



National Transportation Safety Board

Washington, D.C. 20594

Safety Recommendation

Date: October 27, 2009

In reply refer to: A-09-129

Ms. Roslyne Schulman
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Washington, D.C. 20004

The National Transportation Safety Board (NTSB) is an independent federal agency charged by Congress with investigating transportation accidents, determining their probable cause, and making recommendations to prevent similar accidents from occurring. We are providing the following information to urge your organization to take action on the safety recommendation in this letter, which addresses publicizing the methods for alerting the Federal Aviation Administration (FAA) to safety concerns. The NTSB is vitally interested in this recommendation because it is designed to prevent accidents and save lives.

The recommendation is derived from the NTSB's investigation of the June 4, 2007, helicopter accident in Milwaukee, Wisconsin. As a result of this investigation, the NTSB has issued 17 safety recommendations, 1 of which is addressed to the American Hospital Association. Information supporting this recommendation is discussed below. The NTSB would appreciate a response from you within 90 days addressing the actions you have taken or intend to take to implement our recommendation.

On June 4, 2007, about 1600 central daylight time, a Cessna Citation 550, N550BP, impacted Lake Michigan shortly after departure from General Mitchell International Airport, Milwaukee, Wisconsin (MKE).¹ The two pilots and four passengers were killed, and the airplane was destroyed. The airplane was being operated by Marlin Air under the provisions of 14 *Code of Federal Regulations* (CFR) Part 135 and departed MKE about 1557 with an intended destination of Willow Run Airport (YIP), near Ypsilanti, Michigan. At the time of the accident flight, marginal visual meteorological conditions prevailed at the surface, and instrument meteorological conditions prevailed aloft; the flight operated on an instrument flight rules flight plan.

¹ For more information, see *Loss of Control and Crash, Marlin Air Cessna Citation, N550BP, Milwaukee, Wisconsin, June 4, 2007*, Aircraft Accident Report NTSB/AAR-09/6 (Washington, DC: NTSB, 2009), which will be available on the National Transportation Safety Board's website at <<http://www.nts.gov/publictn/2009/AAR0906.pdf>>.

The medical/air ambulance trip was flown under contract to the University of Michigan (UM) Health System and was intended to transport a medical transplant team to MKE so they could harvest an organ and return to YIP for an organ transplant at UM Medical Center. Marlin Air had provided medical transport services for the UM Survival Flight Program under successive contracts for about 19 years before the accident; the accident occurred shortly after takeoff on the return leg of the trip.

The NTSB determined that the probable cause of this accident was the pilots' mismanagement of an abnormal flight control situation through improper actions, including failing to control airspeed and to prioritize control of the airplane, and lack of crew coordination. Contributing to the accident were Marlin Air's operational safety deficiencies, including the inadequate checkrides administered by Marlin Air's chief pilot/check airman, and the FAA's failure to detect and correct those deficiencies, which placed a pilot who inadequately emphasized safety in the position of company chief pilot and designated check airman and placed an ill-prepared pilot in the first officer's seat.

This investigation revealed that, although the UM Survival Flight program personnel had felt comfortable with Marlin Air for most of the 19 years they had contracted with the operator, UM personnel had increasing reservations regarding Marlin Air's operations in the couple of years preceding the accident. UM personnel stated that they began to hear complaints about Marlin Air and their pilots and had concerns about the number of Marlin Air flights cancelled due to mechanical issues. According to the UM program manager, the number of trip cancellations had increased in the year preceding the accident and medical personnel were beginning to think that Marlin Air was unsafe. However, UM personnel did not relay any of these concerns to the FAA before the accident, in part because they were not aware of the procedures by which they might make their concerns known.

Complaints from outside the FAA may alert the FAA to a variety of operator-related safety issues that the FAA can then pursue through a formal investigation or increased oversight. During postaccident interviews, an FAA management and program analyst described the following four programs that could have been used by UM to report concerns about or request additional surveillance of Marlin Air:

- 1) Administrator's hotline.² Developed in the late 1980s, this hotline provides FAA employees and outside organizations a way to raise issues to the FAA administrator. The FAA's Flight Standards Division has 30 to 60 days to react to complaints received on this hotline. Callers who identify themselves will be advised of subsequent actions. Anonymous callers are not so advised.
- 2) Customer Service Initiative. The UM could have described safety concerns and lodged a complaint with the local flight standards district office (FSDO). The FSDO would then have been required to investigate and, if possible, substantiate the complaint. If not satisfied by the FSDO's response, the UM could have appealed to

² Safety concerns may be reported to the administrator's hotline by telephone at 1-800-255-1111 or 1-866-835-5322 (866-TELL-FAA) or online at http://www.faa.gov/contact/safety_hotline or http://www.faa.gov/about/office_org/headquarters_offices/avs/cust_service.

FAA regional management, the director, or the administrator. (This mechanism is typically used by operators rather than the public.)

- 3) Office of Inspector General (OIG) hotline. Used by the public, this hotline normally accepts information related to crimes, but it also accepts safety information. In the past 2 years, the information provided through the OIG hotline was used to pursue safety concerns related to the Southwest Airlines certificate. Information from the hotline was also used to pursue a complaint involving a helicopter emergency medical services operator after a complaint from a nurse. She complained that the operation used by her hospital was unsafe. The FAA regional office sent in two investigative teams and replaced the operator's principal operations inspector.
- 4) Safety hotline, FAA Office of Accident Investigation. Complaints received through the safety hotline are typically from pilots and are acted on by local regional offices and FSDOs.

Had the FAA been aware of UM's concerns, FAA staff could have responded with increased oversight or a formal investigation. The NTSB concludes that customers (such as UM) who contract with aviation operators may not understand the FAA's role in aviation safety or know how to contact FAA personnel when safety concerns arise. As a result, the NTSB is recommending that the FAA require all 14 CFR Part 135 and Part 91K operators to provide their customers, when a business agreement or contract is finalized, with such information. The American Hospital Association is another source of information for the medical/air ambulance industry.

Therefore, the National Transportation Safety Board recommends that the American Hospital Association:

Inform its members, through its website, newsletters, and conferences, of the Federal Aviation Administration's (FAA) role in aviation safety with respect to medical/air ambulance services and provide FAA contact information. Further, the American Hospital Association should urge its members to communicate any safety concerns related to medical/air ambulance services to the FAA. (A-09-129)

The NTSB also issued safety recommendations to the FAA.

In response to the recommendation in this letter, please refer to Safety Recommendation A-09-129. If you would like to submit your response electronically rather than in hard copy, you may send it to the following e-mail address: correspondence@ntsb.gov. If your response includes attachments that exceed 5 megabytes, please e-mail us asking for instructions on how to use our secure mailbox. To avoid confusion, please use only one method of submission (that is, do not submit both an electronic copy and a hard copy of the same response letter).

Chairman HERSMAN, Vice Chairman HART, and Member SUMWALT concurred with this recommendation.

[Original Signed]

By: Deborah A.P. Hersman
Chairman