National Transportation Safety Board
Aviation Accident Final Report

Location:	S. Padre Island, Texas	**Accident Number:**	DFW08FA062
Date & Time:	February 5, 2008, 20:54 Local	**Registration:**	N911VA
Aircraft:	Eurocopter France AS350B2	**Aircraft Damage:**	Substantial
Defining Event:	VFR encounter with IMC	**Injuries:**	3 Fatal
Flight Conducted Under:	Part 91: General aviation - Positioning		

Analysis

The EMS helicopter departed in dark night visual meteorological conditions en route to pick up a patient. The helicopter approached the intended landing zone from the west and reported to approach control that he had the landing zone in sight when he was at 1,000 feet above ground level and approximately 4 miles west of the landing zone. Shortly after that, the helicopter began a left turn approximately two miles to the west of the landing zone, followed by a tighter radius right turn. Several radio recordings from the flight nurse onboard the helicopter were heard to transmit the following: "uh i got lights here...follow the uh the lights out...ok follow the lights out...we're in the clouds again we're gonna abort transport patient by ground." The last radar position was at an altitude of 1,000 feet. Several witnesses saw the lights of the helicopter fall almost straight down, and the helicopter wreckage exhibited damage consistent with a high speed, port side, inverted impact with water. No anomalies were noted with the airframe, systems, and engine. A review of the pilot's experience showed that his most recent actual instrument experience was in 1997 when he completed an instrument competency check in a single-engine airplane. The only instrument experience in a helicopter entered in the pilot's logbook within the past ten years was two entries of simulated instrument time of 0.8 hours in December, 2005. and 0.2 hours in September, 2007.

Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be: The pilot's failure to maintain aircraft control resulting in the helicopter impacting the water. Factors contributing to the accident were the pilot's inadvertent flight into instrument meteorological conditions, the low ceiling, dark night conditions, and the pilot's lack of recent instrument flying experience.

Findings

Aircraft	(general) - Not attained/maintained
Environmental issues	Below VFR minima - Effect on operation
Environmental issues	Low ceiling - Contributed to outcome
Environmental issues	Dark - Contributed to outcome
Personnel issues	Recent instrument experience - Pilot

Factual Information

HISTORY OF FLIGHT

On February 5, 2008, at 2054 central standard time, a Eurocopter France AS350B2 emergency medical service (EMS) helicopter, N911VA, operated by Metro Aviation, Inc., Shreveport, Louisiana, and was registered to Harlingen Comm Emergency Care Foundation, Inc., doing business as Valley Air Care, Harlingen, Texas, impacted the Laguna Madre near South Padre Island, Texas. The helicopter was destroyed. The airline transport pilot, flight nurse, and flight paramedic sustained fatal injuries. Visual meteorological conditions prevailed, and a company flight plan was filed for the 14 Code of Federal Regulations (CFR) Part 91 flight. The helicopter departed the Valley Baptist Medical Center Heliport (49TX), Harlingen, Texas, at 2040 and was en route to pick up a patient at an emergency landing zone in the parking lot of the South Padre Island Convention Center at South Padre Island, Texas.

The flight to the emergency landing zone at South Padre Island from 49TX was 26.7 miles on a magnetic course of 88 degrees. The accident helicopter was equipped with a Global Positioning System (GPS) flight tracking system referred to as OuterLink. According to the OuterLink system, the helicopter powered up for flight at 2037:09 and departed the 49TX helipad at 2040:35. At 2041:12, the pilot using the call sign Air Care One, contacted the controlling Federal Aviation Administration (FAA) air traffic control facility, Valley Approach Control, located in the Corpus Christi Air Traffic Control Tower, Corpus Christi, Texas, and initiated visual flight rules (VFR) flight following for the flight to the destination landing zone. At 2052:24, the pilot told Valley Approach Control "...air care one has the landing zone in sight we're out of nine hundred for landing padre island."

Beginning at 2053, the flight nurse on board made several transmissions on the MedCom radio. At 2053:01, he said, "uh i got lights here," then "(unintelligible) follow the uh the lights out," followed by "ok follow the lights out," and at 2053:23, he said "(unintelligible) we're in the clouds again we're gonna abort transport patient by ground."

Valley Approach Control's radar system recorded a radar hit every 5 seconds. The first radar contacts with the helicopter began at 2040:38 as it departed the 49TX helipad. The radar data showed the helicopter was generally eastbound until it was about 2 miles west of the intended destination and then made a left turn back westbound followed by a tighter radius right turn.

Emergency responders waiting for the helicopter at the emergency landing zone saw the helicopter go down and immediately notified the 911-call center. An immediate search began, and search and rescue teams located the wreckage at 2320, about 2.4 miles west of the destination landing zone.

According to several witnesses located near the destination landing zone, they saw the lights of the helicopter fly eastbound toward the landing zone and then make a left turn westbound. One of those witnesses remembers seeing the lights on the helicopter go almost straight down and shortly afterward heard the sounds of impact.

Another witness staying in an RV camping area about 500 feet from the destination landing zone had watched several times before when medical helicopters came in to meet the ground ambulance and saw the lights of the accident helicopter fly toward the convention center parking lot, but it did not descend as it normally did. The helicopter then made a left turn and headed back to the west. Shortly after the helicopter departed to the west, she saw lights spiraling down, and shortly after that, she heard the sounds of impact.

Another witness was standing in a parking lot behind a restaurant approximately one mile south of the intended landing zone. He was watching the accident helicopter approach the island from the west when it made a turn back to the west and appeared to not be descending to land. He recalled that there were clouds above and it was windy, but the visibility was good.

PERSONNEL INFORMATION

The pilot, age 55, held an airline transport pilot certificate dated April 3, 2003, with ratings in airplane single-engine land, rotorcraft helicopter, and with commercial privileges in airplane multi-engine land, and airplane single-engine sea. He was issued a second class airman medical certificate on December 11, 2007. The medical certificate contained the limitation "must wear corrective lenses."

Metro Aviation, Inc., initially hired the pilot as an EMS helicopter pilot at the Harlingen base, in December 2005, and he worked in that position until April of 2006. They rehired the pilot for the same position in September 2007. At the time of the accident, the pilot had logged 16,896 total hours; with a total of 11,518 hours in helicopters, 1,100 of which in the make and model of the accident helicopter, 18 hours of which were in the past 90 days, and 7 hours within the past 90 days at night. Metro Aviation, Inc. records showed that the pilot had no previous experience with night vision goggles (NVG) and he had not previously been trained in the use of NVGs.

The pilot's logbook shows he had logged a total of 115 hours of actual instrument flying experience and 46 hours of simulated instrument experience. In 1997, the pilot logged 3.1 hours of actual instrument experience in a single-engine airplane during an instrument competency check. In 2003, the pilot logged 9.5 hours of simulated instrument experience when he completed training and a practical test for his airline transport pilot rating for single-engine land airplanes. The only instrument experience in a helicopter entered in the pilot's logbook within the past ten years was two entries of simulated instrument experience for Part 135 training and testing of 0.8 hours in December, 2005. and 0.2 hours in September, 2007.

According to the pilot's logbook, he had a general pattern of employment of flying EMS helicopters during the winter months and agricultural airplanes during seasonal months. His pilot logbook showed he began flying AS350 helicopters at the Harlingen EMS base for Tex-Air Helicopters, Inc. a different Part 135 air carrier beginning in 1998. His logbook showed he had accumulated a total of 1,780 hours in EMS operations within the past twenty years.

The pilot's most recent Part 135.293 competency check, and Part 135.299 line check was completed with a satisfactory rating in all tested areas on September 12, 2007. A Metro Aviation, Inc., check airman conducted the flight check in daylight hours in a Eurocopter

France AS350B2 helicopter.

According to company records, the pilot had seven consecutive days off ending on January 25, 2008, and would have been scheduled for another seven day rest period beginning at 0700, on the morning of February 8, 2008. He had been on the day shift (0645 to 1815) from January 25th through the 31st, 2008, and on February 1, 2008, he had started a seven-day period of duty for the night shift (1800 to 0700).

AIRCRAFT INFORMATION

The accident helicopter was a Eurocopter France AS350B2 model, S/N 2588, that had been converted from a Eurocopter AS350BA at the American Eurocopter facility, Grand Prairie, Texas, in June of 2007. The airframe had accumulated 10,307.3 hours total time at the time of the accident, with an engine total time of 218.8 (engine S/N 19124).

The helicopter was configured with a right pilot seat, a swivel medical seat on the right side behind the pilot, and a medic jump seat on the center aft bulkhead. A stretcher extended from the left front cabin aft, with a Plexiglas shield to separate the patient from the pilot.

The accident helicopter was equipped for NVG operations.

METEOROLOGICAL INFORMATION

National Weather Service (NWS) Surface Analysis for February 6, 2008, at 2100, showed a cold front just west of the accident site, which had moved well to the east of the accident site by 2400.

The Terminal Area Forecast (TAF) for the Brownsville/South Padre Island International Airport (BRO), Brownsville, Texas, located approximately 19 miles southwest of the accident site, was issued at 0720 and showed a forecast beginning at 1800 for conditions of wind from 170 degrees at 10 knots with the visibility greater than six statute miles, and broken clouds at 3,000 feet.

At 1735, the BRO TAF showed a forecast beginning at 2000 for conditions of wind from 140 degrees at 14 knots with the visibility greater than six statute miles and sky conditions clear.

At 2031, the Port Isabel-Cameron County Airport (PIL), port Isabel, Texas, METAR (routine aviation weather report), located approximately 7 miles west of the accident site, reported the wind from 280 degrees at ten knots, gusting to 23 knots, visibility eight statute miles, overcast clouds at 1,000 feet, temperature 23 degrees Celsius, dew point 21 degrees Celsius, and an altimeter setting of 29.79 inches of Mercury, with remarks that a wind shift had occurred at 2011, and the pressure was rising rapidly.

At 2054, the PIL METAR, reported the wind from 318 degrees at eight knots, visibility eight statute miles, scattered clouds at 1,000 feet and overcast clouds at 1,400 feet, temperature 23 degrees Celsius, dew point 21 degrees Celsius, and an altimeter setting of 29.81 inches of Mercury.

At 2006, the BRO METAR, reported the wind from 170 degrees at 14 knots, gusting to 22 knots, visibility nine statute miles, overcast clouds at 800 feet, temperature 22 degrees Celsius, dew point 21 degrees Celsius, and an altimeter setting of 29.70 inches of Mercury.

At 2048, the BRO METAR, reported the wind from 240 degrees at eight knots, gusting to 21 knots, visibility nine statute miles, with overcast clouds at 800 feet, temperature 23 degrees Celsius, dew point 21 degrees, Celsius, and an altimeter setting of 29.80 inches of Mercury with remarks that a wind shift had occurred at 2028 and that the overcast clouds were variable from 800 feet to 1,300 feet.

According to the United States Naval Observatory's Astronomical Applications Department Sun and Moon Data, on the day of the accident, the sunset occurred at 1915, and the moonset occurred at 1800. The moon was waning crescent with 2 percent of the moon's visible disk illuminated.

COMMUNICATIONS AND DISPATCH INFORMATION

At the 49TX helipad, the South Texas Emergency Care foundation operates MedCom, a 911-call center, which serves as a secondary answering point for 911 EMS calls. The dispatchers are responsible for ground ambulance, helicopter, and fixed-wing radio communications. They normally have two people on duty during the day and one at night. The dispatcher communicates with the helicopters on a Motorola SmartNet 800 MHz radio system using one of four different frequencies.

Metro Aviation, Inc. operates one Operational Control Center (OCC) at their headquarters in Shreveport, Louisiana, and uses the services of flight control coordinators at each helicopter base, such at the MedCom dispatcher in Harlingen, Texas.

The aircraft is required to make position reports to the flight coordinator at the MedCom facility who keeps a log of the time and position and is assisted by the use of an Automatic Vehicle Locating device such as OuterLink.

FLIGHT RECORDERS

The helicopter was not equipped with any flight data recorders or cockpit voice recorders.

WRECKAGE AND IMPACT INFORMATION

The main wreckage was located in three to five feet of salt water in the Laguna Madre between Port Isabel and South Padre Island, approximately two miles west northwest of the South Padre Island Convention Center. Other debris, recovered in the days after the accident, was located within a few miles of the main wreckage site.

The wreckage was recovered by barge to the U.S. Coast Guard Station, South Padre Island, Texas, on February 7, 2008.

The aircraft cabin was compromised. The canopy, port side cabin doors, and instrument panel were separated and destroyed, and not recovered to the initial examination. The flight controls (cyclic,
collective, antitorque pedals, throttle quadrant) were still attached to the cabin floor, but were deformed and embedded in the wreckage. All seats were detached from their respective mounts.

The forward portion of the tail boom was still attached to the fuselage and exhibited compression and torsional twisting. Hydrodynamic damage was observed on the upper surface, and the tail boom was bent in a downward direction. The horizontal stabilizer and portion of tail boom separated and exhibited hydrodynamic damage to the left and upper surfaces.

Both of the landing gear cross tubes remained attached to the fuselage and were bent in a forward direction. Portions of the skids remained attached to the cross tubes.

The main transmission exhibited corrosion. The investigation team attempted to rotate the main rotor head, but the transmission was seized and would not rotate. Damage was observed on the lower casing. The main rotor input flex coupling exhibited torsional damage and splaying of the discs.

On the main rotor system, the anti vibrator assembly separated from the main rotor hub and exhibited bending and crush damage. The Starflex rotor head exhibited rotational damage. The red sleeve retreated aft, and the yellow sleeve advanced in the direction of rotation. All three sleeves (red, yellow, and blue) exhibited splintering of the composites (or broom straw damage). All three star arms separated and exhibited angular fracture surfaces.

The forward tail rotor drive shaft (short shaft) remained attached to the engine output. T The tail rotor gearbox input coupling was still partially connected by two bolts and exhibited torsional damage and splaying of the discs. The tail rotor gearbox rotated freely by hand. The tail rotor spar was broken and bent strike tabs were observed on both paddles. One paddle was broken at the cuff and exhibited trailing edge damage.

The accessible flight control tubes, levers, and bell cranks were examined. All hardware was in place, and all breaks exhibited angular fracture surfaces. All main rotor servos and pitch links were found connected.

The upper left side of the engine was crushed. The upper left side of the exhaust pipe was crushed and flattened. The fuel control unit (FCU) was crushed and enveloped by a metal structure. The air inlet cone exhibited rotational scarring and the blades of the axial wheel exhibited foreign object damage (FOD). The axial diffuser stator vanes did not exhibit FOD. The axial compressor was unable to be rotated by hand.

The front engine mount was ruptured near the coupling tube attach point, and the coupling tube was lying inline with the vertical axis of the engine. The bolt holes in the cover were elongated or torn. Rotational scarring was noted on the interior and exterior circumferences of the forward-facing surface of the cover. The free wheel shaft was fractured, and the fracture

surface showed a 45-degree lip.

Post-accident examination and testing of the helicopter systems and engine revealed no evidence of pre-impact malfunction or anomalies that would have precluded flight operations.

MEDICAL AND PATHOLOGICAL INFORMATION

The autopsy was performed on the pilot by the medical examiner in McAllen, Texas, as authorized by the Justice of the Peace, Precinct 1, Cameron County, Texas. The conclusion of the autopsy was that the pilot died as the result of blunt force trauma secondary to a helicopter accident.

During the autopsy, specimens were collected for toxicological testing to be performed by the FAA's Civil Aerospace Medical Institute, Oklahoma City, Oklahoma. Tests for carbon monoxide, and cyanide were not performed. Test results for ethanol and for certain drugs were negative.

ADDITIONAL INFORMATION

Metro Aviation, Inc. was issued an air carrier certificate by the FAA in 1985 to conduct on-demand air taxi operations, and they hold operations specifications authority to conduct both helicopter emergency medical services/air ambulance operations and airplane air ambulance operations under 14 CFR Part 135. They also hold operations specifications authority to conduct helicopter NVG operations.

At the time of the accident, Metro Aviation, Inc. conducted air ambulance operations in 14 states with 43 helicopters located at 30 bases. One of those helicopters is authorized for instrument flight operations, and the remaining helicopters are VFR only. The accident crew was based at 49TX in Harlingen, Texas. The corporate headquarters for Metro Aviation, Inc., including the principal pilot training location, the Director of Operations, Chief Pilot, and Director of Safety, were located in Shreveport, Louisiana. The air carrier certificate was managed by the FAA Flight Standards District Office in Baton Rouge, Louisiana, and was assisted with geographic surveillance from 13 other FAA Flight Standards District Offices.

Each one of the helicopters is usually staffed by three to four full-time pilots and one full-time mechanic. Prior to employment, each helicopter pilot in command must have a minimum of 2,000 hours total time in helicopters, with at least 150 hours at night in helicopters, and each pilot assigned to hospital based EMS programs is required to possess a current commercial certificates with instrument rating.

Metro Aviation, Inc. had been providing Part 135 Helicopter EMS services at the base in Harlingen, Texas, since December 2005. A previous Part 135 air carrier, Tex-Air, Inc., had been providing helicopter EMS operations in AS350 helicopters since operations began at this location on February 1, 1995.

The pilots and mechanics are employees of Metro Aviation, Inc., and the medical crewmembers and dispatchers are employed by divisions of the South Texas Emergency Care Foundation,

Inc., which provides ground ambulance service to most of the Rio Grande Valley of Texas. The foundation is accredited by the Commission on Accreditation of Medical Transport Systems (CAMTS).

OPERATIONS MANUAL

A copy of the Metro Aviation, Inc. Operations Manual was provided to the IIC for the course of the investigation. The Operations Manual section 301 outlined weather minimums for unaided, night, low lighting, non-mountainous local flights as 1,000 foot ceiling and three miles visibility with a note to add 200 feet and 1 mile for preflight planning purposes. The Operations Specifications paragraph A021 defines the conditions for unaided, night, low lighting, non-mountainous local flights as 800 foot ceiling and three miles visibility.

The Operations Specifications paragraph A021 includes a restriction that "the certificate holder is authorized to use no lower than the Visual Flight Rules (VFR) weather minimums in Table 1 below when operating in Class G (uncontrolled) airspace for the conditions specified when conducting HEMS/air ambulance work..."

PRE-FLIGHT RISK ASSESSMENT TOOL

The Metro Aviation, Inc. Safety Manual, pages 200-7, 200-8, and appendix 1300, addresses the use of the Risk Assessment Tool required for use prior to all flights. The pilots are instructed that the tool is to be used to aid the pilot in the Go/ No Go decision. It also includes the instruction that "Medical Attendants have the authority to request termination of a flight segment."

In the risk assessment tool, the pilot evaluates five areas prior to flight: Day or Night Operations, LZ - Scene or unimproved area, Aircraft, Environmental / Operational, and Fatigue / Human Factors considerations. These areas are given a point value based on severity or above normal conditions. The values are then added and a total risk assessment score is weighted against the go/no go decision

A total Risk Assessment Value of 2 to 3 is defined as "Enhanced ADM" and requires the pilot in Command to "be alert to potential safety risks." A value of 4 to 6 is defined as "Caution" and informs the Pilot in Command that "safety risks are present, evaluate carefully." A value of 7 to 10 is defined as "Extreme Caution" and informs the Pilot in Command that "many safety risks are present, evaluate carefully." A value of 11 or greater is defined as "Critical Safety Decision" and informs the Pilot in Command to "consider rejecting flight..."

The Metro Aviation, Inc. Risk Assessment Tool allows the flight to be accepted or continued with a Risk Assessment Value of 11 or greater "if the PIC has assessed all available information and resources, and has determined that the particular risks associated with the flight are acceptable." The Safety Manual instructions on the Risk Assessment Tool also require that the Risk Assessment Value must be written on the flight manifest.

OTHER INFORMATION

The weather conditions that existed at the accident site during the time of the accident were estimated to be overcast clouds and dark night conditions. The helicopter was not equipped with a terrain awareness warning system (TAWS) or a traffic collision avoidance system (TCAS). The pilot was not utilizing a night vision imaging system (NVIS) during the flight.. A radar altimeter was installed on the helicopter. The accident flight was being tracked by a flight following program, and the flight did receive flight dispatch services prior to and during the flights. Additionally, a formal flight risk assessment was performed prior to the flight.

On February 7, 2006, the NTSB issued four safety recommendations to the FAA addressing EMS operations. They are as follows:

NTSB Recommendation No. A-06-12 - Require all EMS operators to comply with 14 CFR Part 135 operations specifications during the conduct of all flights with medical personnel onboard.

NTSB Recommendation No. A-06-13 - Require all EMS operators to develop and implement flight risk evaluation programs that include training all employees involved in the operation, procedures that support the systematic evaluation of flight risks, and consultation with others trained in EMS flight operations if the risks reach a predefined level.

NTSB Recommendation No. A-06-14 - Require EMS operators to use formalized dispatch and flight-following procedures that include up-to-date weather information and assistance in flight risk assessment decisions.

NTSB Recommendation No. A-06-15 - Require EMS operators to install terrain awareness and warning systems on their aircraft and to provide adequate training to ensure that flight crews are capable of using the systems to safely conduct EMS operations.

These four recommendations were also placed on the NTSB's "Most Wanted List of Safety Improvements" in October 2008.

Additionally, the NTSB stated in its January 2006 Special Investigation Report on EMS Operations that they were pleased that the FAA encouraged the use of night vision imaging systems in EMS operations, and that the NTSB would continue to monitor the applicability and usage of these devices in the EMS industry.

Also, on December 21, 2007, the NTSB issued two safety recommendations to the FAA regarding the use of radar altimeters in EMS night operations. They are as follows:

NTSB Recommendation No. A-07-111 - Require helicopter EMS operators to install radar altimeters in all helicopters used in HEMS night operations.

NTSB Recommendation No. A-07-112 - Ensure that the minimum equipment lists for helicopters used in helicopter EMS operations require that radar altimeters be operable during flights conducted at night.

History of Flight

Maneuvering	VFR encounter with IMC (Defining event)
Maneuvering	Loss of control in flight
Uncontrolled descent	Collision with terr/obj (non-CFIT)

Pilot Information

Certificate:	Airline transport; Flight instructor	**Age:**	55,Male
Airplane Rating(s):	Single-engine land; Single-engine sea; Multi-engine land	**Seat Occupied:**	Right
Other Aircraft Rating(s):	Helicopter	**Restraint Used:**	
Instrument Rating(s):	Airplane	**Second Pilot Present:**	No
Instructor Rating(s):	Helicopter	**Toxicology Performed:**	Yes
Medical Certification:	Class 2 With waivers/limitations	**Last FAA Medical Exam:**	December 11, 2007
Occupational Pilot:	Yes	**Last Flight Review or Equivalent:**	September 11, 2007
Flight Time:	16896 hours (Total, all aircraft), 1100 hours (Total, this make and model), 16420 hours (Pilot In Command, all aircraft), 18 hours (Last 90 days, all aircraft), 5 hours (Last 30 days, all aircraft)		

Aircraft and Owner/Operator Information

Aircraft Make:	Eurocopter France	**Registration:**	N911VA
Model/Series:	AS350B2	**Aircraft Category:**	Helicopter
Year of Manufacture:		**Amateur Built:**	
Airworthiness Certificate:	Normal	**Serial Number:**	2588
Landing Gear Type:	Skid	**Seats:**	4
Date/Type of Last Inspection:	January 22, 2008 AAIP	**Certified Max Gross Wt.:**	4961 lbs
Time Since Last Inspection:	9 Hrs	**Engines:**	1 Turbo shaft
Airframe Total Time:	10307 Hrs at time of accident	**Engine Manufacturer:**	Turbomeca
ELT:	C91A installed, not activated	**Engine Model/Series:**	Arriel 1D1
Registered Owner:		**Rated Power:**	732 Horsepower
Operator:		**Operating Certificate(s) Held:**	On-demand air taxi (135)
Operator Does Business As:		**Operator Designator Code:**	HDNA

Meteorological Information and Flight Plan

Conditions at Accident Site:	Visual (VMC)	**Condition of Light:**	Night/dark
Observation Facility, Elevation:	KPIL,19 ft msl	**Distance from Accident Site:**	7 Nautical Miles
Observation Time:	20:53 Local	**Direction from Accident Site:**	280°
Lowest Cloud Condition:	Scattered / 1000 ft AGL	**Visibility**	8 miles
Lowest Ceiling:	Overcast / 1400 ft AGL	**Visibility (RVR):**	
Wind Speed/Gusts:	8 knots /	**Turbulence Type Forecast/Actual:**	/
Wind Direction:	310°	**Turbulence Severity Forecast/Actual:**	/
Altimeter Setting:	29.8 inches Hg	**Temperature/Dew Point:**	23°C / 21°C
Precipitation and Obscuration:			
Departure Point:	Harlingen, TX (49TX)	**Type of Flight Plan Filed:**	Company VFR
Destination:	S. Padre Island, TX	**Type of Clearance:**	None
Departure Time:	20:40 Local	**Type of Airspace:**	

Wreckage and Impact Information

Crew Injuries:	3 Fatal	**Aircraft Damage:**	Substantial
Passenger Injuries:	N/A	**Aircraft Fire:**	None
Ground Injuries:	N/A	**Aircraft Explosion:**	None
Total Injuries:	3 Fatal	**Latitude, Longitude:**	26.138889,-97.206947(est)

Administrative Information

Investigator In Charge (IIC):	Latson, Thomas
Additional Participating Persons:	Faye S Makarsky; FAA San Antonio FSDO; Sam Antonio, TX David Keenan; FAA AAI-100; Washington, DC Lindsay B Cunningham; American Eurocopter; Grand Prairie, TX Joan M Gregoire; Turbomeca USA; Grand Prairie, TX Mike Stanberry; Metro Aviation, Inc.; Shreveport, LA
Original Publish Date:	January 15, 2009
Note:	The NTSB traveled to the scene of this accident.
Investigation Docket:	https://data.ntsb.gov/Docket?ProjectID=67469

The National Transportation Safety Board (NTSB), established in 1967, is an independent federal agency mandated by Congress through the Independent Safety Board Act of 1974 to investigate transportation accidents, determine the probable causes of the accidents, issue safety recommendations, study transportation safety issues, and evaluate the safety effectiveness of government agencies involved in transportation. The NTSB makes public its actions and decisions through accident reports, safety studies, special investigation reports, safety recommendations, and statistical reviews.

The Independent Safety Board Act, as codified at 49 U.S.C. Section 1154(b), precludes the admission into evidence or use of any part of an NTSB report related to an incident or accident in a civil action for damages resulting from a matter mentioned in the report. A factual report that may be admissible under 49 U.S.C. § 1154(b) is available here.