

uninjured but without wearing life preservers. Three of the occupants, including the pilot, drowned when they were unable to climb onto the rocks along the shoreline. The helicopter, which was not equipped with floats, sank and was recovered the following day. Life preservers were found aboard the helicopter, located in their containers beneath each seat. Surviving passengers said that they had not been briefed that life preservers were aboard. The NTSB determined that the probable causes of the accident and fatalities were “. . . failure of the engine-driven fuel pump, which resulted in the loss of power, and the lack of aircraft flotation equipment.” Related factors were “. . . flight over water adjacent to terrain that afforded no suitable forced landing site, and lack of passenger briefing by the operator on the location and operation of life preservers.”

The second accident occurred off the island of Molokai. The flight had been scheduled to tour the island of Maui. However, after receiving information from other tour pilots that the weather conditions along the planned route were deteriorating, the pilot decided to take the passengers to Moloka'i. According to the pilot, the helicopter was in a hover approximately 50 feet above the water and 150 feet from the shoreline to allow passengers to view a large sea cave when the pilot sensed a slowing of the engine/rotor system. The helicopter was equipped with inflatable floats, which the pilot activated as the helicopter entered the water. In order to activate the floats the pilot had to remove his hand from the collective control. According to the NTSB, this action may have led to a hard impact. Of the seven occupants, the passenger who occupied the forward left seat received serious injuries due to water impact and the other six occupants were uninjured. After stabilizing on the surface, the occupants donned life preservers and swam to shore, where they spent the night before being rescued. The NTSB determined that the probable cause of the accident was “* * * the pilot's failure to properly monitor power required versus power available to maintain rotor rpm, resulting in rotor rpm decay and a forced landing.” Related factors were “* * * the pilot's change of the tour route without notifying the company, which delayed rescue, and the location of the arm and fire switches for the flotation equipment, which required the pilot to remove his hand from the collective control to activate that equipment.”

(7) On July 3, 1997 an airplane lost power near Skagway, Alaska while on an air tour to view glaciers. The airplane

ditched about 100' from shore near small cliffs. There were five passengers in addition to the pilot. The passengers exited the airplane without life preservers into 39-degree water. The pilot threw one life preserver out and exited the airplane as it sank. The pilot and one passenger survived. The surviving passenger reported that her husband located the life preserver that was thrown. Her husband placed the life preserver over her head after they were both in the water. The passenger indicated she was not aware the preserver had an inflation cylinder. At one point the passenger noticed the mouth inflation tube on the life preserver when it bumped into her face. She attempted to blow air into the tube, and partially inflated the preserver. The surviving passenger did not recall any briefing about the location or use of the life preservers. Her husband, who was not wearing a life preserver, did not survive. No other life preservers were taken from the airplane. A nearby air tour helicopter arrived after the passengers were in the water and threw additional life preservers near the passengers. Two passengers drowned and two passengers were not found.

(8) On August 24, 1997, a Waco YMF (biplane) crashed into the ocean off the coast of Ocean City, Maryland. The pilot and 2 passengers, who had purchased the 15-minute sightseeing flight, received fatal injuries. According to the NTSB, visual meteorological conditions (VMC) prevailed and the pilot had not filed a flight plan for the part 91 flight. Numerous witnesses on the beach reported watching as the airplane maneuvered off shore. According to their accounts, the airplane was flying between 500 feet and 1,000 feet above the ocean. The witnesses stated that the airplane did two climbing turns, the first heading north, and the second heading south, with the flight path parallel to the shoreline. On a third climbing turn, heading north again, the airplane entered a tight spiral or spin at the top of the climb, and then the rotation stopped. The airplane had approximately a 45-degree, nose-down attitude when it impacted the water. After the wreckage was recovered, a preliminary inspection revealed no mechanical anomalies.

(9) On June 25, 1998, a Eurocopter AS-350-BA helicopter, operated by a Hawaiian air tour company crashed into rugged terrain in the Waialeale Canyon on the island of Kauai, Hawaii. The pilot and all five passengers received fatal injuries, and the helicopter was destroyed. The flight departed from Lihue Airport. Approximately 42 minutes after departure, the pilot

completed a position report. That report was the last known contact between the pilot and the tour operator. When the pilot failed to make further reports, a search was initiated. Searchers located the helicopter from the air, approximately 9 miles northwest of the Lihue Airport, where it struck steep terrain near the top of a ridge. Poor weather was reported in the area of the accident and some operators had cancelled flights on that day.

(10) On July 21, 2000, a commercial air tour helicopter collided with mountainous terrain in the Iao Valley on the island of Maui. The impact site was located on the north face of a 2,900-foot-high mountain, with a slope estimated in excess of 60 degrees. The recorded radar data indicated that at 1019:47 the helicopter was at 3,700 feet and on a northerly track. About 5 seconds later the helicopter commenced a course reversal. Between 1019:52 and 1019:56, the helicopter completed the turn and began flying along a southerly track. The helicopter's location was last recorded by radar at 1020:06. At this time it had descended to 3,100 feet. The accident site was found about 1/8-mile further south from this radar location. Three other helicopter pilots stated that they modified their tour routes to exclude the area flown by the accident pilot because of the inclement weather conditions they observed.

(11) On August 25, 2000, an airplane on an air tour ditched in the Pacific Ocean while attempting an emergency landing at Hilo International Airport, Hawaii. When the pilot determined that he could not reach the airport, he instructed the passengers to don their life preservers and briefed them to prepare for ditching. After the airplane landed in the water, all passengers except one were able to exit the airplane and were reached by rescue personnel within 15 minutes. One passenger was missing and was subsequently located in the airplane under 80 feet of water.

C. The NTSB Report and Recommendations

On June 1, 1995, the NTSB issued a special investigative report entitled, “Safety of the Air Tour Industry in the United States” (NTSB/SIR-95/01). The report is based on NTSB accident investigations and on information gained from two public hearings held during the week of October 19, 1994, in Phoenix, Arizona, and Honolulu, Hawaii. The Report explained the NTSB's concerns about the safety of the air tour industry in the United States. The Report focused on the adequacy of air tour regulations and the FAA's previous amendments to those