Island of Hawaii (and the on to California) contained

several quotes from Mr. Schuman. Therein, Schuman's statements that charter flights are not "sought out as vehicles for illicit acts" and that the pilots of such flights would be unlikely to choose to harm others, shows nothing less than an attempted justification for behavior which I believe evidences an intentional disregard for the safety of the traveling public.

TRAINING MATTERS

LL. On a more specific level, I would also suggest that it would be "careless and reckless" within the meaning of 14 CFR 91.13 (a) to provide only 15.9 hours of flight training to a general aviation flight instructor in a Cessna Caravan (which is four times heavier and more powerful than a typical piston powered training aircraft), before authorizing that pilot to conduct single pilot passenger carrying operations into a remote, uncontrolled field, lacking any kind of dedicated emergency equipment, where she had landed only twice (and only once in a Caravan) . Adding to this is the fact that only 3 ½ hours of this training was conducted as basic daytime VFR familiarization training, none of which involved a demonstration of or "hands on" practice of common emergency procedures such as compressor stalls ("flame outs") or propeller feathering situations or procedures. In addition, the Caravan is equipped with a turbine engine, requiring some significantly different considerations during operational emergencies.

During my subsequent conversations with my then attorney, I had learned that both Richard Schuman and Robert Smith were personally aware of the hazard of potential runway incursions on runway 5 at Kalaupapa. At one time in the past few years, they were pilot and passenger in an aircraft conducting a check ride for Smith which, in fact, incurred in a similar manner and in the same basic location as did the incurring aircraft involved in my own accident. This event spawned an FAA enforcement action targeting the pilot of the second aircraft operated by a flight instructor and her student which conducted a touch and go landing on runway 5. Additional circumstances were apparently brought to light which negated the need to suspend any flight privileges. This attempted enforcement action came about due to the presence of an FAA inspector in the aircraft flown by Smith.

MM. In fact , the only emergency procedure training which I participated in while operating as a crew member were "power off 180s" (essentially short approaches to landings from within the traffic pattern) which were conducted at dusk at nearby Kalaeloa airport. This aspect of the training was discontinued when the tower controller suggested that the lowering light conditions were making them potentially unsafe. Surprisingly, I was able to ride along in earlier daytime flights and observe the two other pilots hired at the time I was, as they received "hands on " training and demonstrated proper prop feathering and compressor stall counter actions. Each of these individuals had several hundred hours of experience flying Caravans.

NN. My training was conducted by Robert Smith, the company Designated Pilot Examiner (DPE), who himself had submitted to a check ride with FAA POI Gino Rezzonico approximately one week before my own part 135 ride with Mr. Smith. The vast majority of my training (12 hours), was conducted after the revenue flying day was completed, when the aircraft became available. This means at night and more often than not, during periods of very poor weather, essentially single-engine, at night and over the ocean. Since the great majority of this training was conducted

in IFR conditions and during early evening hours, no emergency procedures, stalls or ground reference maneuvers were conducted. During this time, my husband, also a pilot and concerned about the bad weather, had complained that he could not see my C208 on publically available computerized aircraft tracking websites. I learned from FAA investigators that this was because MKA employs "Spider" blocking software that prevents public awareness of their aircraft movements and, interestingly, prevents any record of those movements from being stored for more than the FAA's required minimums of about 30 days.

OO. Oddly, due to the fact that I had no Caravan time, MKA's insurance company required that my first 100 hours of single pilot operations with passengers be conducted as "VFR only" flights. Should the weather deteriorate during my flying day below VFR minimums, it was left to me to ask for help by personally contacting other pilots on their days off to come in and fly with me! It is interesting to note that had this been my personally owned Caravan, any insurer would likely require a minimum of at least 50 hours of logged simulator and/or aircraft training before underwriting an insurance policy.

PP. In addition to the above, my IOE (initial operator's experience) was cut short and/or amended due to operational needs. During my interview at the Honolulu FSDO, I advised investigators of this circumstance. Portions of my IOE actually became two pilot line flying activities due to significant weather conditions encountered on one of the days during which my IOE was scheduled. A second IOE day was cut short after I was assigned to fly with another newly hired pilot instead of continuing my IOE with the DPE. With regards to arrivals at the uncontrolled airport at Kalupapa, when I asked if I should normally over-fly the field to look for traffic, DPE Smith advised me not to do this as the air over the field is often "bumpy" and this would be uncomfortable for passengers.

QQ. In hindsight and in fairness to DPE Smith, I believe that our IFR training and joint line flights, conducted as they were during a period of significant weather and at night, had led him to be over confident concerning my overall Caravan related flying skills as we had worked well together. I believe this may have been a factor in causing him to overlook the need to provide basic VFR safety training focusing on in flight related emergencies. In the three hours of VFR training with Mr. Smith, only one aerodynamic stall was demonstrated and a second was set up by him which I then reacted to. This, combined with the "power off 180s" I described earlier, was the total of my "hands on" emergency training. In addition, no simulator training was utilized, nor was any weight added to the aircraft to simulate passengers in transit. I would also point out that during my training, I specifically asked DPE Smith on more than one occasion if we could practice emergency actions (particularly compressor stalls) as part of the training. His response was that we could, but that I would have to wait until after I had flown "a couple of lines" and then, "if the aircrafts' available (at the end of the revenue day) we might do some emergency procedures". I recall discussing this with my husband at the time and we had concluded that the anticipated Part 135 check ride would probably cover these areas. This seemed reasonable because as a flight instructor myself, I have always looked upon "pilot check rides" as great learning tools. Unfortunately, DPE Smith elected to conduct my Part 135 check ride during evening hours in, at times, heavy rain when night time conditions prohibited safely conducting such actions. In fact, on the first attempt that evening, he failed me on the conduct of holding altitude to a standard of + or - 50 feet in a steep turn which was conducted in an instrument hold without reference to an outside horizon (actually a standard required for an ATP rating and not for my commercial/Part 135 authorization). Later on, in a hallway encounter between Smith and Schuman wherein Schuman inquired as to how things had gone, Smith advised him of the steep turn failure and retest (which occurred all in the same flight). Schuman then stated "My pilots don't need steep turns" and criticized Smith for this action, asking why such a thing was tested at all. Smith's response was that it (a steep turn) had been important the week before during another new pilot's

near miss with a jet at Maui on takeoff which was covered by various media outlets. When I interjected that the failure had occurred in rain, at night in an instrument hold, Schuman's response was to put his hands over his ears while walking away, saying "I don't want to hear about it". Based upon the above events, Smith issued (2) separate "135" Airman Proficiency Check forms, based on the same flight, with the first evidencing the steep turn failure.

- RR. On the day following my initial post accident meetings with insurance company representatives and Mr. Schuman and Mr. Mayes, I had been asked by Mr. Mayes to come into MKA to initial training records. Via a series of voice and e mails, I let Bruce Mayes know I was unwilling to come into MKA's offices again (out of personal embarrassment) but that I would be willing to meet elsewhere to review these records. This offer was not responded to.
- SS. Later, on March 21st when I attended the FAA interview at the local FSDO, I was surprised to find that Inspector Rezzonico was not in attendance
- TT. . During the interview, other Inspectors showed me a copy of what were said to be my MKA training records. These records appeared to contain at least one set of initials which had been reported to be, but in fact were not, mine. When I stated that the initials placed thereon were not mine, the investigators clearly appeared to agree with this assessment.
- UU. While MKA's service reliability and price are not at issue, the manner in which it attempts to influence "community views" may be. By openly advertising it's no search policy, ostensibly to enhance efficiency, it opens up its' operation to a litany of potential abuses which include the real danger of terrorism.
- VV. Based upon the foregoing points concerning its' intentionally misleading advertising, incomplete training program, single pilot operations and obvious disregard for common sense security measures and other "best practices", it seems clear that MKA has demonstrated a "careless and reckless" disregard for the safety and property of the flying public in order to enhance their competitive edge and revenues. Furthermore, the FAA POI's failure to scrutinize these intentional, shortsighted or ill-advised policies suggests a lack of willingness to provide professional oversight. Finally, I believe Inspector Rezzonico's actions in ignoring both the spirit and letter of the PBRs by not providing either verbal or written pre interview warnings amounts to a careless and reckless disregard for my rights under the PBR. That these actions were taken in concert with those of Richard Schuman is both telling and even more disturbing.

THE ENFORCEMENT INVESTIGATIVE REPORT (EIR)

- WW. By letter received on July 3, 2017(dated June 30, 2017), I was advised of the Proposed Certificate Action associated with EIR 2017WP130015. I then requested and promptly received a CD disc entitled "Releasable EIR 2017WP130015". As explained in the accompanying letter, "The enclosed EIR (CD) includes all releasable documents upon which the FAA relied in preparing and initiating the ...enforcement action".
- XX. Based on the "releasable portions" of the EIR and FARs cited in the notice of "Proposed Certificate Action", as well as what are referred to in that notice as "... The following facts and circumstances...", it would appear that the proposed suspension was based upon the mistaken assertion that I departed on this flight with a known shoulder harness seatbelt defect relating to a particular passenger.
- YY. This assertion was factually inaccurate and the related conclusion that I therefore operated the aircraft in a "careless and reckless" manner flies in the face of the true nature of my pre-flight actions.
- ZZ.

As stated previously in my April 11, 2017 written response to the April 3, 2017 LOI, (which I incorporate by reference herein)... "I was asked by a woman sitting in the next row forward of my wheel chair bound passenger if I would check the restraint system functionality of her seatbelt which I did, determining that it appeared to work properly." Continuing on in the following paragraph, I wrote that "I did not consider having to adjust tangled seatbelts rose to the level of a reportable maintenance issue. As I was conducting this flight as a single pilot, without the assistance of any cabin crew personnel, I believe it fell within my responsibilities to address such passenger concerns in a common sense fashion. Subsequent events suggest that the passenger's restraints worked properly".

BBB. Elsewhere in this response and in connection with my pre-flight actions, I wrote that "I arrived early and conducted a full and thorough preflight inspection" and that "As this was my first week of 'flying the line' (and) I felt a keen sense of responsibility to my passengers".

CCC. I would further note that I prepared that response in a timely manner after receiving the LOI which lacked any specificity concerning my alleged shortcomings, stating only (in pertinent part) "... That discrepancies discovered during passenger boarding were not reported to maintenance, written up in the aircraft logbook and corrected prior to taking off..." As noted elsewhere in this statement, my efforts to obtain any greater specificity concerning my alleged "discrepancies" were continually rebuffed.

DDD. These actions are contradictory to the provisions of PBR Section 1, paragraph (4) (A) stating that the Administrator shall provide "timely access to any air traffic data in the possession of the FAA that would facilitate (my) ability to productively participate in a proceeding relating to the investigation..." And paragraph 4 (B) (V) which includes in "air traffic data" "investigative reports". Until the filing of FOIA requests, I had not been provided with any information concerning this accident other than what was provided in the LOI and the aforementioned CD which contains only two passenger statements (of the nine passengers occupying the aircraft). Both of these statements were written weeks after the event. There were no other passenger or witness statements provided indicating whether or not witnesses were questioned regarding these particular allegations and/or made contradictory statements.

EEE. Furthermore, after being pressed to submit to interview by FAA Inspector Rezzinico, he failed to participate in that process after having been provided with a choice of interview dates and several days advance notice. During this interview, I cannot recall the raising of issues by the FAA inspectors present concerning any allegations that I had failed to ensure, repair or report a shoulder harness or seatbelt issue concerning the female passenger seat 2A.

SPECIFIC CHALLENGES TO THE EIR

FFF. The information included in the "releasable portions" of the EIR, which "includes all releasable documents upon which the FAA relied in preparing and initiating the above referenced enforcement action" appears to include only two written statements of the nine passengers present.

GGG. I was, therefore, left to assume that due to the very limited focus of this proposed suspension and its basis on the shoulder harness related assertion concerning the passenger in seat 2A, that no further inculpatory or exculpatory interviews were conducted and/or statements were obtained.

HHH. Furthermore, due to the limited nature of the allowable exclusions of the EIR that are considered "privileged" (as the investigator's analysis, recommendations or opinions) or because they contain "personally identifying information concerning other individuals", and the release thereof would constitute a "clearly unwarranted invasion of personal privacy", I had to conclude that no further statements, interviews or records existed concerning this issue which could not have been presented in a redacted format excluding personally identifying or privileged information.

III. Due to the foregoing, I challenged the conclusions based upon this investigation as follows:

The EIR contained no indication that the female passenger occupying seat number 2A was interviewed concerning preflight adjustments made to her seatbelt shoulder harness.

JJJ. The accident related events, as well as the statement of passenger Adam Jansen himself, (the son of the passenger in seat 2A), who noted that immediately after the accident "I (he) looked over to check my mother to confirm she wasn't hurt..." are strongly suggestive that, in fact, the shoulder harness and seatbelt restraint system functioned properly.

KKK.. Were any contemporaneous examinations conducted by qualified personnel to determine the seatbelt restraint system's functionality at seat 2A as part of the immediate accident investigation? If so, are there releasable results? Apparently not.

LLL. In "Section B- Statement Of Case", the statement of passenger Adam Jansen was cited as the source of information relied upon to conclude that I essentially ignored his mother's report of a non-functioning shoulder harness and that I "stuffed the excess belt into the back of the seat", blaming the problems on "humidity". Please demonstrate to me how this can be done. Furthermore, the "statement of case" continues by noting "another statement made by passenger Lisa Gollin also indicated there were issues with the seatbelt before takeoff". This is factually inaccurate. Lisa Gollin's statement of March 24 noted only on page 3, paragraph 3, that "one, possibly two of the seat harnesses were not working". She did not identify any basis for this statement, nor did she make any reference to seat 2A or its occupant.

MMM. The statement of Mr. Jansen, dated 4 April 2017, was written three weeks after the accident. Ms. Gollin's is dated March 24, 2017, two weeks after the accident. As such, neither represents a contemporaneous recollection of events and each therefore allows ample opportunity for the influence of conflicting viewpoints or opinions. In fact, Ms. Gollin's schedule apparently kept her at Kalaupapa for several days.

NNN. Several of the passengers continued to interact after the accident, participating in a visitor's tour of the area, which is the only purpose of tourist travel to this remote destination.

OOO. Even a cursory reading of Adam Jansen's statement of April 4th demonstrates that it is filled with self-serving statements and opinions which were clearly prepared for the purpose of supporting an insurance claim. Examples thereof include statements such as "given the difficulty with life vests the company had last year" which is indicative of a statement prepared after some research concerning the accident history of MKA. In addition, his attribution of pilot stating "oh, no, oh, no, oh, no" at the time of the event is contradicted by Ms. Gollin's statement, as are several other of his assertions.

PPP. Furthermore, his continued focus on his own "actions" and repeated negative descriptions of his perceptions of the inadequate actions of the pilot are exaggerations designed to enhance his claim of back injuries as clearly set out in his final paragraphs.

QQQ. In fact, I did move through the aircraft to the rear of the passenger compartment and attempted to retrieve the medically challenged passenger's wheelchair. Eventually I was assisted in this effort by a Park Ranger.

RRR. While I did, in fact, apologize to passengers stating that I couldn't keep the RPMs (power) up, and that I was terribly sorry, this does not amount to an abrogation of my efforts to assist passengers after the accident. In point of fact, I had struck my head on the aircraft control panel and was eventually taken by a Park Ranger to the Kalaupapa Medical Clinic/Care Home where my vital signs were monitored and I was provided with water.(see attached 16).

SSS. The FAA accident/incident report dated April 11, 2017 cites "operational factors" in block 21B., describing them as "pilot induced , hard landing, loss of control and mismanaged controls". Amazingly, it leaves out "Other Than Pilot" and in the narrative fails to mention the presence of an incurring aircraft

which was on the runway at the threshold of runway 23 and pointed in our direction with its engine (prop) running.

TTT. This same narrative falsely infers that another aircraft which (I) the pilot, had been concerned about was clear of the runway. As events showed, this was not the case. The facts were that on this 2700 foot runway surrounded by ocean and rocky shoreline on three sides, just as I was about to touch down, I observed another aircraft at the opposite end of the runway, somewhere between 2000 and 1500 feet ahead, facing me with its' engine running. Whether or not this was the aircraft which I had spoken to (3) times during my approach and had given ample time to clear the runway (and after having been advised that it was "clear off runway") was unknown to me in that moment. There are no off runway areas at the runway thresholds of 5 or 23 at Kalaupapa. There are no taxiways other than the ramp to the small terminal building located about 700 feet down runway 5 on the right. Per my conversation with the airport manager at Kalaupapa a short while after the accident, this is not a standard practice at Kalaupapa (to "hide" in a "turnabout") awaiting another aircraft's arrival. I faced the confusing and real possibility of a third aircraft's presence and was unaware of its' intentions. My reflexive action was very much as I have been taught and as I have in turn, instructed my many students: Go around...and in this instance also "see and avoid".

UUU. That these facts are ignored in the FAA report is all the more surprising since the date of the narrative's creation is one week after the date of passenger/witness Gollin's written statement which extensively documents these circumstances and yet is otherwise relied upon by investigators to improperly corroborate passenger Jansen's statement regarding his uninjured mother's allegedly unaddressed shoulder harness issue. Indeed, Ms. Gollin refers to photos and videos confirming the presence of the other aircraft as well as to her own visual observation and accurate descriptions of it.

VVV. The narrative continues, ignoring both my own statements and those of passenger Gollin, by stating "The pilot appeared to be distracted by the aircraft in the turnaround area at the end of the runway and failed to maintain control of the aircraft resulting in a crash landing"...Once again, this is a mischaracterization of the situation and my actions. When landing at Kalaupapa there is only the landing aircraft and the runway. There are no "cul de sacs, turn arounds, turnabouts or rotaries" for other aircraft to occupy or utilize. My statement and that of witness Gollin, seated in the aircraft's cockpit next to me, clearly indicate that I was attempting to fly the aircraft during a go around.

WWW. Finally, the narrative states that "Markings on the runway show the prop struck multiple times in a low pitch configuration before being feathered". Who arrived at this conclusion? Did the writer rely upon his own expertise or was this conclusion based upon what he had been told by someone else? What are his or her qualifications and how does this analysis exclude markings made by an already feathered or partially feathered propeller?

XXX. As I noted in my post accident statements "After coming to a stop, I proceeded to shut down the engine". This includes the fact that I did not pull the prop lever back to the feathered position until that time.

YYY. Post accident news photos of the aircraft as well as my own observations of the plane indicated to me that the propeller had been feathered at the time of initial impact. In fact, subsequent photo evidence obtained via the FOIA, clearly show that the propeller was in a feathered position upon impact. Interestingly, the photos were not displayed (and possibly not passed on) in the NTSB final report. That report included only two pictures, one from a great distance with the propeller undiscernible, and the other of a wingtip. In addition, the report makes no mention of the propeller or the engine.

ZZZ. I have been advised by a high time retired military pilot who is also an experienced aircraft accident investigator that he personally observed the propeller and accident aircraft at Kalupapa a day or two after this event and concluded that the propeller had been feathered at time of impact.

AAAA. In connection with the requirement that I file an NTSB Form 6120.1, I responded to an e mail received from Mr. Michael Hicks of the NTSB. In my e mail response dated 3/29/2017, I specifically requested that "...the NTSB conduct a technical examination of the accident aircraft power plant/propeller to determine whether any mechanical anomaly contributed to this accident". (see attached enclosure 5). A review of the documents which I have received via the FOIA indicate that this and other logical technical examinations were not done. This is rather surprising in light of the NTSB's own Safety Recommendation Report adopted (3) months earlier on 12-05-2016, and entitled "Preventing the Incorrect Installation of the Beta Arm in Pratt and Whitney Canada PT6A Engines"(see attached 6) which stated in part that "The NTSB is concerned that any PT6A engine that has undergone improper maintenance to the beta valve assembly can travel un-commanded to the feather position during any phase of flight"... This report was initiated after (5) accidents had occurred over time, traced to this causal factor. It is highly illuminating to compare the very complete FAA accident investigation of the first noted event in this series- also a Cessna 208 Caravan (IAD01LA048)- a cargo flight without passengers or injury of any type(see attached 8)- to the so called investigative report of my 03-11-2017 accident, wherein the FAA did not respond to the scene or conduct any technical review of aircraft systems but instead relied upon the "investigation" conducted by the sole owner of an airline with the most to gain by deflecting attention away from his maintenance and training practices. I believe that my on scene post accident statements, echoed by witnesses thereto, that I was unable to keep" my RPMs up" is highly consistent with the symptoms described and conclusions reached in the aforementioned Safety Recommendation Report and the investigative results in IAD01LA048.

BBBB. I have learned that in spite of the fact that insurance company representatives advised Richard Schuman in my presence that the aircraft was likely a total loss and would be replaced, (as well as Schuman's own statement to this same effect in the newspaper on 03-13-2017 wherein he both publically blamed me and stated that "it is totaled and it will never fly again, the damage is that bad"), Schuman subsequently elected to maintain control of the airframe and power plant and have repairs affected. Other sources have advised that the turbine engine of this aircraft had not been significantly damaged, which would be more consistent with a post feathered prop impact. While I have been unable to verify this information and there may be valid business reasons for MKA to adopt this approach, it seems curious that Schuman would have elected to forego obtaining a timely replacement. It is my understanding that as of this writing, the repaired aircraft has been placed back in service.

CCCC. It should be noted that the well publicized 2013 MKA Caravan accident at Kalaupapa in which the Director of the Hawaii State Health Care system lost her life, resulted in a significant amount of legal complications for MKA and Richard Schuman. In that instance, a compressor stall shortly after takeoff resulted in a masterfully executed water ditching by the pilot. Unfortunately for all concerned, the passenger, referred to above, died from a heart attack triggered by the accident. While the NTSB report issued concerning that accident stops short of blaming the event on a willful failure to comply with known engine maintenance manual and service bulletin requirements, it does offer the opinion that the accident may have been preventable by compliance therewith. In a counter suit of sorts filed along with a wrongful death action against the engine manufacturer and Cessna, the victim's family eventually settled the matter out of court. In connection with these interrelated actions, MKA claimed that the maintenance program which allowed MKA to extend the engine's TBO from 3600 to 8,000 hours had not been clear in requiring that it comply not only with the extension related Service Bulletin, but also the engine maintenance manual. More specifically, the NTSB report had noted that compressor blades had cracked and separated causing the catastrophic loss of power, and that required "hot section" inspections which were not done would have likely identified the conditions contributing to this event. As these events unfolded, MKA was forced to purchase some specialized inspection equipment at a reported cost of approximately \$17,000 and train their head mechanic to utilize it. MKA avoided financial responsibility for the accident by assisting and cooperating with the victim family's law firm in reaching the settlement.

DDDD. As further evidence of Richard Schuman's desire to avoid any form of oversight or responsibility for his actions, I would cite NTSB accident report LAX02LA217 involving a Euro copter tail strike accident in Honolulu of an MKA aircraft operated by Schuman. Interestingly, the report ends with the notation; "

Despite numerous attempts by the safety board, the pilot and operator failed to submit an NTSB pilot/operator aircraft accident report".

EEEE. As I advised my then attorney (at his request in writing) prior to my March 21st FSDO interview, during informal conversations with Mr. Schuman in January 2017 relating to my hiring, Richard Schuman at one point took a copy of the FAR/AIM and threw it over his shoulder, indicating that this was his attitude toward the FAA regulations concerning safety and maintenance issues.

REQUESTED ACCIDENT RELATED ACTIONS

Therefore, based upon the foregoing, I would request the following steps be taken

1. A review of the investigative file for any interviews of any other passenger/witnesses or ground personnel who witnessed either my preflight actions or the accident event and its aftermath. I believe these statements are necessary in order to provide a more accurate and balanced account of events.
2. Follow up investigation conducted by independent FAA investigators to ascertain what the examination, teardown and/or repair of the propeller, propeller control unit, power plant and related controls, as well as any stored electronic data associated therewith, such as from a power analyzer recorder system, indicated regarding the state of the engine and propeller at the time of the accident.
3. The examination of any photographs, videos, cell phone pictures or other pictorial exhibits which are or previously were in the possession of the FAA concerning this event, including but not limited to, pictures of runway marks, runway environment, aircraft (post accident) and aircraft instrumentation (both prior to and after the accident).
4. A review of the accident aircraft maintenance files to ascertain the existence of any prior history of reports for malfunctions or repairs regarding the functionality of the shoulder harness of seat 2A, as well as an examination of appropriate aircraft records to determine when proper power plant, gearbox, propeller and propeller control unit maintenance had been performed, and AD and SB compliance had been accomplished.
5. A review of the NTSB Final Report to consider the appropriateness of amending the probable cause statement portion to state that "The pilots loss of directional control occurred during an attempted "go around" which she conducted due to the runway incursion of another airplane, which investigation had determined had reported being clear of the runway. As no technical examinations of the propeller or power plant were conducted, the possible failure of these components and their contribution to these events could not be determined. A review of the air carrier's associated training records indicated that a lack of training in the appropriate emergency procedures may have also contributed to these events."
6. A review of my training records at MKA. While I was briefly shown a small portion of what was said to be my MKA training records at my interview at the Honolulu FSDO for the purpose of confirming that I had never initialed them, I have not obtained any copies of any detailed examination of them and/or comparison to similar records to determine the validity of the record keeping process or of my records in particular. Since my initials do not appear on the copies of the records I have received, I believe the documents provided were in all likelihood prepared after the fact of these events.

REVIEW OF INVESTIGATORY ACTIVITIES

Separate and apart from the requested additional document reviews and technical examinations, I would ask that the actions and inactions of the assigned FAA investigators (Gino Rezzenico and Christopher Howard) be reviewed to determine whether their actions and inactions, as documented in multiple inter-related investigative reports and summaries thereof, represent the

conduct of a fundamentally fair and complete inquiry as required by internal FAA regulations. More specifically, I would point out that:

1. The FAA Accident Report signed by Inv. Howard on 04-11-2018 cites only "pilot induced error" under block 21B; "Operational Factors" in spite of an additional category for "Other Than Pilot" and extensive additional evidence in the record of a runway incursion by another aircraft. (See statement of passenger/witness Gollin (seated in the co-pilots position) as well as this report's own statement in Section 43 of "Block 42, item 4 (that) the pilot appeared to be distracted by the aircraft in the turn around area at the end of the runway..." It should be noted that while the runway does widen at each end (5/23) to allow for long landings and taxi turns, these areas are PART OF THE RUNWAY AS MARKED and are not places set aside to await the arrival of other landing traffic. As noted above, this factor has been part of prior attempts at FAA enforcement actions personally involving an FAA inspector, DPE Smith and R. Schuman.
2. Block 35 indicates that the FAA did not participate in the investigation "on scene" in spite of a timely notification. Therefore, who conducted the on scene investigation? Who took the pictures shared with the FAA? Who directed me to write a statement at the scene (while still in distress) and provided this to the FAA without my review or approval? And who spoke to the press as well as the incurring pilot and two days later offered his opinion publically as to fault without any competent review of the facts and circumstances?
3. Sections 33 and 43; the "Narrative" and "Brief Explanations of Issues Involved" sections of this report contain several statements unsupported by any physical evidence or witness statements to include: the pilot "seemed to be extremely nervous", and "...the pilot appeared to be overly concerned with the location of the other aircraft" and "The pilot appeared to be distracted by the aircraft in the turn around area at the end of the runway..." The narrative also states; "Markings on the runway show the prop struck multiple times in a low pitch configuration before being feathered"..... None of the witness statements describe the pilot as "extremely nervous". No passenger was wearing a headset or was privy to the radio communications between myself and what turned out to be the incurring aircraft. Unless they were mind readers, they would not have been aware of my concerns, particularly over the normal aircraft noises of a C208. In addition, as an experienced flight instructor with over 2000 hours in the air and having prepared students for more than 30 successful check rides for ratings from Private Pilot to ATP, I would not describe myself as "extremely nervous" in the air. Additionally, the inference that there is a (separate) "turn around area" is intentionally misleading : THIS IS PART OF THE RUNWAY. As for the runway prop markings, the photos I have been provided via the FOIA are very indicative of a feathered prop, as is THE VERY CLEAR SCIMITAR LIKE DEFORMATION of the all the propeller blades. That these photos of the propeller were excluded (or withheld) from the NTSB Report is rather telling.... As for the concept that a pilot might be overly concerned or "distracted" by the presence of another aircraft on the runway, with its' prop turning and pointed in the direction of her landing aircraft, no more than 2000 to 1500 feet away (anywhere between roughly 4 to 10 seconds ahead) is absurd. But attempting to suggest that this is the case speaks volumes about the intent of the narrator.
4. Both the NTSB Final Report and interim Factual Report concerning this accident state in part that "As the pilot descended through 150 feet above ground level she noticed that the airplane she had communicated with had not cleared the runway" This is incorrect and, again, not supported by witness statements or any physical evidence. My handwritten statement, prepared at the scene, clearly states "As I was preparing to transition to land, I noticed an airplane..." This occurred in the "round out" or "flare to land" and NOT AT 150 FEET. Furthermore, in NTSB Investigator Michael Hicks' own "Memorandum For The Record" dated 05-22-2017, he apparently transcribed my entire statement for the file, "...due to the truncated nature of the NTSB form 61210.1". Comparing paragraphs 7 and 8 of that transcription to paragraph 2 of both the NTSB Factual and Final Reports it becomes clear where this mistaken and erroneous altitude reference comes from.(See Attached 17). The only estimate of altitude describing the point where problems

began was in the Jansen letter which referenced 30 feet. Furthermore, the portion of this statement identifying the other aircraft pointing at me on the runway with its' engine running as "...the airplane she had communicated with..." PRESUMES that I knew that this was in fact that same airplane. In that moment, I KNEW NO SUCH THING. In fact, every study I have reviewed in my efforts to understand these events suggests that such a conclusion is far less likely to be quickly realized by the pilot as it is contrary to the information that he or she had recently obtained.. That such an assumption is even in an NTSB accident report, presumably written by an investigatory person of some degree of experience, is indicative of another attempt to get the "facts" to fit the theory provided to the FAA investigators via MKA. I can only assume that this NTSB reporting was based upon faulted FAA conclusions. It is worth remembering that these events unfolded at an uncontrolled and very scenic airport frequented primarily by general aviation flights focused on the natural beauty of the surroundings and surrounded by the Pacific on three sides. In the light wind conditions present on this occasion, it would have been entirely possible for an aircraft to land or take off on the opposite runway.(see statement of incurring pilot who very likely intended to do just that).

5. In addition, the NTSB Aviation Accident Factual Report notes under the heading of Pilot Information that no toxicology was performed. This is factually incorrect, as I submitted to the legally required blood and breath screenings on the day of the accident as required by law. The results were, of course, negative for any alcohol or drugs. This error, posted on a publically available FAA website, has caused rumors to circulate that I had been under the influence of some illegal substance and has damaged my reputation further within the flying community. Further, under the aircraft heading, the report attributes two engines to an aircraft equipped with only one. This is in addition to the above discussed error concerning the altitude at which I detected the incurring aircraft.(see attached 7).
6. These NTSB reports are also of interest for what is not mentioned within them. Neither mentions the pilots attempted "go around" or bothers to describe the nature of the propeller damage, instead only stating in part "The airplane sustained substantial damage to the right side of the fuselage and the right wing" Curiously, this statement is consistent with what one might conclude if looking at the only two photos of the accident aircraft that were attached to the NTSB report.
7. The FAA Accident Report contains the statement "Markings on the runway show the prop struck multiple times in a low pitch configuration before being feathered". Examining all records provided to me via the FOIA requests issued to the multiple agencies and subdivisions therein, I have found no reports or documentation supporting this conclusion. I can only assume that it was made by investigator Howard who signed the report. This is all the more interesting, as the same report indicated that the FAA NEVER RESPONDED TO THE SCENE to conduct their own investigation of this airline accident. Presumably, he reached this conclusion from a review of photos taken by Schuman, the review of which show an interesting change in photographic angles, proximity and number of pictures between alleged low pitch and feathered prop markings.
8. Furthermore, the previously referenced NTSB "Factual" and "Final" reports each state in part "Examination of the accident airplane by Federal Aviation Administration Aviation Safety Inspectors determined that there were no PREIMPACT (capitalization mine) mechanical anomalies that would have prevented normal (flight) operation". Again, I have seen no such supporting evidence of any reports of technical examinations attributed to anyone to support this claim in any fashion through my review of the FOIA obtained material. It is highly instructive on this point to compare this statement to the investigative efforts documented in the accident report associated with investigation IAD01LA048 and the recent joint FAA/NTSB Safety Recommendation Report (see attached 6 and 8) conducted along these same lines of inquiry.
9. The narrative of the assigned FAA investigator's efforts previously cited noted that an interview was conducted of the incurring pilot. Via the FOIA, I received a copy of the written statement he apparently provided to the FAA (attached 18). As noted in other reports, he was, at best, difficult

to understand on the radio. A review of his written statement strongly indicates a lack of familiarity with English. Although a foreign national, he holds a U.S. commercial pilot's license. The standard for holding such a license includes both written and verbal fluency in English. Despite his actions of 3-11-2017 as documented in several witness statements and his own admissions as set out in his poorly written statement, I have been informed by reliable sources that no enforcement action was initiated against his license. I found this surprising considering the extensive documentation of his intentional disregard for runway safety contained in the record and his own disjointed written admissions. I can only assume that other factors unknown to me influenced this lack of action (see MKA/ Schuman press report of 3-13-2017 (see attached 19).

10. A review of FOIA materials provided by the FAA also included a number of e mails passing through or initiated from sources within MKA. Of particular interest is how various witness statements forwarded by Park Rangers, (2) passengers and Kalaupapa Care Home personnel were apparently screened through MKA before being provided to FAA investigators.
11. At no point in the FOIA provided record does investigator Rezzonico document that he complied with the guidance to investigators set forth in FAA Directive N 8900.230 concerning talking to me or obtaining my statements. And using the owner of the very airline he was assigned to oversee as its' P.O.I. is simply a way to circumvent the rules. It seems clear to me that beginning on the accident date, investigator Rezzonico acted in concert with Richard Schuman (see sections 7, 12 and 14 of above, attached 12). While I am certainly no expert on the internal regulations of the FAA or their proper implementation, I think it's pretty clear these were not followed in my instance.

While I recognize my responsibility in inadequately responding to the challenges of these events, I also would point out that my immediate after accident statements were to accept my failure to maintain control of the aircraft and to cooperate with all concerned.

Oddly enough, I eventually did have an occasion to view the movie "Sully" as had been sarcastically recommended to me by Richard Schuman after my accident. Interestingly, I noted that in addition to the actual time expended in maneuvering the aircraft to a safe water landing, the film dramatized a request by the flight crew to the FAA to add 35 seconds to their allotted reaction time in trying to "work the problem".

In light of this, I would point out that my window of opportunity to react to my perceived situation was only a very few seconds and on my own.

I also recall hearing Captain Sullenberger, a high time former USAF fighter pilot, state upon interview that he had practiced this very same ditching maneuver in a simulator many times.

As such, this clearly supports what AOPA is fond of stating: "The most important piece of equipment in an aircraft is a well trained pilot".

I think it is pretty clear that in my situation on March 11th, 2017 I had not been properly trained to deal with a known possible emergency at a location that presented potential pilot challenges personally known to both Mr. Schuman and his DPE Robert Smith.

By way of a certified letter dated April 3, 2017 (see attached 20), I had been notified by the HNL FSDO that I would need to take a 709 check ride in an aircraft of my choice with an "emphasis" in certain commercial pilot standards under 49 U.S.C. 44709. Shortly thereafter, I voluntarily surrendered my pilot's license to the FSDO and received a series of temporary certificates which would allow me to train for the check. During this time, I had repeatedly asked Inspector Howard to allow me to schedule the check ride with any inspector other than Inspector Rezzonico, as I had been told by both Schuman and my attorney that he was intent on failing me. Inspector Howard repeatedly assured me that this request would not be

a problem and stated that he would "post" an internal circulating e mail soliciting a response from other Inspectors.

Over the next few months, the check ride was put off by the FSDO due to inspector scheduling problems and my own difficulties in scheduling an instructor. I had to reapply for extensions of my temporary certificate at 60 days. During the course of my conversations with inspector Howard, I was repeatedly assured that another examiner would still be available. Shortly before extending for 90 days, Inspector Howard advised me that only Inspector Rezzonico would be available through September. Upon hearing my objection he told me that if this was unsatisfactory, I could be put in touch with the FSDO manager. It was at this same point that I also received the Notice of Proposed Suspension of 155 days (dated June 30, 2017). In addition, at this point I began to receive voice mails from Inspector Rezzonico stating that he was calling "to reschedule my check ride" with him.

I therefore contacted the FSDO manager and she graciously agreed to honor my request.

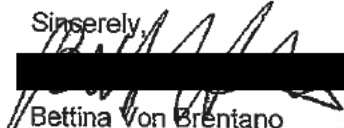
I must also note that I was somewhat bitterly encouraged by personally observing an added emphasis on emergency "go around" training in July of 2017 conducted by DPE Smith with apparent new MKA "hires" (while at nearby Kalaheo Airport preparing for my own FAA required "709" check ride in a rented aircraft). Yet, during that same period, I was in the traffic pattern at Kalaupapa Airport, (where my accident occurred), about to turn base, when I heard DPE Smith announce a straight in approach to runway 5 from several miles out. This essentially ignored generally recommended and accepted standards to give way to traffic already in the pattern, as well as publically announced new MKA policies too always overfly the field at Kalaupapa before landing which were stated by Schuman in the newspaper shortly after the accident. I would also hasten to point out that he had publically criticized me in the same newspaper for not taking such actions, despite my MKA training to forego this action... I transmitted on the air that I would do a "360" for spacing (as I had done on 3-11-2017). Moments later, I heard the same Cessna 172 that had incurred during the accident of 3-11-2017 "check in" on the radio nearby. My instructor, a DPE himself, observed in good humor that "That's great, everybody is here!"

Despite the fact that I passed my "709" and had my licenses returned, of continuing concern to me is that I still have unanswered questions concerning all the forces which affected my loss of control during my reaction to these events.

On a more personal level, my loss of employment and damaged professional reputation were major factors in bringing about my family's relocation to the Mainland, which was both financially challenging and personally difficult for my children.

Even more troubling to me is the question of why a particular FAA investigative report would attempt to focus upon inaccurate, poorly documented and unsupported conclusions regarding the adjustment of a passenger's seat belt in order to color my actions as "careless and reckless", while intentionally deflecting attention away from the more obvious issues at work.

Sincerely,


Bettina Von Brentano



U.S. Department
of Transportation
Federal Aviation
Administration

Office of the Chief Counsel

Enforcement Division
Western Team
1601 Lind Avenue, SW
Renton, WA 98057

U.S. CERTIFIED MAIL – RETURN RECEIPT REQUESTED
and FIRST CLASS MAIL

JUN 30 2017

Bettina Anne Von Brentano

[REDACTED]
Kailua, HI 96734

RE: Bettina Anne Von Brentano, Case No. 2017WP130015

NOTICE OF PROPOSED CERTIFICATE ACTION

Based on the following facts and circumstances, it appears that you violated the regulations of the Federal Aviation Administration:

1. You are now, and at all times mentioned herein were, the holder of Commercial Pilot Certificate No. [REDACTED] and Flight Instructor Certificate No. [REDACTED].
2. At all times referenced herein, Schuman Aviation Company, Ltd. was the holder of Air Carrier Certificate No. MKHA108K, authorizing it to operate as an air carrier under Title 14, Code of Federal Regulations, (14 C.F.R.) part 135.
3. At all times referenced herein, you were employed as a pilot by Schuman Aviation Company, Ltd. d/b/a/ Makani Kai Air Charters (Makani).
4. On or about March 11, 2017, you were the pilot in command of a Cessna 208B aircraft, Civil Registration No. N865MA, on a passenger carrying flight operated by Makani that departed from Honolulu, Hawaii, and terminated in an accident at Kalaupapa Airport on the island of Molokai, Hawaii.
5. On the above occasion, the flight was operating under Part 135 of the Federal Aviation Regulations.
6. Prior to departure, a passenger told you that the shoulder harness for her seat was fully extended and would not retract.
7. You attempted to get the above-referenced shoulder harness to retract.
8. When the shoulder harness failed to retract, you stuffed the excess belt back into the seat cushion.

A-1

9. Stuffing the excess belt back into the seat cushion did not repair the shoulder harness.
10. You did not document the failure of the shoulder harness to retract as a maintenance discrepancy in the aircraft maintenance log.
11. You did not document the corrective action you took or your deferral of actions regarding the failure of the shoulder harness to retract in the aircraft maintenance log.
12. You then departed without having the shoulder harness repaired and with a passenger occupying that seat.
13. Because of the unrepaired shoulder harness with a passenger occupying that seat, N865MA was unairworthy.
14. Your actions described herein were careless or reckless so as to endanger the life or property of another.

As a result, it appears that you violated the following Federal Aviation Regulations:

- a. 14 C.F.R. § 91.7(a), which states that no person may operate a civil aircraft unless it is in an airworthy condition;
- b. 14 C.F.R. § 91.7(b), which states that the pilot in command of a civil aircraft is responsible for determining whether that aircraft is in condition for safe flight. The pilot in command shall discontinue the flight when unairworthy mechanical, electrical, or structural conditions occur;
- c. 14 C.F.R. § 91.13(a), which states that no person may operate an aircraft in a careless or reckless manner so as to endanger the life or property of another; and
- d. 14 C.F.R. § 135.65(b), which states that the pilot in command shall enter or have entered in the aircraft maintenance log each mechanical irregularity that comes to the pilot's attention during flight time. Before each flight, the pilot in command shall, if the pilot does not already know, determine the status of each irregularity entered in the maintenance log at the end of the preceding flight.

Pursuant to the Administrator's authority under 49 U.S.C. § 44709, we propose to suspend your Commercial Pilot Certificate No. [REDACTED] for a period of 155 days.

Unless we receive, in writing, your choice of the alternatives explained in the enclosed Information Sheet within fifteen (15) days of your receipt of this Notice, an Order suspending your certificate, as proposed above, will be issued.

This Notice does NOT suspend your certificate; however, if you wish to make the suspension effective immediately, you must physically surrender your certificate to this office as provided in Option #1 of the enclosed information sheet.

Please direct all communications to: Alexi Fong, FAA, AGC-300, Enforcement Division-Western Team, 1601 Lind Avenue SW, Renton, WA 98057, telephone (425) 227-1417, fax (425) 227-1007, email: alexi.fong@faa.gov.

Naomi Tsuda
Assistant Chief Counsel for Enforcement

By: 
Alexi Fong, Attorney
Enforcement Division, Western Team
1601 Lind Avenue, SW
Renton, WA 98057
Email: alexi.fong@faa.gov
Telephone: (425) 227-2007 (main)
(425) 227-1417 (direct)
(425) 227-1007 (fax)

Enclosures: Information Sheet and Reply Form
14 C.F.R. § 13.19
Access to Information Under the Pilot's Bill of Rights

cc: AWP-230, HNL FSDO

02/02/2010

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Available "on Line" AT FAA.gov

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Accident investigation; 03-11-2017; Kalaupapa, HI. C208B; Schuman Aviation

Wed, Mar 29, 2017 05:16 PM

From :**Subject :** Accident investigation; 03-11-2017; Kalaupapa, HI. C208B; Schuman Aviation**To :** Hicks Michael <michael.hicks@ntsb.gov>

Dear Sir,

During the course of my steps to obtain competent legal counsel in connection with this matter, I have learned the following information which I have been able to independently verify. I believe, taken in total, the information set forth below suggests a pattern of activity indicative of a historical lack of credibility on the part of the operator Schuman Aviation). I therefore respectfully request that the NTSB conduct a technical examination of the accident aircraft power plant/propeller to determine whether any mechanical anomaly contributed to this accident.

1. The NTSB aviation accident final report (WR14FA068) deals with the fatal C-208B accident at Kalaupapa, Hawaii in December 2013. While this report stops short of blaming this accident on a willful failure to comply with known engine maintenance manual and Service Bulletin requirements, it does offer the opinion that the accident may have been preventable by compliance therewith.
2. As noted in NTSB accident report LAX02LA217, a Eurocopter AS 350 (N141MK) was significantly damaged while landing in a tail strike accident near Honolulu. This aircraft was being operated by Richard Schuman under Schuman Aviation's license and the report cites Schuman Aviation was "doing business as Makana Kai". Interestingly, the NTSB report ends with the following notation: "despite numerous attempts by the Safety Board, the pilot and operator failed to submit an NTSB pilot/operator aircraft accident report (form 6120.1/2)."
3. This same helicopter, under N141MK, was again involved in another accident/incident in January 2009, as set forth in WPR09FA072. Once again, it was being operated under Schuman Aviation's license, doing business as "Makana Kai Helicopters"
4. On December 3, 2001 a Bell 206 copter, N986YC, was involved in a work crew/ridgeline pick up accident (LAX02LA039). The NTSB report cites that it was owned by Schuman aviation, doing business as Makana Kai helicopters.
5. A Honolulu Star advertiser article entitled "Company Five Incidents in Past, FAA Records Show", dated 14 December 2013, recites some of the above listed matters, along with two others, and notes in particular "However, Makana Kai claims on its website that neither its airplanes or helicopters have had an accident or incident in the company's more than 20 year history".
6. A review of the Makana Kai Helicopter website notes that this claim has been somewhat modified to now read "we are fortunate to have an unblemished safety record, never having experienced an accident or incident in our four operations."
7. The same website notes company Safety Management System Dir. and chief pilot, Bruce Mayes, "who has a thing about safety" and is "a former Aloha Airlines 737 pilot" has implemented a "robust and viable" "risk analysis and mitigation program". It does not, however, note Mr. Mayes own aviation accident history.

During my own post accident conversations with Richard Schuman which were conducted in his office the day after this event, Mr. Schuman, in the company of myself and Bruce Mayes discouraged me from suggesting that "anything unknown" had contributed to the accident, stating that if I did "NTSB could get involved".

Returning to the issue of legal counsel, through personal contacts with the local "99s" chapter and AOPA, I was able to identify three attorneys (only one which was AOPA certified) who might be experienced in these matters.

As it turned out, two of those three attorneys were "conflicted out", the first because he was on retainer to Schuman Aviation and the second because of extensive prior aviation related business dealings with Mr. Schuman and his own personal preference to "not get crosswise with Richard".

The company's recent acquisition, in 2017, of specialized equipment designed to conduct the above referenced engine inspections, cited as lacking in the events leading up to the December 2013 accident, is more telling in that it suggests that Schuman Aviation only implements changes to its operating practices when they are forced upon them by outside events or interests. This is also borne out by recent actions since the March 11 accident wherein Schuman has amended its piloting practices to now require two pilots in the cockpit during a new pilots first one hundred hours of operational flying which by prior FAA mandate may only occur in VFR conditions (if they have no prior C208B time).

While I have no specific information which might indicate that the technical review of the power plant or propeller components conducted by Schuman employees might be less than trustworthy, nonetheless I believe that the company culture and track record at Schuman Aviation do not suggest that a full and fair analysis is likely.

Ultimately it was just as well that the first attorney we contacted was on retainer to Mr. Schuman, as we learned later that this individual had been previously disbarred in both California and Hawaii after a federal drug-related money laundering conviction. After a 42 month suspension, he somehow received his licenses to practice law (and apparently fly) back.

National Transportation Safety Board
Washington, D.C. 20594



Safety Recommendation Report
Preventing Incorrect Installation of the Beta Arm in
Pratt & Whitney Canada PT6A Engines

Accident Number:	IAD01LA048 and ANC13WA057
Operator/Flight Number:	Multiple
Aircraft and Registration:	Multiple
Location:	Multiple
Date:	Multiple
Adopted:	December 5, 2016

The National Transportation Safety Board (NTSB) is providing the following information to urge the Federal Aviation Administration (FAA) and Pratt & Whitney Canada to take action on the safety recommendations in this letter. These recommendations are intended to prevent the incorrect installation of the reversing lever (beta arm) and related components in PT6A engines, which can cause the propeller to transition uncommanded to feather in flight.¹ They are derived from investigations in which the beta arm or related components were found incorrectly positioned. As a result of these investigations, the NTSB is issuing one safety recommendation each to the FAA and Pratt & Whitney Canada.

Background and Analysis

As a result of a previous NTSB investigation, we became aware of a safety issue concerning the possibility of the reversing lever (beta arm) and related components in PT6A engines being incorrectly positioned.² If the beta arm is not positioned such that it is secured under its guide pin, the unsecured linkage could release oil pressure in the beta valve and cause uncommanded travel of the propeller to the feather position (figure 1 shows exemplar engines with correctly and incorrectly positioned beta arms.)

¹ The beta arm in PT6A engines provides propeller blade angle feedback to the beta valve.

² More information about this accident, NTSB case number ERA15FA129, can be found in the Aviation Accident Database at www.nts.gov.

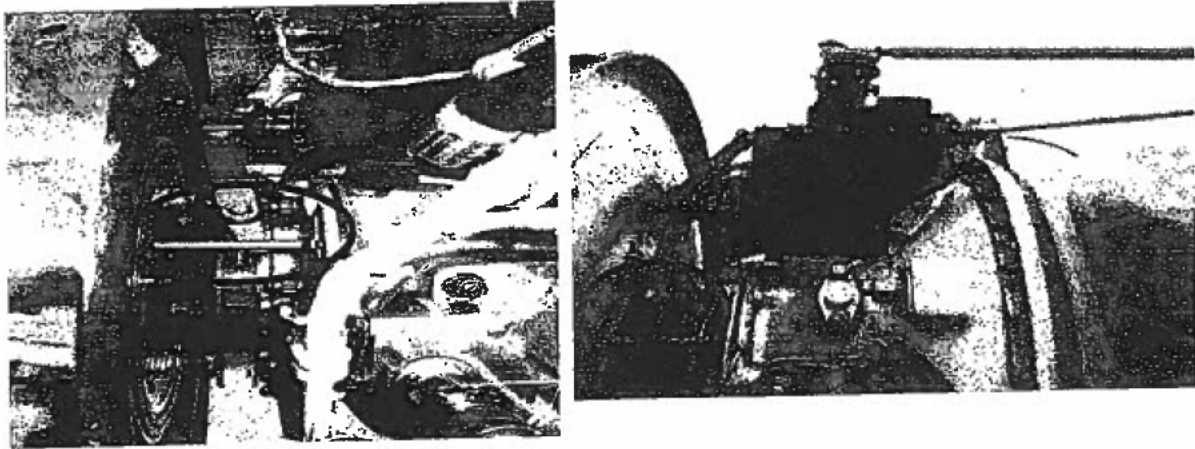


Figure 1. Photographs of exemplar engines showing correct (left) and incorrect orientation (right) of the beta arm

The NTSB notes that the critical beta arm/guide pin connection and orientation are reinstalled any time the propeller is removed from the engine for an engine inspection or propeller replacement. The airplane maintenance manual contains general warnings about improper adjustment of the beta valve but no specific warnings about the beta arm-to-guide pin connection and orientation. Out of concern that this may be a recurring safety issue, the NTSB reviewed other accident investigations in which the incorrect position of the beta arm was found.

The NTSB's review found four events in which the incorrect position of the beta arm in a PT6A engine was noted and that occurred within 100 flight hours after maintenance of the beta arm or related components.³ In a fifth event (NTSB case number ERA15FA297), the investigation found that the guide pin had been installed backward, which allowed the beta arm to be free-floating, that is, neither above nor below the guide pin (figure 2 shows the installation on the engine involved in this accident).⁴ The NTSB is aware that one operator has welded a tab to the top of guide pins to make it physically impossible to incorrectly install the beta arm over the pin but notes that this fix would not prevent an intentional reversal of the guide pin if, for example, a mechanic chose to do so to provide clearance for maintenance work.

³ Two of the events resulted in incidents (FAA ID WP27201402461 and Transportation Safety Board of Canada ID A141A0053), and two resulted in accidents (NTSB case numbers IAD01LA048 and ANC13WA057). Because it pre-dates June 1, 2009, the docket for IAD01LA048 is not available on our website; information in this docket may be obtained by using our [online contact form](#). ANC13WA057 was reported to the NTSB by the Korea Aviation and Railway Accident Investigation Board (ARAIB), which investigated the accident. Additional information about this accident may be obtained by contacting the ARAIB.

⁴ The incorrect orientation of the guide pin did not cause this accident but was cited as a finding in this investigation. More information about this accident, NTSB case number ERA15FA297, can be found in the Aviation Accident Database at www.nts.gov.

A-6 (2)

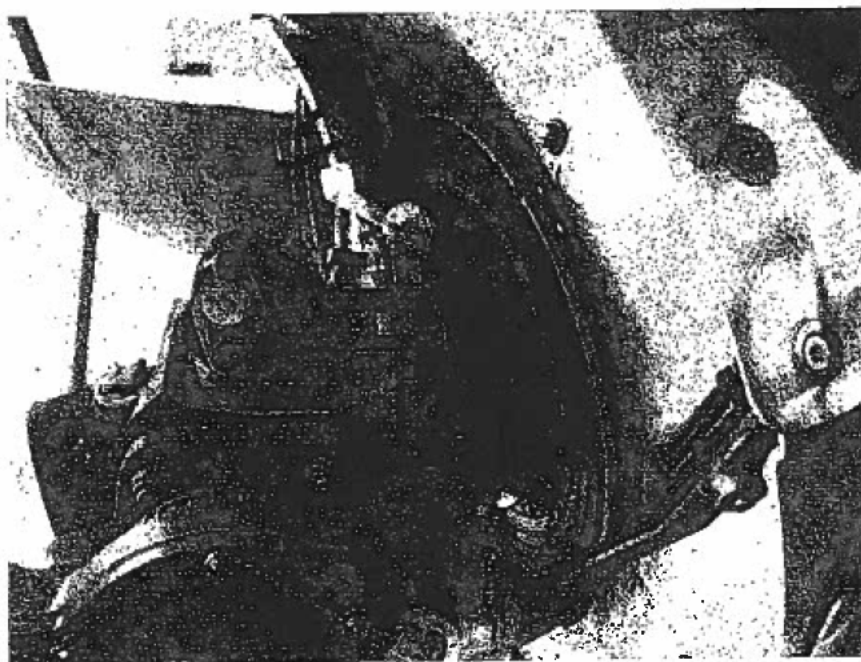


Figure 2. A photograph showing a beta arm guide pin installed incorrectly in the aft direction (the red arrow points forward, indicating the pin's correct orientation).

Depending on airplane make and model, warnings about this issue in aircraft maintenance manuals vary, ranging from a general warning about the hazards of a misadjusted beta valve assembly to no warning at all. In March 2016, Pratt & Whitney Canada issued Service Letter PT6A-239R1, "Reversing lever guide pin bracket assembly," to alert operators about the hazards of incorrectly installing the propeller beta arm. The company also revised its engine maintenance and overhaul manuals and started efforts to redesign the guide pin. However, there is no set date to complete the redesign and implementation of the new guide pin.

The NTSB is concerned that any propeller on any PT6A engine that has undergone improper maintenance to the beta valve assembly can travel uncommanded to the feather position during any phase of flight. Due to the critical function of this assembly, the NTSB believes that short- and long-term action should be taken to address this safety issue. Although Pratt & Whitney Canada has revised its engine maintenance and overhaul manuals, the NTSB believes that the design of this assembly needs to be revised to minimize the possibility of human error during maintenance. *

Because the beta arm-to-guide pin connection and orientation are clearly visible between the front of the engine and the rear of its propeller spinner, minimal additional effort would be necessary to visually verify that the beta arm is positioned correctly. Therefore, the NTSB recommends as a short-term mitigation that the FAA issue a special airworthiness information bulletin that directs maintenance personnel, during routine scheduled inspections of and after propeller installation on Pratt & Whitney model PT6A engines, to visually verify that the propeller beta arm and guide pin are correctly installed and, if necessary, to fix any improper installations. Such an action would not only detect errors during inspections but also heighten awareness in the



National Transportation Safety Board Aviation Accident Final Report



Location:	Plattsburgh, NY	Accident Number:	IAD01LA048
Date & Time:	04/26/2001, 1945 EDT	Registration:	N974FE
Aircraft:	Cessna 208B	Aircraft Damage:	Substantial
Defining Event:		Injuries:	1 None
Flight Conducted Under:	Part 135: Air Taxi & Commuter - Non-scheduled		

Analysis

The pilot said the preflight, engine start, run-up, taxi and takeoff were "normal". The pilot said that during the climb after takeoff, approximately 1,000 to 1,500 feet above the ground, the airplane's engine "spooled down, slowly and smoothly, like a loss of torque or the propeller going to feather." The pilot performed a forced landing to a field, where the airplane nosed over, and came to rest inverted. Examination of the engine and propeller revealed that the propeller-reversing lever was installed on the wrong side of the reversing lever guide pin, and that the reversing linkage carbon block was no longer installed, and had departed the airplane. Examination of the airplane's maintenance records revealed that the carbon block was replaced during a 100-hour maintenance inspection, 5 hours prior to the accident. Installation of the reversing lever on the incorrect side of the guide pin resulted in improper seating and premature wear of the carbon block. According to the engine manufacturer, any disconnection in operation of the propeller control linkage will cause the propeller governor beta control valve to extend, and drive the propeller into feather.

Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be: The incorrect installation of the propeller reversing lever and carbon block assembly, which resulted in a loss of propeller thrust.

Findings

Occurrence #1: LOSS OF ENGINE POWER
Phase of Operation: CLIMB - TO CRUISE

Findings

1. (C) PROPELLER GOVERNOR CONTROL, LINKAGE - DISCONNECTED
 2. (C) MAINTENANCE, INSTALLATION - INCORRECT - COMPANY MAINTENANCE PERSONNEL
 3. (C) PROPELLER FEATHERING - UNCONTROLLED - PILOT IN COMMAND
-

Occurrence #2: FORCED LANDING
Phase of Operation: DESCENT - EMERGENCY

Occurrence #3: IN FLIGHT COLLISION WITH TERRAIN/WATER
Phase of Operation: EMERGENCY DESCENT/LANDING

Findings

4. TERRAIN CONDITION - OPEN FIELD

Factual Information

On April 26, 2001, at 1945 eastern daylight time, a Cessna 208B, N974FE, was substantially damaged from collision with terrain during a forced landing in Plattsburgh, New York. The airplane was operated as Wiggins Airways flight 7417, doing business as Federal Express. The certificated airline transport pilot was not injured. Visual meteorological conditions prevailed for the flight that originated at the Plattsburgh International Airport (PLB), destined for Albany, New York. An instrument flight rules flight plan was filed for the cargo flight conducted under 14 CFR Part 135.

The pilot provided both a telephone interview and a written statement. During the telephone interview, the pilot said the flight was a scheduled cargo flight for Federal Express. He said the preflight, engine start, run-up, taxi and takeoff were "normal". The pilot said that during the climb after takeoff, approximately 1,000 to 1,500 feet above the ground, the airplane's engine "spooled down, slowly and smoothly, like a loss of torque or the propeller going to feather."

In a written statement, the pilot said:

"Shortly after takeoff, the engine spooled down smoothly and gradually (there was definitely no catastrophic or sudden failure, such as turbine disintegration or bearing failure). I perceived the event as a loss of torque but it might have been propeller blades going to feather. I'm afraid I cannot recall the altitude at which this occurred, but I estimate it was about 1000 to 1500 feet AGL.

"[I] checked fuel selector positions (both on), checked fuel quantity indicators (650 lbs. apiece), checked all power lever positions (throttle at take-off power, prop fwd, condition lever hi), and put the ignition switch "on" (or determined that it was still on from takeoff, I'm not sure which). I made a radio call to [Air Traffic Control] reporting the power failure.

"The controller pointed out the old airbase to my left and PLB at 6 o'clock. I replied that I would not be able to reach either of those and he said that he would notify emergency personnel. I pulled the emergency power lever out of detent and moved it forward gradually to the full forward position, and did not detect any change in engine operation or sound.

"...Up to the time when I decided to try the emergency power lever, there were no warning lights shining on the annunciator panel. At this point, with very little time left for planning the forced landing, I considered the forced landing inevitable and made no further attempts to restore power. I moved the prop control to feather for better glide, and to my surprise did not feel any response to that action."

The pilot said that he assumed the propeller had not feathered, and that an unfeathered prop would provide aerodynamic braking, and a steeper approach angle. Instead, the pilot said the airplane glided "very well and efficiently" and it caused him to over fly his intended point of touchdown. He said, "I crossed the field with lots of speed and ran out of room. I touched down and flipped over."

The airplane wreckage was examined at the site on April 27, 2001, by Federal Aviation Administration (FAA) safety inspectors. In a telephone interview, the operations inspector said the airplane came to rest inverted, and the engine was displaced approximately 70 degrees out of alignment.

The inspector said that a review of weight and balance information revealed an accurate

depiction of what was loaded on the airplane, and that the airplane had been loaded within limits.

The engine and propeller were removed from the airplane and transported to Burlington, Vermont, for further examination. The airframe was transported to the Plattsburgh International Airport.

The ~~Power Analyzer Recorder System~~ (PARS) computer was removed, and the data was retrieved under the supervision of the FAA primary maintenance inspector (PMI) for Wiggins Airways. Examination of the data revealed that during the most recent takeoff and initial climb, the engine exceeded its torque limit of 1,980 foot-pounds for 99 seconds. The peak torque value over that duration was 2,649 foot-pounds.

On April 30, 2001, a representative of Pratt and Whitney Aircraft under the supervision of the FAA primary maintenance inspector examined the engine and propeller and provided a written report. According to the report:

"The engine had been removed from the airframe by sectioning and mechanical disassembly at the airframe firewall. The external cowling had been removed with the exception of the nose bowl. The other items, including the propeller, exhaust duct, inlet shrouding, and engine mount structure, remained attached. The engine was laying inverted on a flat-bed trailer.

"The propeller blades are in the feather position, with uniform deformation away from the direction of rotation.

"The engine housings display no apparent deformation. The engine related controls and accessories are in place and intact. All external lines and connections were intact except as were sectioned or disassembled for removal of the airframe. The engine pneumatic lines, P3 and P4 were in place and intact, with all accessible connections intact and lockwired.

"The forward power control linkage propeller reversing linkage carbon block assembly was not in place. The propeller-reversing lever was riding on the left hand side of the guide pin. The guide pin and lever displayed axial rub marks and polishing on the as-discovered contact faces. The normal as-installed contact faces displayed indications of previous contact, but the faces appeared oxidized and dirty. Inspection access was severely limited due to the nose bowl and prop spinner being in place.

"As discussed yesterday, any disconnection in operation of the forward power control linkage will cause the propeller governor beta control valve to extend, driving the propeller into feather. The propeller deformation is characteristic of the propeller being at feather at the time of impact, being driven by the gas generator with torque being absorbed during the ground contact."

The forward power control linkage propeller reversing linkage carbon block assembly was not recovered.

The engine was examined at the Pratt and Whitney Canada Service Investigation Facility in St. Hubert, Quebec, Canada, on May 29-30, 2001, under the supervision of the Transportation Safety Board (TSB) of Canada. Other than the propeller-reversing lever installed on the left side of the guide pin, which was opposite the prescribed right-side position, examination of the engine revealed no mechanical anomalies.

Functional testing of the propeller governor revealed no mechanical anomalies.

 The pilot reported the airplane was returned to service on April 23, 2001, after a 100-hour maintenance inspection. He said the airplane logbooks reflected a satisfactory inspection with no discrepancies carried over. The pilot said the airplane had accrued 5 hours of flight time since that date. According to the pilot:

"The plane seemed 100 percent fine to me up until the loss of engine power."

In a written statement, the mechanic who performed the 100-hour inspection described the replacement of the reversing lever carbon block assembly. According to the mechanic:

"The new block was installed to the arm and the retaining snap ring was seated and snug in its groove. During installation of the arm I had to reach down to the block to guide the block onto the channel because it had turned on the first attempt.

"The block was still a slip, but no daylight could be seen between the block and channel. The beta arm was positioned underneath the retaining bar. The center pin was installed with washer and cotter pin. The bolt opposite end of the block was installed with a nut and cotter pin."

During the engine exam at the Pratt and Whitney facility, the TSB investigator supervised the installation of a carbon block assembly on a factory training aid. The reversing lever was installed correctly and incorrectly, in relation to the guide pin. According to the TSB investigator, the incorrect installation "...was not difficult to achieve."

According to Pratt and Whitney, installation of the reversing lever on the incorrect side of the guide pin resulted in improper seating and premature wear of the carbon block.

The pilot reported 9,144 hours of flight experience, 137 hours of which were in the Cessna 208B. The pilot said all of his experience in the 208B was in the 90 days prior to the accident.

At 1953, the weather reported at Plattsburgh, New York was clear skies with winds from 250 degrees at 3 knots.

A-8 (5)

IAD01LA048

100 (5)

Pilot Information

Certificate:	Airline Transport	Age:	46, Male
Airplane Rating(s):	Multi-engine Land; Single-engine Land; Single-engine Sea	Seat Occupied:	Left
Other Aircraft Rating(s):	None	Restraint Used:	Seatbelt, Shoulder harness
Instrument Rating(s):	Airplane	Second Pilot Present:	No
Instructor Rating(s):	Airplane Multi-engine; Airplane Single-engine; Instrument Airplane	Toxicology Performed:	No
Medical Certification:	Class 2 Valid Medical--w/ waivers/lim.	Last Medical Exam:	12/14/2000
Occupational Pilot:		Last Flight Review or Equivalent:	02/07/2001
Flight Time:	9144 hours (Total, all aircraft), 137 hours (Total, this make and model), 9144 hours (Pilot In Command, all aircraft), 137 hours (Last 90 days, all aircraft), 48 hours (Last 30 days, all aircraft), 2 hours (Last 24 hours, all aircraft)		

Aircraft and Owner/Operator Information

Aircraft Manufacturer:	Cessna	Registration:	N974FE
Model/Series:	208B	Aircraft Category:	Airplane
Year of Manufacture:		Amateur Built:	No
Airworthiness Certificate:	Normal; Utility	Serial Number:	099
Landing Gear Type:	Tricycle	Seats:	2
Date/Type of Last Inspection:	04/24/2001, 100 Hour	Certified Max Gross Wt.:	8750 lbs
Time Since Last Inspection:	5 Hours	Engines:	1 Turbo Prop
Airframe Total Time:	5993 Hours	Engine Manufacturer:	P&W Canada
ELT:	Installed, activated, did not aid in locating accident	Engine Model/Series:	PT6114
Registered Owner:	Federal Express Corporation	Rated Power:	600 hp
Operator:	Wiggins Airways	Air Carrier Operating Certificate:	On-demand Air Taxi (135)
Operator Does Business As:	Federal Express	Operator Designator Code:	



National Transportation Safety Board Aviation Accident Factual Report

Location:	Kalaupapa, HI	Accident Number:	GAA17CA191
Date & Time:	03/11/2017, 0830 HST	Registration:	N865MA
Aircraft:	CESSNA 208	Aircraft Damage:	Substantial
Defining Event:	Loss of control in flight	Injuries:	2 Minor, 7 None
Flight Conducted Under:	Part 135: Air Taxi & Commuter - Non-scheduled		

The pilot of the commuter airplane reported that she was going to establish an approach and landing to runway 05 at an airport with a single runway and no taxiways. While on a seven-mile final, she communicated with the pilot of an airplane that was on short final for the same airport. The pilot that was on short final reported that he would report when he was clear of the runway, and he did. The commuter pilot acknowledged the other pilot's clear of runway transmission, and initiated the approach.

much lower
As the pilot descended through 150 feet above ground level, she noticed that the airplane that she had communicated with was not clear of the runway. The airplane on the ground was near the runway 23 numbers with the propeller turning, facing toward her landing airplane. She aborted the landing but the airplane did not climb. The airplane impacted the runway hard and bounced. She reported that when the airplane touched down after the bounce, she "applied left rudder pedal to steer the aircraft off the runway and out of the way of the other aircraft's possible flight path." The airplane exited the left side of the runway and ground-looped to the left. The airplane sustained substantial damage to the right side of the fuselage and the right wing. *no mention of prop/powerplant?*

After the ground-loop, the pilot of the airplane near the runway 23 numbers attempted to takeoff. He was contacted via radio transmission by the airport manager and vehemently told that the runway was closed until further notice. *not clear*

Examination of the accident airplane by Federal Aviation Administration, Aviation Safety Inspectors, determined that there were no preimpact mechanical anomalies that would have prevented normal flight operation. *where & when*

*NTSB AT
photos saved
on laptop*

Pilot Information

Certificate:	Flight Instructor; Commercial	Age:	49, Female
Airplane Rating(s):	Multi-engine Land; Single-engine Land	Seat Occupied:	Left
Other Aircraft Rating(s):	None	Restraint Used:	
Instrument Rating(s):	Airplane	Second Pilot Present:	No
Instructor Rating(s):	Airplane Multi-engine; Airplane Single-engine; Instrument Airplane	Toxicology Performed:	No <i>Wrong</i>
Medical Certification:	Class 1 With Waivers/Limitations	Last Medical Exam:	02/17/2017
Occupational Pilot:	Yes	Last Flight Review or Equivalent:	02/28/2017
Flight Time:	(Estimated) 2002 hours (Total, all aircraft), 31 hours (Total, this make and model), 1674 hours (Pilot In Command, all aircraft), 44 hours (Last 90 days, all aircraft), 24 hours (Last 30 days, all aircraft), 4 hours (Last 24 hours, all aircraft)		

Aircraft and Owner/Operator Information

Aircraft Manufacturer:	CESSNA	Registration:	N865MA
Model/Series:	208	Aircraft Category:	Airplane
Year of Manufacture:	2002	Amateur Built:	No
Airworthiness Certificate:	Commuter; Normal	Serial Number:	208B0996
Landing Gear Type:	Tricycle	Seats:	10
Date/Type of Last Inspection:	Unknown	Certified Max Gross Wt.:	8750 lbs
Time Since Last Inspection:		Engines:	2 Turbo Prop <i>Wrong</i>
Airframe Total Time:		Engine Manufacturer:	P&W
ELT:	Installed, not activated	Engine Model/Series:	PT6A SER
Registered Owner:	SCHUMAN AVIATION CO. LTD	Rated Power:	675 hp
Operator:	SCHUMAN AVIATION CO. LTD	Air Carrier Operating Certificate:	Commercial Air Tour (136); Commuter Air Carrier (135); On-demand Air Taxi (135)
Operator Does Business As:	Makana Kai Air	Operator Designator Code:	KDS

A-7 (2)

Meteorological Information and Flight Plan

Conditions at Accident Site:	Visual Conditions:	Condition of Light:	Day
Observation Facility, Elevation:	PHMK, 443 ft msl	Observation Time:	0154 UTC
Distance from Accident Site:	8 Nautical Miles	Direction from Accident Site:	244°
Lowest Cloud Condition:	Scattered / 2600 ft agl	Temperature/Dew Point:	27° C / 21° C
Lowest Ceiling:		Visibility	10 Miles
Wind Speed/Gusts, Direction:	6 knots, 200°	Visibility (RVR):	
Altimeter Setting:	29.99 inches Hg	Visibility (RVV):	
Precipitation and Obscuration:	No Obscuration; No Precipitation		
Departure Point:	Honolulu, HI (PHNL)	Type of Flight Plan Filed:	None
Destination:	Kalaupapa, HI (PHLU)	Type of Clearance:	VFR
Departure Time:	0800 HST	Type of Airspace:	Class G

Airport Information

Airport:	KALAUPAPA (LUP)	Runway Surface Type:	Asphalt
Airport Elevation:	23 ft	Runway Surface Condition:	Dry
Runway Used:	05	IFR Approach:	None
Runway Length/Width:	2700 ft / 75 ft	VFR Approach/Landing:	Go Around; Traffic Pattern

Wreckage and Impact Information

Crew Injuries:	1 Minor	Aircraft Damage:	Substantial
Passenger Injuries:	1 Minor, 7 None	Aircraft Fire:	None
Ground Injuries:	N/A	Aircraft Explosion:	None
Total Injuries:	2 Minor, 7 None	Latitude, Longitude:	21.211111, -156.973611 (est)

Administrative Information

Investigator In Charge (IIC): Michael A Hicks

Additional Participating Persons: Christopher Howard; FAA; Honolulu, HI
Gino D Rezzonico; FAA; Honolulu, HI

Note:

This accident report documents the factual circumstances of this accident as described to the NTSB.

Investigation Docket:

<http://dms.nts.gov/pubdms/search/dockList.cfm?mKey=94884>

A-7(3)



National Transportation Safety Board Aviation Accident Final Report

Location:	Kalaupapa, HI	Accident Number:	GAA17CA191
Date & Time:	03/11/2017, 0830 HST	Registration:	N865MA
Aircraft:	CESSNA 208	Aircraft Damage:	Substantial
Defining Event:	Loss of control in flight	Injuries:	2 Minor, 7 None
Flight Conducted Under:	Part 135: Air Taxi & Commuter - Non-scheduled		

Analysis

The pilot of the commuter airplane reported that she was going to establish an approach and landing on runway 05 at an airport with a single runway and no taxiways. While on a 7-mile final, she communicated with the pilot of an airplane that was on short final for the same airport. The pilot that was on short final reported that he would report when he was clear of the runway, and he did. The commuter pilot acknowledged the other pilot's clear-of-runway transmission and initiated the approach.

As the pilot descended through 150 ft above ground level, she noticed that the airplane that she had communicated with was not clear of the runway. The airplane on the ground was near the runway 23 numbers with the propeller turning facing toward her landing airplane. She aborted the landing, but the airplane did not climb. The airplane impacted the runway hard and bounced. She reported that, when the airplane touched down after the bounce, she "applied left rudder pedal to steer the aircraft off the runway and out of the way of the other aircraft's possible flight path." The airplane exited the left side of the runway and ground-looped to the left. The airplane sustained substantial damage to the right side of the fuselage and the right wing. *NO mention of GO A/R or damage to prop/pump/rudder*

After the groundloop, the pilot of the airplane near the runway 23 numbers attempted to take off. He was contacted via radio transmission by the airport manager and told that the runway was closed until further notice.

Examination of the accident airplane by Federal Aviation Administration Aviation Safety Inspectors determined that there were no preimpact mechanical anomalies with the airplane that would have prevented normal operation.

Probable Cause and Findings

Changed to Normal Flight operation

CRITICAL

where where of by whom?

The National Transportation Safety Board determines the probable cause(s) of this accident to be:

The pilot's loss of directional control during the aborted landing, which she conducted due to another airplane, whose pilot had reported being clear of the runway, still being on the runway, and resulted in a hard landing and ground loop.

NO MENTION OF ATTEMPTED GO AROUND

Another AIRCRAFT, turned, pointing Down Runway toward us,
ENGINE RUNNING OF UNKNOWN ORIGIN

Findings

Aircraft

Directional control - Not attained/maintained (Cause)

Climb capability - Capability exceeded

Personnel issues

Aircraft control - Pilot (Cause)

Environmental issues

Aircraft - Effect on operation (Cause)

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Factual Information

History of Flight

Approach-VFR pattern final	Attempted remediation/recovery
Approach-VFR go-around	Loss of control in flight (Defining event)
Landing	Collision with terr/obj (non-CFIT)

Pilot Information

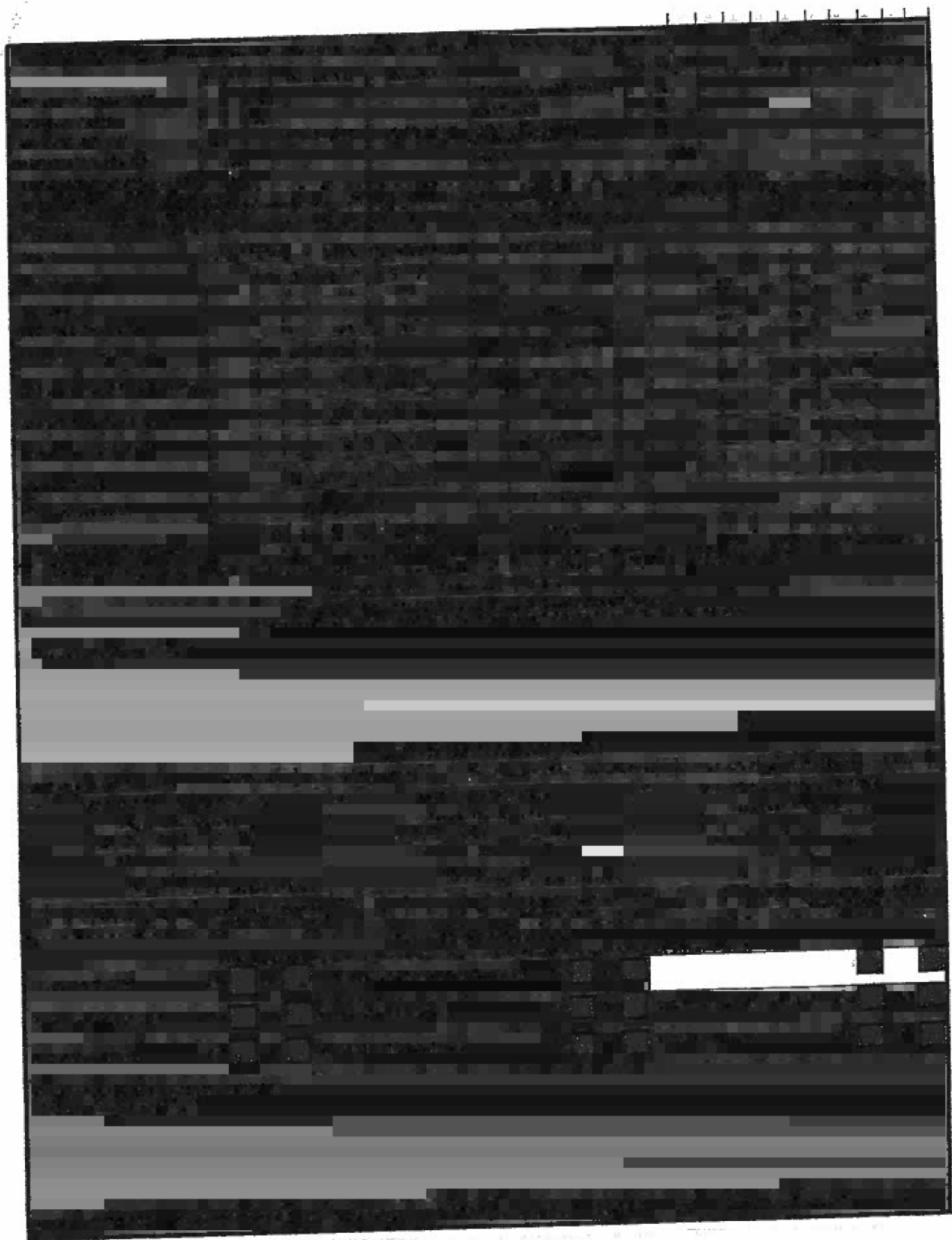
Certificate:	Flight Instructor; Commercial	Age:	49, Female
Airplane Rating(s):	Multi-engine Land; Single-engine Land	Seat Occupied:	Left
Other Aircraft Rating(s):	None	Restraint Used:	
Instrument Rating(s):	Airplane	Second Pilot Present:	No
Instructor Rating(s):	Airplane Multi-engine; Airplane Single-engine; Instrument Airplane	Toxicology Performed:	No ?
Medical Certification:	Class 1 With Waivers/Limitations	Last Medical Exam:	02/17/2017
Occupational Pilot:	Yes	Last Flight Review or Equivalent:	02/28/2017
Flight Time:	(Estimated) 2002 hours (Total, all aircraft), 31 hours (Total, this make and model), 1674 hours (Pilot In Command, all aircraft), 44 hours (Last 90 days, all aircraft), 24 hours (Last 30 days, all aircraft), 4 hours (Last 24 hours, all aircraft)		

Aircraft and Owner/Operator Information

Aircraft Manufacturer:	CESSNA	Registration:	N865MA
Model/Series:	208	Aircraft Category:	Airplane
Year of Manufacture:	2002	Amateur Built:	No
Airworthiness Certificate:	Commuter; Normal	Serial Number:	20880996
Landing Gear Type:	Tricycle	Seats:	10
Date/Type of Last Inspection:	Unknown	Certified Max Gross Wt.:	8750 lbs
Time Since Last Inspection:		Engines:	2 Turbo Prop ?
Airframe Total Time:		Engine Manufacturer:	P&W
ELT:	Installed, not activated	Engine Model/Series:	PT6A SER
Registered Owner:	SCHUMAN AVIATION CO. LTD	Rated Power:	675 hp
Operator:	SCHUMAN AVIATION CO. LTD	Air Carrier Operating Certificate:	Commercial Air Tour (136); Commuter Air Carrier (135); On-demand Air Taxi (135)
Operator Does Business As:	Makana Kai Air	Operator Designator Code:	KDS

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FAA ACCIDENT / INCIDENT REPORT				A W P 1 3 1 7 76 10			
1. ACCIDENT ☒ INCIDENT ☐				2. AMENDED DATE MO ☐ DA ☐ YR ☐			
3. DATE OF EVENT MO ☐ 03 DA ☐ 11 YR ☐ 17				14. FAR PART NUMBER			
4. FAA OFFICE W P 13 REGION OFFICE NUMBER				15A. TYPE OF AIRCRAFT			
5. NTSB ID G A A 1 7 C A 1 9 1				16. POWER PLANT MAKE/MODEL SERIES			
6. LOCATION: CITY/STATE/ZIP KALAUPAPA HI 96742				17. PROPELLER MAKE/MODEL SERIES			
7. OPERATOR NAME SCHUMAN AVIATION FOUR LETTER IDENTIFIER M K H A				18. BIOHAZARD AREA YES ☐ NO ☒			
8. AIRPORT KALAUPAPA (IF APPLICABLE) J-OR 4-LETTER ID P H L U				19. TYPE OF LANDING GEAR			
9. LOCAL TIME 34-HOUR CLOCK 0910				20. INJURY/ON-BOARD SUMMARY			
10A. LATITUDE 21 12 37 N 10B. LONGITUDE 156 58 30 W				21. FACTORS - IDENTIFY PRIMARY FACTOR AS A. IDENTIFY SECONDARY FACTORS, IF ANY, AS X.			
11. AIRCRAFT DAMAGE ☐ NONE ☐ MINOR ☐ SUBSTANTIAL ☒ DESTROYED				22. TYPE OF OPERATIONS			
12. COLLISION - BETWEEN TWO AIRCRAFT ☒ YES ☐ NO ☐ AIR GROUND				23. WX BRIEFING SOURCE			
13. AIRCRAFT REGISTRATION NUMBER N865MA YEAR OF MANUFACTURE 2002				24. PRECIPITATION			
MAKE/MODEL CESSNA 208B TOTAL AIRFRAME HRS 7824				25. WEATHER FACTORS			
SERIAL NO. 208B0996 AIRFRAME CYCLES				26. ACTUAL WEATHER			
21A. TECHNICAL FACTORS				21B. OPERATIONAL FACTORS			
X GEAR COLLAPSE				A FUEL DEPLETION			
GEAR UP LANDING				PILOT INDUCED ERROR			
FIRE OR EXPLOSION				GROUND CREW ERROR			
FUEL CONTAMINATION				OTHER THAN PILOT			
BLADE PROPELLER FAILURE				PARACHUTE INCIDENT			
DESIGN OF AIRCRAFT				OVER GROSS WEIGHT			
METAL FATIGUE				CG OUT OF LIMITS			
IMPROPER MAINTENANCE				STRUCK ANIMAL			
IMPROPER INSTALLATION				BIRD STRIKE			
AD NON-COMPLIANCE				PAX DISTURBANCE			
DECOMPRESSION				STOLEN AIRCRAFT			
FIRE AFTER LANDING				HIJACK AIRCRAFT			
SYSTEM FAILURE							
RADIO/COMMUNICATION							
21F. JASC CODE				21G. PART NUMBER			
21D. MANUFACTURER				21H. PART NUMBER			
23. WX BRIEFING SOURCE				24. PRECIPITATION			
X NOT APPLICABLE/NOT AVAILABLE				X NOT APPLICABLE/NOT AVAILABLE			
NATIONAL WEATHER SERVICE				RAIN			
FLIGHT SERVICE STATION				HAIL			
COMMERCIAL WX SERVICE				SLEET			
PATWAS				SNOW			
VOICE RESP. SYSTEM				FREEZING DRIZZLE			
COMPANY				FREEZING RAIN			
MILITARY				DRIZZLE			
PIREP				OTHER			
OTHER							
25. WEATHER FACTORS				26. ACTUAL WEATHER			
X NONE / NOT APPLICABLE				IMC ☐ VMC ☒ NOT AVAILABLE ☐			
HAZE				27. RUNWAY CONDITIONS			
DUST				TIME REPORTED			
SMOKE				NOT APPLICABLE ☒			
FOG				DRY ☐ WET ☐ SLUSH ☐ SNOW (WET) ☐ SNOW (DRY) ☐			
BLOWING DUST				ICE (COVERED) ☐ ICE (PATCHES) ☐ STANDING WATER ☐			
BLOWING SMOKE				OTHER ☐			
ICING CONDITIONS							
GUSTY WINDS							
THUNDERSTORM							
CROSSWIND							
TURBULENCE/WINDSTORM							
DENSITY ALTITUDE							
LIGHTNING STRIKE							
BLOWING SNOW							
WHITE OUT				SMOG			
WIND SHEAR				SANDSTORM			
OTHER							



16. POWER PLANT MAKE/MODEL/SERIES

P&W PT6A SER PCE-PC1128

17. PROPELLER MAKE/MODEL/SERIES

SANTA MONICA 3GFR34C703-B N/A

33. NARRATIVE

N865MA DEPARTED HONOLULU INTERNATIONAL AIRPORT FOR KALAUPAPA AIRPORT (PHLU). UPON ARRIVING AT PHLU, THE PILOT PERFORMED A 360 DEGREE TURN FOR SPACING PURPOSE IN RESPONSE TO ANOTHER AIRCRAFT REPORTED ON THE FIELD. THE PILOT WAS CONCERNED THAT THE OTHER AIRCRAFT HAD NOT CLEARED THE RUNWAY. UPON RECEIVING CONFIRMATION FROM THE OTHER AIRCRAFT THAT IT WAS CLEAR OF THE RUNWAY, N865MA ENTERED AN EXTENDED FINAL FOR LANDING. PASSENGERS REPORTED THE PILOT APPEARED OVERLY CONCERNED WITH THE LOCATION OF THE OTHER AIRCRAFT.

PASSENGER VIDEO SHOWS THE APPROACH TO LANDING APPEARED NORMAL UNTIL SHORT FINAL, AT WHICH TIME THE AIRCRAFT SUNK RAPIDLY AND VIOLENTLY IMPACTED THE RUNWAY. PASSENGERS REPORTED THE AIRCRAFT THEN BOUNCED AND BRIEFLY BECAME AIRBORNE, STRUCK THE RUNWAY A SECOND TIME, AND BEGAN SLIPPING AND ROLLING SIDE TO SIDE BEFORE COMING TO REST JUST OFF TO THE SIDE OF THE RUNWAY, FACING 180 DEGREES OPPOSITE THE LANDING DIRECTION. INVESTIGATION INDICATES THAT AFTER THE AIRCRAFT TOUCHED DOWN FOR A SECOND TIME, THE NOSE GEAR COLLAPSED. BOTH WING IMPACTED THE GROUND AT SOME POINT WHICH IS INDICATED BY THE UPWARD BEND OF EACH WINGTIP. MARKINGS ON THE RUNWAY SHOW THE PROP STRUCK MULTIPLE TIMES IN A LOW PITCH CONFIGURATION BEFORE BEING FEATHERED.

THE EVACUATION OF THE AIRCRAFT WAS INITIATED AND PERFORMED BY PASSENGERS WITHOUT THE ASSISTANCE OF THE PILOT WHO REMAINED SEATED THE ENTIRE TIME. AS A RESULT OF THE HARD LANDING, ONE PASSENGER SUFFERED MINOR CUTS AND BRUISES. TWO OTHER PASSENGERS REPORTED SORENESS AND BACK PAIN SEVERAL DAYS LATER.

43. BRIEF EXPLANATION OF ISSUES INVOLVED

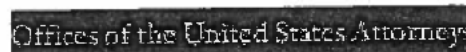
~~SOME PASSENGERS~~ STATED THE PILOT MENTIONED IT WAS ONLY HER THIRD FLIGHT AS PIC AND SEEMED TO BE ~~EXTREMELY~~ NERVOUS AND DID NOT INSTILL A SENSE OF CONFIDENCE IN THE PASSENGERS. ON SHORT FINAL THE PILOT APPEARED TO LOSE CONTROL OF THE AIRCRAFT JUST PRIOR TO TOUCHDOWN AS THE AIRCRAFT SUNK RAPIDLY TO THE RUNWAY IN A NOSE-HIGH FLARE ATTITUDE (AS SHOWN ON PASSENGER VIDEO).

BLOCK 42, ITEM 4: THE PILOT APPEARED TO BE DISTRACTED BY THE AIRCRAFT IN

Appendix

Report Number : AWP1317010

THE TURN-AROUND AREA AT THE END OF THE RUNWAY AND FAILED TO MAINTAIN
CONTROL OF THE AIRCRAFT RESULTING IN A CRASH LANDING.



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908. Elements of 18 U.S.C. § 1001

Section 1001's statutory terms are violated if someone:

1. "falsifies, conceals or covers up by any trick, scheme or device a material fact,"
2. "makes any false, fictitious or fraudulent statements or representations,"
3. "makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry"
4. and, for cases arising after the 1996 amendments, the item at issue was material.

Whether the above acts are criminal depends on whether there is an affirmative response to each of the following questions:

1. Was the act or statement material?
2. Was the act within the jurisdiction of a department or agency of the United States? and
3. Was the act done knowingly and willfully?

[cited in [USAM 9-42.001](#)]

[907. Statements Warranting Prosecution](#)

[UP](#)

[909. False Statement](#)

- (2) Issues periodic notices (electronically or by hard copy) to managers regarding their responsibilities to remind employees about the standards of conduct and their responsibilities for maintaining high standards of ethical conduct to comply with the requirements of this policy.
- (3) Provides advice, guidance and counsel (primarily through the Office of Labor and Employee Relations (LER), Headquarters (HQ) and Regional Operations offices) to managers in the administration of employee relations programs.

c. FAA Managers:

- (1) In addition to the responsibilities described in paragraphs 6 and 7 below, managers, after consulting with their servicing LER Headquarters (HQ) or Regional Operations office, apply the FAA's conduct and discipline program to employees under their supervision.
- (2) Provide positive leadership and serve as role models for their subordinates by demonstrating a commitment and sense of responsibility to their job and compliance with this policy.
- (3) Remind employees (at least on an annual basis) of their obligation to review and comply with the standards of conduct addressed in this policy including, as appropriate, the Standards of Ethical Conduct for Executive Branch Employees, 5 CFR Part 2635, transmitted by FAA Order 3750.7 (series) Ethical Conduct and Financial Disclosure Program.
- (4) Verify that required financial disclosures are filed and mandatory annual training regarding ethical conduct and financial disclosure is completed by obligated employees.
- (5) Treat employees with dignity, respect and in a fair and equitable manner in conformance with the FAA Model Equal Employment Opportunity (EEO) Program. Communicate to their staff that they will not tolerate or condone discrimination, or the appearance of discrimination, on the part of any employee.
- (6) Notify (promptly) their Security Servicing Element (SSE) and their servicing LER HQ or Regional Operations office, of known or suspected violations of the law (including suspected criminal activity) on the part of employees. In accordance with FAA Order 1600.1 Personnel Security Program, report any information that would raise doubts about an employee's continued eligibility for access to classified information.
- (7) Adhere to, fully support and comply with all DOT and FAA regulations, policies and programs. Take necessary corrective action or a disciplinary or adverse personnel action when employees under their supervision commit offenses in violation of law, regulations, policies or programs.

d. Employees:

- (1) Must adhere to this policy and observe basic on-the-job rules as described in this policy.
- (2) Become familiar with the standards of conduct and their responsibilities for adhering to the requirements set forth in this policy and other governing provisions (see paragraph 3 – Authorities).

6. Guiding Principles. An employee's conduct on the job has a direct bearing on the proper and effective accomplishment of official duties and responsibilities. Employees are expected to approach their duties in a professional and businesslike manner and maintain such an attitude throughout the workday. It is also expected that employees will maintain a professional decorum at all times while in a temporary duty travel status or otherwise away from their regularly assigned duty location, such as when teleworking, whether at home or at an alternative worksite, or attending training. Employees, who enter

A-10 (J)
10 (1)

Government work space, even when not on duty, must maintain a professional attitude and decorum. Those employees in direct contact with the public bear a heavy responsibility as their conduct and professionalism significantly impacts the image of the Federal service and the FAA.

Employees must maintain high standards of honesty, integrity and impartiality, and conduct themselves in a manner which will ensure that their activities do not discredit the Federal Government and the FAA.

Employees are also expected to conduct themselves off-duty in a manner which will not adversely reflect on the agency's ability to discharge its mission, cause embarrassment to the agency by the employee's activity or behave in a manner that will cause the public and/or managers to question their reliability, judgment and trustworthiness in carrying out their responsibilities as employees of the Federal Government.

7. General Conduct Expectations. All employees are responsible for conducting themselves in a manner which will ensure that their activities do not discredit the Federal Government and the FAA. Employees must observe the following basic on-the-job rules:

- a. Maintain regular attendance, report for work on time and in a condition that will permit performance of assigned duties (i.e., wear appropriate clothing and/or outfitted with required tools or equipment; free from any effects of alcohol and/or drugs that impair job performance or conduct; physically fit as needed by job requirements; and in a mentally alert condition to perform the duties of his/her position).
- b. Render full and industrious service in the performance of assigned duties. Employees are to keep their manager fully apprised of the status of assignments in an effort to ensure an efficient workflow.
- c. Respond promptly to, and fully comply with directions and instructions received from their manager or other management officials.
- d. Exercise courtesy and tact at all times in dealing with fellow workers, managers, contract personnel and the public. Employees must treat everyone with dignity and respect, and support and assist in creating a productive and hospitable work environment. They are obligated to avoid disrespectful, abusive or other inappropriate behavior toward other personnel, management officials and customers.
- e. Maintain a clean and neat personal appearance to the maximum practicable extent during working hours. Employees are expected to dress appropriately in clothing that communicates professionalism appropriate to the position held. Individual decisions related to work attire should reflect sound and professional judgment.
- f. Safeguard and handle appropriately all classified information and unclassified information that should not be given general circulation as provided for in FAA Order 1600.2 Classified National Security Information and FAA Order 1600.75 Protecting Sensitive Unclassified Information.
- g. Conserve, protect and assure appropriate use of Federal funds, time, property, equipment, materials, information and personnel (both Federal and contract).
- h. Observe and abide by all laws, rules, regulations and other authoritative policies and guidance. Employees will familiarize themselves with the Standards of Conduct contained in this Human Resources Policy Manual (HRPM), as well as, the Standards of Ethical Conduct for Executive Branch Employees, 5 CFR Part 2635, transmitted by FAA Order 3750.7 (series) Ethical Conduct and Financial Disclosure Program.
- i. Immediately report known or suspected violations of law, regulations or policy through appropriate channels and fully participate in inquiries. Including, but not limited to:

A-10-(3)
1 1 (1)

United States Government and its citizens to place loyalty to the Constitution, laws and ethical principles above private gain. To ensure that every citizen can have complete confidence in the integrity of the Federal Government, each employee shall respect and adhere to the principles of ethical conduct set forth in this section, as well as the implementing standards contained in this part and in supplemental agency regulations.

(b) *General principles.* The following general principles apply to every employee and may form the basis for the standards contained in this part. Where a situation is not covered by the standards set forth in this part, employees shall apply the principles set forth in this section in determining whether their conduct is proper.

(1) Public service is a public trust, requiring employees to place loyalty to the Constitution, the laws and ethical principles above private gain.

(2) Employees shall not hold financial interests that conflict with the conscientious performance of duty.

(3) Employees shall not engage in financial transactions using nonpublic Government information or allow the improper use of such information to further any private interest.

(4) An employee shall not, except as permitted by subpart B of this part, solicit or accept any gift or other item of monetary value from any person or entity seeking official action from, doing business with, or conducting activities regulated by the employee's agency, or whose interests may be substantially affected by the performance or non-performance of the employee's duties.

(5) Employees shall put forth honest effort in the performance of their duties.

(6) Employees shall not knowingly make unauthorized commitments or promises of any kind purporting to bind the Government.

(7) Employees shall not use public offices for private gain.

(8) Employees shall act impartially and not give preferential treatment to any private organization or individual.

(9) Employees shall protect and conserve Federal property and shall not use it for other than authorized activities.

(10) Employees shall not engage in outside employment or activities, including seeking or negotiating for employment, that conflict with official Government duties and responsibilities.

(11) Employees shall disclose waste, fraud, abuse, and corruption to appropriate authorities.

(12) Employees shall satisfy in good faith their obligations as citizens, including all just financial obligations, especially those—such as Federal, State, or local taxes—that are imposed by law.

(13) Employees shall adhere to all laws and regulations that provide equal opportunity for all Americans regardless of race, color, religion, sex, national origin, age, or handicap.

(14) Employees shall endeavor to avoid any actions creating the appearance that they are violating the law or the ethical standards set forth in this part. Whether particular circumstances create an appearance that the law or these standards have been violated shall be determined from the perspective of a reasonable person with knowledge of the relevant facts.

(c) *Related statutes.* In addition to the standards of ethical conduct set forth in this part, there are conflict of interest statutes that prohibit certain conduct. Criminal conflict of interest statutes of general applicability to all employees, 18 U.S.C. 201, 203, 205, 208, and 209, are summarized in the appropriate subparts of this part and must be taken into consideration in determining whether conduct is proper. Citations to other generally applicable statutes relating to employee conduct are set forth in subpart I and employees are further cautioned that there may be additional statutory and regulatory restrictions applicable to them generally or as employees of their specific agencies. Because an employee is considered to be on notice of the requirements of any statute, an employee should not rely upon any description or synopsis of a statutory restriction, but should refer to the statute itself and obtain the advice of an agency ethics official as needed.

A-10 (4)

4 April 2017

Inspector Christopher M. Howard
 Honolulu FSDO
 Federal Aviation Administration
 135 Nakolo Place
 Honolulu, Hawaii 96819

Jansen
 +
Gollin letters

Inspector Howard-

To the best of my recollection, the following is a true and honest retelling of the events that occurred on 11 March 2017 aboard the 8am Makani Kai flight from Honolulu, Hawaii to Kalaupapa, Molokai:

A little after 8am on 11th March, my wife, my mother and I proceeded to board the plane and take the seats assigned to us by the pilot. There was one passenger in a wheelchair who was helped onto the plane, and strapped in personally by the pilot. During the seating process, the pilot made her way from the back of the plane checking that everyone was strapped in. At this time, my mother, who was seated in seat 2A across the aisle from me, brought to the pilot's attention that her shoulder strap was fully extended and would not retract into the seat. After a brief period of time tugging and probing at the belt (estimate to be less than 30 seconds), the pilot proceeded to stuff the excess belt back into the seat, shrugged her shoulders and commented that it must be due to the humidity. In no way shape or form did the efforts of the pilot do anything to affect any repair on the seatbelt, as immediately upon pulling, the belt extended to its full length and refused to retract. The pilot continued on anyway to check the other passengers.

After the pilot took her seat, she provided what I considered to be an overly short safety briefing. None of the equipment was actually demonstrated, and instruction for the life vest consisted of instruction to place over head, buckle around waist and to not inflate until after exiting the vessel. Given the difficulty with life vests the company had last year, I found this to be very disconcerting. I was further put aback when she announced this was only her third day on the job; and when I asked how many hours she had on this plane, she responded by stating that she had thousands of flight hours and was an instructor. To which I replied "but how many hours on *this* plane?", she did not reply. During the preflight check, which she had the checklist in her lap - I don't know if it is worth mentioning or not - but not less than six times she powered up the throttle without the plane actually moving anywhere. While I am not familiar with preflight on this model of plane, I have flown commercially a lot, and found this process rather unnerving. Eventually, she worked through whatever needed to be done and then asked "ready to go?"; and finally started moving the plane.

The flight itself was uneventful and smooth. There was little to no turbulence and the visibility was relatively clear despite the vog. We approached the Kalaupapa peninsula from the west, turned south before we crossed land, then approached the airport directly from the south-west. Again, very smooth approach, my wife was using her iPhone to film the approach of the landing about five minutes before

touchdown, as the scenery was very beautiful (as shown in video slip provided to FAA). We were coming in for a landing, in a classic nose up position, approximately 20-30 feet above the runway when suddenly the plane just seemed to drop out of the air and hit the ground HARD. There was no warning, no notice from the pilot, just the sudden impact. Then we were back in the air briefly, slipping and rolling first one way, and then slipping and rolling to other side. At no time during this event do I recall ever hearing the engine powering up, nor any instructions from the pilot to assume any crash posture. The only comments I heard from the pilot seat were 'Oh, no, oh, no, oh, no'.

Contradicts FM
WTR flight log
150 ft

Finally, the plane violently crashed to the ground a second time, striking nose first with the tail whipping around 180 degrees as the plane continued to slide backwards down the runway; coming to rest in the grass west (oceanside) of the runway, nose down and listing to starboard. Immediately upon coming to a full stop, I looked up at the pilot expecting some instruction as to how to proceed, only she had her head down on the instrument panel. I could hear her apologizing "I'm so sorry, this has never happened to me before" "I have never even blown a tire" "This is only my third day, I'm never going to fly again" "I'm so sorry" "I couldn't keep the RPMs up". Throughout the flight, I had a camera strapped to my hand so I could take pictures on the way in; I snapped a picture of the pilot - not believing this is actually happening (photo provided to FAA). Let's see if Contradict positions

Given the unknown state of the airplane and the complete lack of leadership from the pilot, I was concerned for the safety of my family and decided that someone had to evacuate the plane. I looked over to check on my mother to confirm she wasn't hurt, unstrapped my seatbelt and handed her my camera. Upon standing up to work my way to the back of the plane to check on my wife, I noticed that the handicapped passenger was laying on his back in the aisle. Working back to the passenger in the aisle, I performed a visual check on the other passengers and asked if they were ok as I passed, looking and listening for a positive confirmation. My wife was obviously very rattled, but appeared unharmed. I stepped over the passenger lying in the aisle to open the back door, which had no visible instructions on how to open. The top half opened relatively easily, the bottom half unlatched, but required a good kick to open and deploy the stairs/ladder.

Upon turning around to assist the handicapped passenger, I noticed that there was blood on the floor and on the seat, that I assumed was from that person. I bent over him and told him that I was going to pick him up by the arms and carry him out of the plane, and asked if he was ok with that. I received a positive acknowledgement and attempted to lift and pull him out of the aisle. At this point, I was having difficulty moving him. As I was tugging, my wife (who was seated across from him) informed me that he was still buckled in. That comment took a moment to register with me, as it didn't make sense that a person could be lying in the aisle, but still be wearing a seatbelt. Upon further examination, he was indeed still buckled in. The seatbelt had failed to retain its length and loosened to its maximum size; cutting him around his middle -- hence the blood. Another passenger was able to unbuckle him while I half carried/half dragged him over to the rear door.

After some maneuvering and assistance from another passenger, I was able to carry the handicapped passenger down the stairs and off the plane. During this entire time, I neither saw nor heard from the pilot. As the first passenger off the plane, I did look down the runway and saw 'the other' plane. It appeared to be at the extreme far end of the runway, and from my vantage point, appeared to be in the grass off to the east of the runway. Only after all the other passengers had disembarked from the plane

Contradicted
by
GOL 100

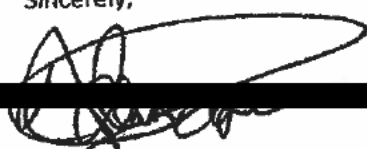
and the emergency services from the National Park Service (NPS) was arriving in their truck on the scene did the pilot finally appear, again seeming to be in a state of shock and continuing on about how sorry she was and how she 'couldn't keep the RPMs up' (as shown in video clip provided to FAA). At no time did she appear to be helping or participating in evacuating passengers, rendering first aid or moving them to a safe distance from the crash site. Generally, she milled about the plane, walking around it in circles examining the damage; appearing more concerned with the state of the plane than the people.

NPS Park Rangers arrived at the scene and immediately took control of evacuating the passengers to a safe distance, providing medical evaluations for any serious injuries and taking contact information for follow up investigations. The second plane had taxied up the run way at one point, and eventually came into the terminal; but at no time did the pilot of the second plane appear to throttle up sufficiently to attempt a take off.

In the aftermath of the incident, my wife and I have both missed work as a result of injuries we incurred directly as a result of the crash. I had injured my back either as a result of the primary and/or secondary impact with the ground or, more likely, from carrying the passenger off the plane; needing the use of a cane for two weeks to provide assistance in walking. My wife has been suffering emotionally trauma from the event, having been in the back of the plane and thus experienced the most violent of the movements. Both of us have been seeing a psychologist specializing in trauma therapy as a result of the accident.

Should you have any further questions, or need me to go into greater detail on any of the events contained above, please do not hesitate to contact me.

Sincerely,


Adam Jansen

Contradicted
by other
reports

Maybe not

Accident Statement: Kalaupapa Airport Hard Landing, Makani Kai Air, Moloka'i, Hawai'i, 03-11-2017 Lisa Gollin

Lisa Gollin

I was a passenger on the Makani Kai 8am flight (HNL-KALA, Moloka'i, Hawai'i) that crash-landed. I was in the front co-pilot seat. Leaving Honolulu, the pilot told us that she was 3-days into the job and from New York. During the preparation for take-off she was polite, apologetic and attentive to passenger comfort. She showed me how to fasten the belt and harness. She apologized to me for turning the air vent on high. It was very humid. She seemed slightly uncomfortable. One of the passengers wanting reassurance, asked her about her experience. I believe she said she had a 1,000 hours of experience (not sure, where or what timeframe). She did multiple checks of the controls before we took off. She told the passengers that she would point out whales on the way and tip the wing towards the ocean if she spotted whales. - CONTRA to

The take-off was unremarkable, the flight smooth. Approaching the Kalaupapa runway, everything looked clear. It was a vuggy day, but from my vantage point of the front seat, the runway looked empty. I sensed that the pilot was distressed in some way. She kept repeating a question on the radio. I could not quite hear what she was saying, but she seemed upset in some way. We did a circle around and then returned to the front of the runway where she again asked a question on the radio. She got the go ahead to land.

The descent to the runway was smooth until we neared the ground and the plane started violently swaying side to side. I thought this was odd, as there were no strong winds. I have landed at similarly sized airports in small planes (Cessnas) in difficult conditions many times, having taken numerous "bush" flights when I lived in Borneo, Indonesia. I never experienced such a rough landing. I think we banged along the runway once or twice. Initially, I thought it was a sloppy landing. I was surprised. Then I realized something was really wrong. I was focusing on what the pilot was doing. She seemed to be struggling with the levers (throttle?) to her right, my left, trying to do something with the plane that was not working. I later learned she was trying to get lift. I thought there was some plane malfunction. I cannot remember if was before I was intently watching the pilot or after, I looked up and saw another plane on the runway. Again, I cannot quite remember what position it was in and where it was, if it was moving or not. I believe it was parked on the side or moving slowly. It was close enough for me to make out the wave-like stripes along the side of the plane. My first thought was - *that is really odd, they have funny customs at this airport. I've never seen another plane on or anywhere near the runway.* I turned my attention back to the pilot. She was wildly steering, as though trying to avoid a pile-up accident on a freeway. My co-pilot steering wheel was also wildly swing from back and forth. The pilot was saying something in anger/upset/distress. Again I could not quite hear. The plane was now out-of-control to the point where I expected we were going to roll and braced myself by relaxing my body and covered my face and head with my arms. One of the passengers had been screaming, *oh no, oh no, oh no.* The pilot turned toward the pebble/rock buffer lining the runway and onto the grass. The plane spun around in semi-circle. The front landing gear had been crushed and, I later learned, one of the tires had blown off and both wings were damaged. The plane was totaled. - CONTRA to

The pilot was upset and folded her arms over the steering wheel repeating, *I've never had an accident. This has never happened...* The pilot was extremely distressed. I tried to sooth/calm her down, rubbing her shoulder and assuring her that no one had been hurt and that was the most important thing. I am not sure when she killed the engines, but I later found a video on my cell phone that will help with the investigation. The video camera had been accidentally triggered when we hard-landed. It shows the few moments after landing up until when the pilot steps out of her seat to get off the plane. In the video it sounds as though something is still running: engines, propellers?

CAN'T hear the engines

Passengers helped each other off the plane. I believe the pilot exited the plane everyone was safely out. I know someone else put the ladder down for the passengers and started helping people out. I cannot remember who put down the ladder so I could exit - the pilot or someone else. Once outside the plane, the pilot kept repeating that she had 20-years of experience and had never had an accident. And that she could not *get enough RPMs*. I later learned this meant she could not get enough speed to get lift to avoid the other plane (a Japanese tourist flight school plane - resting at the turn out and taking photographs of the ocean). The pilot then was saying, *what was that plane doing there? They said it was "all clear."* I asked three times.

One of the NPS Forest Rangers with EMT training checked each of the passengers out for injuries, blood pressure, etc. The only person injured was the Kalaupapa patient in the back seat (DH). He had been thrown to the other side of the plane and either his seat belt did not function or he had unbuckled it. He was bleeding on his arm and hand and was quickly picked up and taken to the care home. I went to visit him a day or so later. His injuries were minor. My right knee and left elbow were sore for a few days from being thrown from right to left into the door and into the pilot. My left elbow swelled and then went down in about 2-3 days.

I am attaching photographs of the plane console, taken during the flight and on our approach to the runway for the investigation. There is a shot of the runway as we are preparing to land. It looks empty until you zoom and enlarge the photo, you can see the other airplane sitting at the turn out near the end of the runway. Through the fog, it was almost imperceptible. I would also like to send the video which should answer more questions.

Aftermath: my perceptions and concerns

I state my bias; I am always pleased to see women pilots. Flying in and out of remote, dangerous and tricky airports in Kalimantan, Borneo, I know that small-plane "bush" pilots are ace. And, in my experience, calm and confident in hairy situations. I just sensed this pilot's unease, even before take-off. On the unspoken side of the experience, I remember 'chanteling' my confidence to her piloting both at take-off and before we landed because something just felt amiss. On some level she needed help. Post hard-landing, she did not conjure the presence of mind to help passengers or (possibly handle other plane operations I would not know about). Myself and others were trying to calm her and tell her everything was okay. I said, "you saved the day. Nobody was hurt. It could have been much worse." I did not realize until later that planes in these circumstances can explode in fire.

Initially, my overriding concern was that planes are allowed to touch and go on the Kalaupapa airport anytime. The Japanese flight school pilot/flight instructor and the two tourist students tried

A-9 (5)

to flee in the plane and then by foot a couple of times. People at the airport witnessed their attempts and it is best to talk to those observers to learn more about what happened. The instructor pilot told someone (airport personnel?) that in Japan it is allowable to hang at the end of the runway and that is why he told our pilot on the radio that it was "all clear."

Over the days that followed, during my one week stay at Kalaupapa, I learned more that raises questions. It now seems a perfect storm of major and minor miscommunications, miscalculations and malfunctions on the part of pilots, plane and airport. Happily, this did not end in disaster this time. I am concerned for the Kalaupapa residents and workers who fly in and out of Kalaupapa daily. My questions and suggestions based on my own and the observations of others in order from greatest to least concern:

1. Most critically, what was the other plane doing on the runway after telling our pilot the runway was "all clear?"
 - a. Why are private and commercial (especially flight school) planes allowed to touch and go on the runway anytime *especially* because there is no control tower and it is not possible for approaching pilot and airport personnel to see the end of the runway. Not to mention, there are no medical, fire, or emergency ground crew capabilities at Kalaupapa and the settlement and surroundings is a restricted area?
2. How well had the Makani Kai pilot been vetted? There was word that it was either her first or second time flying into KALA and that she had never flown this model of plane? In a sense, was a rookie.
 - a. Did she land the MK plane too far onto the runway, leaving too little room to avoid the other plane?
 - b. Why didn't she realize that our plane was too heavy and too late to get lift and touch and go to avoid the other plane? *How does she suppose this?*
3. Was the Makani Kai plane ready to fly? One, possibly two of the seat harnesses were not working. If the plane had rolled, those passengers could have come out of their seats. All the bags inside the plane, shifted. My bag ended up in the back of the plane. Ones in the back slid to the front. *Non-Fat with 3000 lbs*
4. Since there is no control tower, was an airport personnel posted in the safe zone at the end of the runway who could have radioed the presence of the other plane?
5. The question was also raised by others as to why there was damage to both of the wings? One pilot's observation, not mine. Apparently, this is unusual?

In the final analysis, the main responsibility for the accident falls on the shoulders of the instructor piloting the tourist flight school plane. My aim in providing this statement is to help, not hurt anyone involved in the safeguarding of everyone at the airport and flying in and out of Kalaupapa.

Please contact me if I can be of any further assistance in the investigation.


Lisa Gollin, March 24, 2017

I was pilot in command for N865MA -Caravan, 9 passengers.
I was flying the passenger flight from PHL - PHLU.
Flight was very calm. When I was released from
Molokai Tower in transition to Kalaupapa airport,
I switched to frequency for Kalaupapa radio traffic.
I heard an airplane in pattern and told Kalaupapa
radio that I was on 7 mile final for Runway 5.
Other pilot in pattern told me that he was
in pattern and would report "clear of runway".
I asked him if he wanted me to execute a
360 to give him more time. Pilot of other aircraft
Pilot said "ok". I executed a 360^{3 miles out} to give more
time for ~~any~~ other aircraft to either do
touch and go or back taxi of runway.
I then decided after 360, to set up on
a base to final instead of final, again to give
more time for pilot in other aircraft to clear
runway for my landing. Pilot in other aircraft
told me he was clear of runway. I as
I had a bit of problem understanding pilot's accent
him, "So you are clear of runway and I can
land." He said he was clear of runway.
As I came to final (3 mile final), I was
came. A-11(1)

~~I was~~

I was prepared to land "long" and back taxi to parking. As I was preparing to transition to land, I noticed an airplane at the end of the runway. I did not understand what airplane was trying to do. I tried to initiate a go around but was ~~was~~ worried about going straight ahead, as I did not know what other pilots intentions were. I tried to initiate left turn out, so as to not run into airplane at end of runway. I initiated a turn and power but could not get enough lift. ~~I~~ I wanted to avoid a runway incursion. I could not tell what the pilot's ~~at~~ at the end of the runway intentions were.

A-11 (2)

March 12, 2017

On March 11, 2017, I was the Pilot In Command of a Cessna Caravan (N865MA) during a morning commercial flight from Honolulu to Kalaupapa airport, located on the island of Molokai. I was carrying nine passengers, with one seated in front next to me. Winds were relatively light and overall weather conditions were VFR in spite of a persistent haze, with scattered cloud layers reported at 2,500 and 4,500 feet.

When approximately 7 miles from my destination, along the "north shore arrival" for a straight in approach to runway five, I overheard a radio transmission indicating that there was an aircraft in the pattern at Kalaupapa. A male voice stated that he was "base for runway five at Kalaupapa".

I advised that I was a Cessna Caravan on a 7 mile final for runway five. A male voice responded to my transmission and in broken English, stated that he would "land and clear the runway".

I advised him that I would conduct a "360" degree turn from my present position and do an extended left base to final to give him time to back taxi and clear the runway (due to the lack of taxiways at the destination airfield). He responded "okay, okay".

After conducting the above maneuvers, I radioed the other Cessna pilot that I was "base to final" and requested confirmation that he was "clear of the runway".

The other pilot then stated he was "clear off runway".

Thanking him, I proceeded with my approach. Having completed my pre-landing checklists, I proceeded with the final descent for landing. Passing through 250 feet agl, the aircraft experienced a left rolling tendency which I immediately corrected for with proper control inputs and a slight addition of power. Descending through 150 feet agl, it again rolled slightly and, once again, I corrected with appropriate control response.

Approaching the transition to landing, I detected motion at the opposite end of runway five and immediately observed what appeared to be a rotating propeller pointed down the runway in our direction.

I immediately added power to "go around". My aircraft yawed left and I attempted to correct while maintaining a climb attitude. The aircraft refused to climb and immediately dropped, impacting the runway midway on the bottom of the airframe. After bouncing once, it continued its travel in contact with the runway.

I applied left rudder pedal to steer the aircraft off the runway and out of the way from the other aircraft's possible flight path. The Caravan exited the runway surface and I continued to apply left rudder, which I believe induced a left ground loop.

After coming to a stop, I proceeded to shut down the engine. Exiting my seat, I walked into the passenger compartment, opened the main cabin door and was assisted in doing so. I then assisted a wheelchair-bound passenger in exiting the airframe at the rear of the aircraft.

Upon establishing that my passengers were all uninjured, I was approached by the airport manager. The manager stated that he had been confused by the pilot of the other aircraft's actions and had tried to call out to him on the radio to also confirm his location and that he was, in fact, clear of the runway.

In brief, the manager stated that he had been looking for the other aircraft after he did not see it in the ramp area or the airport flight pattern.

Only a few minutes thereafter, I observed the other aircraft, identified as a Cessna 172 with registration N243SP, attempting to taxi past the accident scene for the purpose of taking off from runway five.

The airport manager then stopped the 172. The 172 pilot asked how long the runway was prior to the accident scene, indicating a desire to attempt to take off. The manager advised him that the runway was closed and no takeoff would be permitted. The Cessna 172 pilot then proceeded to park his aircraft on the grass area near the ramp. After a short time, the other pilot, accompanied by his two male companions elected to "hike out" of this isolated area, leaving their aircraft behind. I believe that the Park Ranger had inferred that this individual was a flight instructor who was accompanied by students.

After speaking to a Park Ranger who had responded to the accident scene, the 172 pilot spoke with me. When I asked why he had been at the end of runway five, he stated in broken English that he "does this all the time" (apparently waiting for other aircraft to land).

I was then briefly interviewed by the park ranger and provided appropriate identification to him.

A post accident view of the Caravan appeared to indicate that the propeller was feathered and heavily bent.

Bettina von Brentano


4-13(2)

8/5/13

Also see "Foundations of Aviation Law" Penner & Riley Ch 5

FAA Directive N 8900.230
to Investigators

(6) Any other air traffic or flight data in the FAA's possession that would facilitate the individual's ability to productively participate in a proceeding related to the flight operation under FAA investigation.

b. **Government Contractor Air Traffic Data.** The PBR also states that the individual can obtain air traffic data in the possession of a government contractor providing operational services to the FAA (e.g., contract control towers and FSS) that would facilitate the individual's ability to productively participate in a proceeding related to the flight operation under FAA investigation, provided that the individual identifies the:

- Facility at which such information is located; and
- Date on which such information was generated.

c. **Notification of Air Traffic Data Availability.** The PBR provides that except in an emergency case, the Administrator may not proceed against an individual who is the subject of an investigation relating to the approval, denial, suspension, modification, or revocation of an airman certificate during the 30-day period beginning on the date on which any air traffic data is made available to the individual. The FAA interprets this provision as meaning that the FAA may not issue a non-emergency order suspending, modifying, or revoking an airman certificate until 30 days have passed since the date the Administrator made the air traffic data available to the airman. Therefore, in such cases the Administrator will advise an airman in the notice proposing certificate action issued by FAA legal counsel that air traffic data is available.

d. **Providing Requested Government Contractor Air Traffic Data to the Individual.** The FAA expects to issue shortly a Federal Register Notice and establish a Web site to inform airmen how to request and obtain air traffic data from government contractors. The FAA expects to provide a centralized means through the FAA Web site for airmen to seek FAA assistance in obtaining air traffic data from government contractors.

e. **Inspector Requests to Maintain Relevant Air Traffic Data.** Inspectors must request that the ATO and any other FAA organization maintain all air traffic data as defined in paragraph 6.a relating to the investigation of an apparent operational violation. Even if such air traffic data will not be included as an item of proof in the Enforcement Investigative Report (EIR), inspectors must still request that the relevant air traffic data associated with an apparent operational violation under investigation be preserved while the investigation and any subsequent enforcement action are pending. Any air traffic data that is received by investigative personnel also must be retained in accordance with retention requirements in FAA Order 1350.15C, Records Organization, Transfer, and Destruction Standards.

Note: Any investigative personnel receiving a request from an airman for air traffic data should note the date of the request and must coordinate the release of such data with the Regional Counsel. Any air traffic data released during the investigation and before an EIR is generated must be included in the EIR.

7. **When Written Notification is Required Under the PBR.** Except when giving the required notification under the PBR would threaten the integrity of the investigation as described in paragraph 14, written notification of investigation is required in these circumstances:

*

8/5/13

N 8900.230

a. **LOI to an Airman.** See paragraph 8.

b. **Other Circumstances.** Other circumstances when a LOI is not issued and an EIR has not been opened on an airman:

- At the time an individual submits an application for an airman certificate, rating, or inspection authorization. See paragraph 9.
- In a letter requesting reexamination of an airman's qualifications to hold an airman certificate, rating, or inspection authorization. See paragraph 10.
- Potential violations by an airman involving air traffic data described in paragraph 6.a., for which an EIR has not yet been opened. See paragraph 11.
- Other contacts with an airman that result in an investigation that relates to the airman's certificate, rating, or inspection authorization. See paragraph 12. //

c. **Formal Remedial Training.** See paragraph 13.

8. **LOI for Airman Certificate Actions.** Inspectors must use the Sample Letter of Investigation of Airman Certificate Actions (Appendix A) for any investigation for which there is an EIR opened on an airman that might result in the suspension, revocation, or modification of an airman certificate, including any ratings or inspection authorizations. Modification of a certificate would include the suspension or revocation of a rating, or the imposition of a limitation on an airman certificate (e.g., no circling approaches, no passengers).

a. **Timing.** Except as provided in paragraph 14, the LOI referenced in paragraph 8, above, must be issued to the individual in a timely manner. Inspectors should make every effort to issue the LOI no later than 5 business-days after the EIR is opened in EIS.

b. **Return Receipt.** The inspector must send the letter via certified mail, or hand deliver the letter, in order to be able to record the date the airman received the information required by the PBR.

9. **Application for an Airman Certificate, Rating, or Inspection Authorization.** Applications for airman certificates, ratings, or inspection authorizations involve FAA investigations of an individual's qualifications to hold the airman certificate, rating, or inspection authorization for which the individual has applied. Because such investigations are not for the purpose of determining whether a violation exists, the inspector does not issue an LOI and therefore only some of the written notifications under the PBR apply. Any individual who applies for an airman certificate, rating, or inspection authorization must receive and acknowledge receipt of the written notification of investigation (Appendix B) at the time of the application. The signed acknowledgment of receipt of the written notification must be retained with the individual's application.

10. **Letters Requesting Reexamination under 49 U.S.C. § 44709.** Letters requesting reexamination under 49 U.S.C. § 44709 involve FAA investigations of an individual's qualifications to continue to hold an airman certificate, rating, or inspection authorization. Because reexaminations of an individual's qualifications are not investigations for the purpose of determining whether a violation exists, only some of the written notifications under the PBR

A-12 (d)

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N 8900.230

apply in these cases. Inspectors must use the Letter Requesting Reexamination under 49 U.S.C. § 44709 (Appendix C) for any airman who is the subject of a reexamination of his or her qualifications to continue to hold an airman certificate, rating, or inspection authorization. This letter will provide the required notification for a situation where the airman places his or her certificate on temporary deposit pending reexamination.

Note: The inspector must send the letter requesting reexamination via certified mail, or hand deliver the letter, in order to be able to record the date the airman received the information required by the PBR.

11. Notification to Certificated Airmen in Cases Involving Air Traffic Data for which an EIR Has Not Yet Been Opened, Including Cases that May be Closed by Administrative, Informal, or No Action. Where a case under investigation involves air traffic data, time is of the essence because some air traffic data is routinely destroyed or disposed of in the ordinary course of business. In such a case, except as provided in paragraph 14, inspectors should provide in a timely manner the written Notification of Investigation under the Pilot's Bill of Rights (Appendix D) to an airman identified to the inspector as the subject of an investigation for a possible violation involving air traffic data. The inspector should retain a copy of this notification and if an EIR is opened, include the copy in the EIR.

Note: The inspector must send the written notification via certified mail, or hand deliver the written notification, in order to be able to record the date the airman received the information required by the PBR.

12. Other Contacts with a Certificated Airman that Result in an Investigation that Relates to the Airman's Certificate, Rating, or Inspection Authorization, Including Cases that May be Closed by Administrative, Informal, or No Action. Under the PBR, the individual subject to an investigation under the Act must be given written notification that any response to an inquiry by the FAA in connection with the investigation may be used as evidence against them. For instance, if an inspector seeks to interview an individual who the inspector knows is the subject of the investigation, but for some reason the inspector has not issued the LOI to the individual or has not yet opened an EIR (e.g., during a routine ramp inspection), the inspector must provide timely, written notification under the PBR (Appendix E) unless, as described in paragraph 14, providing the required notification at that time would threaten the integrity of the investigation, and the inspector obtains the concurrence of Regional Counsel to invoke the exception to the notification requirements. The airman must acknowledge receipt of this notification that the FAA inspector would retain and if an EIR is later opened, the inspector would include the signed acknowledgment in the EIR.

13. Formal Remedial Training. Inspectors must use the Sample Letter of Investigation for Remedial Training (Appendix F) for any investigation for which there is an EIR opened on an airman where formal remedial training is offered but that might also result in the suspension, revocation, or modification of an airman certificate, including any ratings or inspection authorizations. Modification of a certificate would include the suspension or revocation of a rating, or the imposition of a limitation on an airman certificate (e.g., no circling approaches, no passengers).

A-12 (3)
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8/5/13

N 8900.230

a. **Timing.** Except as provided in paragraph 14, the LOI referenced in paragraph 13, above, must be issued to the individual in a timely manner. Inspectors should make every effort to issue the LOI no later than 5 business days after the BIR is opened in EIS.

b. **Return Receipt.** The inspector must send the letter via certified mail, or hand deliver the letter, in order to be able to record the date the airman received the information required by the PBR.

14. Exception to the Notification Requirement under the PBR. The Administrator may delay timely written notification required under the Act if he or she determines that such notification may threaten the integrity of the investigation. Notification must be provided once the threat to the integrity of the investigation has ceased. Examples of circumstances where the integrity of the investigation could be threatened by providing written notification to an airman include:

a. **Destruction/Concealment.** Providing the required notification under the PBR presents a risk of:

(1) Destruction of evidence.

(2) Concealment of evidence.

Note: Once the evidence of concern has been obtained, the Administrator must provide the required written notification.

b. **Death or Serious Bodily Harm.** Delay caused by giving the required notification under the PBR presents a risk of death or serious bodily injury, or destruction of property;

Note: Once the risk has been abated, the Administrator must provide the required written notification.

c. **Time.** Circumstances where there is not enough time to give written notification under the PBR but oral notification can be provided. For example, the individual subject to investigation will be unavailable within required timeframes for processing an FAA certificate action.

 **Note:** An inspector may delay providing the written notifications required under this exception of the Act and subsequently provide them after a delay, only after consultation with and concurrence of the Regional Counsel.

15. Voluntary Surrender of Certificate. If an airman elects to voluntarily surrender his or her certificate for cancellation and the FAA accepts the surrender in accordance with the guidance in the current edition of FAA Order 2150.3, FAA Compliance and Enforcement Program, Chapter 5, subparagraph 10.b., then an inspector does not provide the notification required under the PBR. In this situation, there is no investigation relating to the approval, denial, suspension, modification, or revocation of an airman certificate, nor any inquiry of the airman that might elicit a response that could be used as evidence against the airman.

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MAKANI KAI AIR

"We believe that aloha spirit is more than a catch phrase:
it is the philosophy by which we live."

FAQ'S

These are some of our Frequently Asked Questions and common concerns.

How about carry on items such as purses, backpacks, etc?

For our regularly schedule service, passengers are allowed to bring one "carry on" bag or parcel at no charge. The reason carry on is in quotations is because not all carry on items actually fit in the passenger area and may have to be stowed in the baggage pod underneath the aircraft. In real world terms, we consider your carry on anything up to the size of a small backpack. Our charter customers can bring any non-hazardous item they wish on board the cabin of the aircraft, or stow it in one of the luggage compartments.

Can we book a charter flight at night?

Yes. One of the chief advantages of a charter flight is that it departs when you want and flies according to your schedule.

Will I have to go through TSA screening?

No. Boarding the aircraft couldn't be simpler: you simply show up and go to the aircraft. There are no lines, no one with a wand, and no one will open your suitcase. Bring as much shampoo as you want.

Can I bring hazardous materials?

Our pilots and ground crew are specially trained to handle hazardous materials such as medical items, biological specimens and the like. Please call us ahead of time to discuss your particular situation.

Is there a bathroom on the airplane?

No, so make sure you take care of business before you board.

Will I see the volcano?

Hawaii's active volcano, Kilauea, is located on the Big Island of Hawaii, which is about 250 miles from Oahu. We are happy to take our charter customers there and even fly over the volcano if they so wish.

How many people can fit in the airplane?

Both the Cessna Grand Caravan and the Piper Chieftain can carry a total of nine persons.

Will I have a good view?

Every seat in both types of aircraft have their own window, so you are guaranteed an excellent view.

the wind and weather here, the particulars for each arrival and departure, the routes with the least turbulence and the most brilliant views. We maintain this expertise so that you can relax and enjoy your travel.

Our charter department operates 24 hours a day, 7 days a week, 365 days a year. Our call out for a charter flight averages one hour. We conduct our business as an FAA Part 135 Air Carrier and have not had a tour or charter safety incident or accident since we began flying in 1988.

Makani Kai Air focuses on what has been missing in the marketplace:

- One-call convenience
- A system to provide price quotes in moments
- A concierge service to pamper you with anything you need
- Specialty catering
- A thorough understanding of Hawaii: these Islands are our home

Our staff is ready to serve your needs now and in the future. We are committed to providing you with the best in aviation. We will pay attention to your every need and desire. We take our responsibility to fly you and yours, wherever and whenever the need arises, safely and on time.



A-15(2)

A-15(3)

Company had 5 incidents in past, FAA records show

10W

Hulu Star-Advertiser • 14 Dec 2013 • B1 • By Dave Segal dsegal@staradvertiser.com

Makani Kai Air, whose plane crash Wednesday killed state Health Director Loretta Fuddy, has had five previous accidents or incidents involving the helicopters that the company also operates.



One of those was a midair collision between a company helicopter and another plane.

However, Makani Kai claims on its website that neither its airplanes nor helicopters have had an accident or incident in the company's more than 20-year history.

Makani Kai President Richard Schuman could not be reached for comment Friday.

The Federal Aviation Administration released records Friday that revealed the five previous accidents or incidents for Schuman Aviation, which does business as Makani Kai.

None, however, involved injuries or fatalities. Those incidents are as follows: >> July 8, 1996: A Hughes 369 helicopter had a midair collision with a Mooney M20 plane near Diamond Head during a movie shoot. The helicopter went down in the ocean, and the Mooney landed without incident.

>> June 30, 1998: A Bell 206B helicopter landed without incident in an open field on Oahu after the pilot reported hearing a noise in the main rotor area.

>> July 7, 2002: An AS350 helicopter made a hard landing near Wiliwilinui Ridge.

>> Jan. 5, 2009: An AS350 made a hard landing near Wiliwilinui Ridge following a reported loss of engine power.

>> May 13, 2012: An AS350 made an emergency landing after ingesting trash into the tail rotor at Honolulu Airport.

Sept. 29, 2017

To whom it may concern,

Based on conversations with my staff of the Kalaupapa Care Home, on March 11, 2017, Ms. Bettina Von Brentano, pilot of Makani Kai Airlines, was briefly observed at the Kalaupapa Care Home where she was provided water and her vital signs were checked. Once her vital signs were within normal levels, she was released from the care home.

Sincerely,

A handwritten signature in black ink, which appears to read "John Callaway", is written over a solid black rectangular redaction mark.

John Callaway, D.O.N. Kalaupapa Care Home

A-16



MEMORANDUM FOR RECORD

Michael Hicks

Air Safety Investigator

(GAAID) General Aviation Accident Investigation Division

May 22nd 2017

NTSB Accident Number: GAA17CA191

Aircraft Registration & Make/Model: N865MA, Cessna, 208B

Accident Location: Kalaupapa, HI

Accident Date: 11MAR2017 @ 0830 (HST)

Subject: Memorandum of Statement provided by the pilot in command (PIC)

In support of the NTSB Air Safety Accident Investigation involving accident airplane N865MA, the NTSB Investigator-in-charge (IIC) copied the entire statement of Mrs. von Brentano due to the truncated nature of the NTSB Form 6120.1.

PIC:

March 12, 2017

On March 11, 2017, I was the Pilot In Command of a Cessna Caravan (N865MA) during a morning commercial flight from Honolulu to Kalaupapa airport, located on the island Molokai. I was carrying eight passengers, with one seated in front next to me. Winds were relatively light and overall weather conditions were VFR in spite of a persistent haze, with scattered cloud layers reported at 2,500 and 4,500 feet.

When approximately 7 miles from my destination, along the "north shore arrival" for a straight in approach to runway five, I overheard a radio transmission indicating that there was an aircraft in the pattern at Kalaupapa. A male voice stated that he was "base for runway five at Kalaupapa".

I advised that I was a Cessna Caravan on a 7 mile final for runway five. A male voice responded to my transmission and in broken English, stated that he would "land and clear the runway".

I advised him that I would conduct a "360" degree turn from my present position and do an extended left base to final to give him time to back taxi and clear the runway (due to the lack of taxiways at the destination airfield). He responded "okay, okay".

After conducting the above maneuvers, I radioed the other Cessna pilot that I was "base to final" and requested confirmation that he was "clear of the runway".

The other pilot then stated he was "clear off runway".

Thanking him, I proceeded with my approach. Having completed my pre-landing checklists, I proceeded with the final descent for landing. Passing through 250 feet agl, the aircraft experienced a left rolling tendency which I immediately corrected for with proper control inputs and a slight addition of power. Descending through 150 feet agl, it again rolled slightly and, once again, I corrected with appropriate control response.

Approaching the transition to landing, I detected motion at the opposite end of runway five and immediately observed what appeared to be a rotating propeller pointed down the runway in our direction. 

I immediately added power to "go around". My aircraft yawed left and I attempted to correct while maintaining a climb attitude. The aircraft refused to climb and immediately dropped, impacting the runway midway on the bottom of the airframe. After bouncing once, it continued its travel in contact with the runway.

I applied left rudder pedal to steer the aircraft off the runway and out of the way from the other aircraft's possible flight path. The Caravan exited the runway surface and I continued to apply left rudder, which I believe induced a left ground loop.

After coming to a stop, I proceeded to shut down the engine. Exiting my seat, I walked into the passenger compartment, opened the main cabin door and was assisted in doing so. I then assisted a wheelchair-bound passenger in exiting the airframe at the rear of the aircraft.

Upon establishing that my passengers were all uninjured, I was approached by the airport manager. The manager stated that he had been confused by the pilot of the

But see
TP 4, p. 1 of
N9499 Final Rpt

other aircraft's actions and had tried to call out to him on the radio to also confirm his location and that he was, in fact, clear of the runway.

In brief, the manager stated that he had been looking for the other aircraft after he did not see it in the ramp area or the airport flight pattern.

Only a few minutes thereafter, I observed the other aircraft, identified as a Cessna 172 with registration N243SP, attempting to taxi past the accident scene for the purpose of taking off from runway five.

The airport manager then stopped the 172. The 172 pilot asked how long the runway was prior to the accident scene, indicating a desire to attempt to take off. The manager advised him that the runway was closed and no takeoff would be permitted. The Cessna 172 pilot then proceeded to park his aircraft on the grass area near the ramp. After a short time, the other pilot, accompanied by his two male companions elected to "hike out" of this isolated area, leaving their aircraft behind. I believe that the Park Ranger had inferred that this individual was a flight instructor who was accompanied by students.

After speaking to a Park Ranger who had responded to the accident scene, the 172 pilot spoke with me. When I asked why he had been at the end of runway five, he stated in broken English that he "does this all the time" (apparently waiting for other aircraft to land).

I was then briefly interviewed by the park ranger and provided appropriate identification to him.

A post accident view of the Caravan appeared to indicate that the propeller was feathered and heavily bent.

Bettina von Brentano

This is page 3 of 3 and nothing follows.

downwinds radio call can I ~~land~~ ^{land} first?

"I am left downwind can I land first?"

karavan was
called
3 miles north
360°

→ I did short Approach Runway 5 landed after transist
parking continue taxi to turnaround area with
until karavan radio call (no wind ^{calm} very little tail wind)
no radio call (I'm sure how long) I slowly move
airplane to look 240° heading (~~airplane heading is 045°~~ ^{airplane heading is 045°}) I saw many people cars

I did not hear any radio call after I landed till

I looked runway and move to ^{near} site accident area and turn around
~~try to cross runway~~ ^{try to walk} ~~so~~ ~~so~~ ~~so~~
I man ^{on safety} I turn around then
looking, thinking, ^{above} parking then turn around all people clear runway
so I slowly safely move (check runway) taxi back to parking
(left side on centerline)

First time I hear radio call is this time ("Runway is close")

I call "I going to park"

Yoshiya Kawabata

Although I was familiar with Richard Schuman from having seen him around Honolulu Airport on a few occasions over the past two years, the first time I engaged in any kind of extensive conversation with him was as part of what I would describe as an informal initial interview process in connection with my consideration for employment as a pilot in his organization.

I had been referred to Mr. Shuman by the owner of George's Aviation where I had been providing flight instruction for the better part of the last two years.

During a wide ranging conversation regarding various aviation topics which I had with Mr. Schuman on this occasion and which occurred during mid January of 2017, at one point he took a copy of the FAR/Aim text and tossed it over his shoulder, indicating that this was essentially his attitude toward the FAA regulations concerning safety and maintenance issues. While I was somewhat shocked at this gesture I deflected its potential implications by telling Mr. Schuman that his act carried no significance, since he had only tossed an expired (2016) copy of the FAR/AIM.

Shortly thereafter, Mr. Schuman introduced me to Bruce Mays, the Director of Operations, in a nearby conference room. At that time, Bruce and I engaged in a very positive discussion about various training issues to include the possibility of flying the company's twin engine Piper Chieftan as well as obtaining my ATP rating (but at my own expense) and providing pilot instruction for the company.

Mr. Schuman invited me to attend a safety meeting which the company had scheduled for the day after tomorrow. As I was leaving, I asked if it was really okay for me to come to the safety meeting (as I was not yet sure if I was going to be hired). Mr. Schuman responded that "I'd like you to come, so long as you shut up and don't say anything".

Two nights later, I attended the safety meeting which focused on the new CTS training system. Several other topics were also discussed by others. I kept quiet and left at the end of the meeting.

The following Friday night, I received a phone call advising me that my "due diligence flight would be conducted the following late afternoon or early evening in the company twin. After participating in the flight with "Mac" (Robert Smith) who is the Director of Training, Mr. Shuman inquired of me as to how I felt it went. I stated that I felt a little disappointed with my landings which were not exactly on centerline but that my air work had gone well. I would note that this was the first time I ever flown a Piper Chieftan. Mr. Schuman responded that "an airplane is an airplane, they go up and down. You pull it up and push it down. There are no excuses." I responded that if I had more hours in it, I would do a better job. His reaction was to state that "that's cocky of you" and in front of some other people told me to "shut up now and quit talking" and I reacted by stating that "no, I just meant that I could fly it but it could be better" he said "Okay, well just shut up now and go".

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Later in January or early February I attended ground training sessions which were conducted in the company's conference room. It should be noted that during the ground training provided to myself and the other two "new hires" (both of whom had extensive Caravan time), the company was transitioning from formal traditional classroom training to a new computerized training system (CTS) approach. We were therefore required to complete both programs.

During one of the in person ground training sessions on hazardous materials, Mr. Shuman took the opportunity to enter the conference room. The other two "new hires" as well as the company's chief helicopter pilot, Doug, were present. Mr. Shuman began speaking about an aircraft accident that had occurred in the past in or around Molokai Island wherein a student pilot had lost his life.

Mr. Shuman offered his opinion that as far as he was concerned, the instructor (although not present in the aircraft) had killed the student through improper training because, he alleged, she had not prepared the student to deal with a cloud layer which had apparently been a contributing factor to this accident which involved controlled flight into terrain. Mr. Shuman then shifted the conversation to "excuses" in aviation and offered his opinion that he is not concerned about a pilot's "hours" but how he or she flies. He then brought up my prior conversation with him from a week or two before regarding my due diligence flight in the Chieftain, stating that he was not interested in any excuses about performance, reiterating his statement that "an airplane is an airplane. They go up and they go down..."

After the aircraft accident at Kalaupapa, Schuman Aviation was notified and Richard Schuman arrived on scene flying one of the company helicopters. Prior to his arrival, a responding Park Ranger drove me to the nearby medical facility where a nurse monitored my initially high blood pressure until I had become a little more relaxed, providing me with bottled water. After arriving and speaking with the airport officials, but before he asked me to write down my recollection of events, Mr. Schuman handed me the airport telephone and told me to speak to "Gino". Because of his attendance at a recent company aviation safety meeting, I knew him to be an FAA representative.

I recall telling Gino on the telephone that I had seen something down the runway and had tried to go around and had lost control. I recall that his response was, in substance, that "ultimately it's on you, you are the PIC, ultimately it's your responsibility and your fault". He ended the conversation by saying "don't talk to anybody".

Shortly thereafter, Mr. Schuman asked me to provide a handwritten statement regarding the event while at the scene, which I did.

On the next Monday following the accident, I spoke with Bruce Mays, who asked me to attend a brief meeting at Schuman Aviation later that morning. Upon attending the meeting, I was invited into Mr. Schuman's office where two representatives of the company's insurance provider were present along with Mr. Schuman and Bruce Mays. After a meeting at which I answered various questions for Insurance Company purposes, the insurance company representatives left the room.

At that time, Mr. Shuman, in the presence of Bruce Mays, stated that he knew why the accident had happened and told me that "your personality did this, you are a bad pilot". He continued by saying that

it was also his fault for having hired me because it had gone against his better judgment. He then volunteered that although he has had two aviation accidents himself and has even hired pilots who have experienced aviation accidents, the difference was that he had learned from his mistakes, suggesting that I might be incapable of the same response. He then accused me of having bragged to the insurance company representatives that I had never even popped a tire as a flight instructor. I explained that I had made this remark trying to indicate to them my level of commitment to safe flying practices.

At the close of this conversation, with a bit of a grin on his face, Mr. Schuman asked me "You're not suicidal or anything"? I responded "No, I have children" and he appeared to adopt an expression indicating some annoyance at my response. Either he or Bruce then noted that someone would be coming to provide some form of psychological counseling to company employees concerning the incident and, almost as an afterthought, invited me to attend, which I declined.

A-14(3)



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

Western-Pacific Region
Honolulu Flight Standards District Office

135 Nakolo Place
Honolulu, HI 96819-1845

Telephone: (808) 837-8300
Facsimile: (808) 837-8399

Copy

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

April 3, 2017

Ms. Bettina Anne Von Brentano

[REDACTED]
Kailua, HI 96734-3958

Dear Ms. Von Brentano:

The Honolulu Flight Standards District Office has conducted an investigation of an accident that occurred at the Kalaupapa airport on March 11, 2017. Based on that investigation, the Federal Aviation Administration has reason to believe that your competence as a certificated airman is in question, and that reexamination of your qualification to be the holder of an airman certificate is necessary in the interest of safety. Therefore, under the authority in Title 49 U.S.C., § 44709, the Federal Aviation Administration requests that you call or appear at this office, no later than 10 days after receipt of this letter, to make an appointment for a reexamination.

The reexamination will consist of an oral and flight in a single engine airplane of your choice and include the knowledge and skill necessary to be the holder of a commercial airplane certificate in accordance with the current Practical Test Standards for Commercial Pilot, Airplane, FAA-S-8081-12C, with emphasis on the following areas:

- I. Area of Operation – Preflight Preparation
 - Task B: Airworthiness Requirements
 - Task F: Performance and Limitations
- II. Area of Operation – Preflight Procedures
 - Task A: Preflight Inspection
 - Task B: Cockpit Management
- IV. Takeoffs, Landings, and Go-Arounds
 - Task B: Normal and Crosswind Approach and Landing
 - Task L: Go-Around/ Rejected Landing

If you make an appointment with a Flight Standards District office in another area, please advise this office.

If you do not accept the opportunity for reexamination by the date set forth above, we will begin proceedings to suspend your airman certificate until such time as you demonstrate your competence to exercise its privileges. If, for reasons beyond your control, you are unable to be reexamined at this time, please contact me prior to April 10, 2017, so that the FAA can determine whether to grant an extension of time to you.

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In accordance with the Pilot's Bill of Rights, we also inform you that:

- (1) The nature of this investigation is to reexamine your qualifications to be the holder of an airman certificate in the interest of air safety pursuant to the Administrator's authority under 49 U.S.C. § 44709.*
- (2) Any response to an inquiry made by a representative of the FAA Administrator by you in connection with the reexamination of your qualifications described above may be used as evidence against you.*
- (3) If the reexamination of your qualifications results in a legal enforcement action against your certificate, the releasable portions of the Administrator's investigative report will be made available to you upon your written request addressed to the FAA's legal counsel handling the enforcement action.*

Please note that the incident that occurred on March 11, 2017 is still under investigation to determine whether other enforcement action is appropriate. If additional enforcement action is to be taken, you will be advised in a separate letter.

We will be pleased to discuss this matter with you and provide any further information that may assist you. Our office is open from 07:30 am to 04:00 pm, and our telephone number is 808-837-8300.

Your cooperation in this matter will be appreciated.

Sincerely,



Christopher M. Howard
Aviation Safety Inspector
808-837-8330

A20-(d)



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

Western-Pacific Region
Honolulu Flight Standards District Office (FSDO)

135 Nakolo Place
Honolulu, HI 96819-1845

Telephone: (808) 837-8300
Facsimile: (808) 837-8399

July 31, 2017

Ms. Bettina Von Brentano
567 Keolu Drive, Apt. C
Kailua, HI 96734

Dear Ms. Von Brentano:

This letter is to inform you that reexamination of your ability to exercise the privileges of Commercial Pilot conducted on July 21, 2017, at Honolulu International Airport was satisfactory.

The results of this reexamination are a matter of record and will be forwarded to the Airman Records Office in Oklahoma City, OK.

Sincerely,

Kyle M. Bartler
Principal Operations Inspector

A-20 (3)

XFINITY Connect

+ Font Size -

Re: Your Letter of Investigation; EIR number 2017WP130015**From :** [REDACTED]

Mon, Apr 10, 2017 08:00 PM

Subject : Re: Your Letter of Investigation; EIR number 2017WP130015**To :** gino <gino.d.rezzonico@faa.gov>

Hello Gino;

I apologize for not attaching my cell number with this morning's letter. Please feel free to call me, at any time, if you have questions, regarding this investigation, that would require answers in an expeditious manner. My cell number is 781-444-7931. Thank you for your time.

Respectfully, Bettina von Brentano

From: [REDACTED]**To:** "gino" <gino.d.rezzonico@faa.gov>, "christopher m howard" <christopher.m.howard@faa.gov>, "kyle m bartler" <kyle.m.bartler@faa.gov>**Sent:** Monday, April 10, 2017 10:32:03 AM**Subject:** Your Letter of Investigation; EIR number 2017WP130015

Gentlemen;

I am in receipt of your above identified letter dated April 3, 2017. In substance and part, this letter states that "...discrepancies discovered during passenger boarding were not reported to maintenance, written up" or otherwise noted or corrected prior to take off. In addition, this letter states that a "records inspection revealed the required preflight was not accomplished in accordance with" the F.A.R.s or the company G.O.M.

Unfortunately, the vague nature of the letter's language and its lack of specificity prevents me from providing you with a coherent response. Nor does it allow me to "productively participate in a proceeding related to an investigation" as set out in Public Law 112-153; sections 2 (b) (2), (4) (B) (V) and (I).

I therefore respectfully request that you respond in kind, providing me with the specific nature of your findings in the above cited regards, as expeditiously as your time allows. I am certain that this will allow me to respond in a timely manner and I suspect that once I am provided with greater detail, I would be willing to assist you in furthering your investigation.

Respectfully, Bettina von Brentano

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