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The following narrative details my account of the events that took place on Tuesday, 10/29/2013 that resulted in an aircraft accident involving Hawaii Life Flight AS350 B3, N985EW.

The three nights prior to the accident were normal with adequate, uninterrupted rest at the Kona Crew House maintained by Hawaii Life Flight (HLF). I had complete two training flights in the two previous evenings with AMRG Chief Pilot, Robert White.

I began my duty day on 10/29/2013 at 11:30AM HST with flight planning and reviewing study material in preparation for a flight evaluation to be conducted later in the afternoon and into the evening. I ate lunch with Robert White, at the Royal Kona Hotel. I ate a turkey sandwich with French fries and drank water.

I picked up Robert White at the Kona Seaside Hotel at approximately 3:30PM and together we drove to the Kona Airport.

From approximately 4:00PM until take off we performed a preflight of the helicopter, reviewed logbook and documentation and were present during refueling. 25 gallons of Jet A fuel was put into the aircraft by Air Service, bring the total fuel on board to approximately 140 Gallons.

We took our positions in the helicopter; I was in the right side pilot seat and Robert in the left side pilot seat. We were the only occupants aboard the helicopter.

Aircraft starting and run-up were conducted using the aircraft checklist and proceeded normally. Our first planned maneuver was to be manual throttle control with FADEC disengaged using the Auto/Manual switch. Robert briefed me on the maneuver and I conducted a back brief to ensure understanding of the planned maneuver.

Weather and airport information was received using ATIS and a request made to the control tower to reposition to the intersection of taxiways L and A for hovering flight maneuvers. Liftoff was at precisely 5:00PM. We repositioned to the taxiway with the FADEC in Auto Mode and landed the aircraft normally. The maneuver was again briefed and I was instructed that once the FADEC was disengaged I was to use manual throttle control to maintain Rotor RPM in the normal operating range while lifting to a hover and executing hovering turns.

Robert used the Auto/Manual switch to disengage the FADEC by switching to Manual while the helicopter was on the ground, collective full down and with me at the flight controls. The red GOV light on the Caution/Warning Panel illuminated. I used the collective to increase main rotor pitch while manipulating the throttle control on the collective to maintain normal Rotor RPM. My initial reaction was that the throttle control was excessively stiff and difficult to rotate. While still on the ground, I checked the throttle control friction wheel and determined that no friction was applied. I have never conducted this maneuver in a Eurocopter helicopter and had no reference as to how stiff the control was supposed to be. Robert assured me that it was normal and was purposely stiff to avoid over controlling.

Once at a 3-foot hover, I used the anti-torque pedals to execute a 360-degree, stationary hovering turn (nose to the right) while using the throttle control to maintain normal Rotor RPM. I then executed the same maneuver while turning the nose to the left. All portions of these maneuvers were conducted normally and as briefed. It took a good bit of effort to rotate the

throttle control, but I did so effectively enough to maintain normal Rotor RPM (in the green) throughout.

While still at a hover over the taxiway and while still in manual mode, Robert asked me if I was ready to perform a left, closed, traffic pattern back to the taxiway. I informed him that I was. I made a radio call to the control tower to request the traffic pattern and was given a takeoff clearance. I was briefed to perform a normal takeoff using non-abrupt control inputs in order to maintain normal Rotor RMP. The takeoff phase and the transition into cruise flight on the downwind were normal for manual mode while I controlled the throttle manually. I made a radio call to report my turn from base leg to final and was told to "land at my own risk". From an altitude of approximately 700' AGL I began a descending left turn to line up with my final approach path over taxiway A. I did so by simultaneously adjusting the flight controls to initiate a normal descent and manipulating the throttle control to maintain Rotor RPM. The initial descent was normal and Rotor RPM was in the normal operating range. I remember hearing the automated readout of altitude when passing 400' AGL. This is the last readout that I remember hearing.

At some point below 400' AGL I noticed that the Rotor RPM was decreasing though I was making no change in collective position or throttle position. I rotated the throttle control to increase Rotor RPM. I did this by twisting the top of the throttle control away from me (top towards the left). While doing so, I noticed that Rotor RPM was continuing to decrease. I made continuing inputs to the throttle in an effort to increase Rotor RPM with seemingly no effect. At some point I heard the Low Rotor RPM Audio. I felt Robert come on the controls though I did not relinquish any flight control. I (we) lowered the collective to full down to enter an autorotational descent. Rotor RPM never recovered to normal range even though we had rotated the throttle control to maximum (MAX).

At approximately 50' AGL I attempted to apply initial pitch input to decrease the rate of descent, but Rotor RPM was quite low and the attempt was unsuccessful. I do not remember a numerical value of the Rotor RPM at this point. After determining that impact was imminent, I adjusted the cyclic to level the aircraft so as not to make contact with the ground while at an unusual attitude. We adjusted the collective to full-up but insufficient Rotor RPM remained and no cushioning was effected. The aircraft impacted the ground in a fairly level attitude. At contact, the front cross-tube collapsed (spread) and the underside of the front portion of the fuselage contacted the ground. I adjusted the cyclic in an effort to keep the still turning main rotor system from contacting the ground. The aircraft slid forward on the taxiway and yawed (nose) to the left.

When the aircraft came to a stop on the taxiway I made a personal assessment of possible injury and felt as though I was uninjured. Robert and I each verbally checked the condition of the other. I saw and smelled a cloud of smoke and determined that I needed to exit the aircraft immediately in the event of a post impact fire.

I did not adjust any switches or levers. In other words, I made no attempt to shutdown the engine or turn off electricity. I don't know when or how the engine became shutdown. I noticed that Robert had applied the Rotor Break. I opened the right side pilot door normally and exited the helicopter. I was still wearing my flight helmet and it was still plugged into the helicopter. At this point, Robert reminded me to wait until the main rotor blades came to a stop before walking away from the helicopter. I removed my helmet as the blades came to a stop. When I stepped out of the helicopter, my kneeboard slid down my right leg to my ankle. The notecards I kept on the kneeboard were scattered downwind. I walked a safe distance away from the helicopter and determined that no post impact fire was detectable. I saw that Robert was also a safe distance away from the helicopter.

At some point after we exited the helicopter, the front cross-tube flexed and the front of the helicopter sprang back to approximately normal skid height. I made an attempt to recover the

notecards that had come off my kneeboard and retrieved all that I saw. The first time I remember looking at my wristwatch after exiting the aircraft it was 5:17PM.

The fire department was deployed to our location where we started to undergo personal evaluations and checking of vital signs. I could not determine that I was injured in any way nor have I experienced any physical effects since.