Attachment 20

Operations Group Chairman's
Factual Report

NYC03FA080

Inspector Ken Shauman's Statement
(Former Grand Aire PMI)

The following is an accounting of my understanding concerning Grand Aire Express, Inc., Air Carrier Certificate Holder (GXPA543E) and FAA Certificate Holding District Office (CHDO) assignments. Times, dates, and sequences of events haven't been documented/verified, but are reasonably accurate.

Grand Aire Express, Inc. began construction of a new Corporate Headquarters/Principal Base of Operations (PBO), relatively unnoticed, at Toledo Express Airport (TOL) in the Fall of 1998. They were, until January 1999, based at Monroe Custer Airport (TTF), Monroe, MI, and the Detroit FSDO had been the CHDO since their original certification in July 1986.

Grand Aire Express, Inc. officially relocated to their TOL location over the New Years weekend 98/99. I understand that there had been some understanding/agreement by the Operator that the Detroit FSDO would retain CHDO responsibilities, even though the Operator was no longer located in their Geographic District, but now in the CLE FSDO Geographic District.

Shortly after the CLE FSDO became aware that Grand Aire Express, Inc. was in fact located and operating in the CLE FSDO District, the CLE FSDO Office Manager approached the FAA Great Lakes Region Flight Standards Division Manager about a CHDO transfer of the Operator from Detroit FSDO to CLE FSDO.

This was unceremoniously accomplished in February/March 1999. The Detroit FSDO literally dropped boxes of the Operator's FSDO files, manuals, etc. on the CLE FSDO's door step and ran. When those boxes were examined, it was found that none of the Airworthiness information was included. With that, the Detroit FSDO was contacted, a Detroit FSDO Inspector gathered up the missing files, enrouted to CLE, met a CLE FSDO inspector in the CLE Terminal, handed over the files and enrouted back to Detroit FSDO.

A CLE FSDO Certificate Management Team (CMT), Ellen Tom, POI, Dave Pesarchick, PAI, and Ken Shauman as PMI were assigned to GXPA. Our first visit to their TOL PBO was in conjunction and at the request of the DOD/CARB Team. GXPA was in a temporary non-use status by the DOD/CARB, pending satisfactory follow-up/re-evaluation of their previous findings of non-conformance to their safety standards. At the conclusion of this visit, GXPA was still under temporary non-use. Some of the DOD/CARB findings had been satisfactorily addressed, not all. The areas in which the DOD/CARB was not satisfied during this follow up were not regulatory by the FAA. Mr. Kevin Kelsey, GXPA Director of Maintenance while based in Monroe, elected not to remain with the company after its move.

During the review of the files transferred by the Detroit FSDO, it became apparent that there was confusion with the issuance of the GXPA Operations Specifications (OPSS). Contained in the file were partial re-issuance of OPSS using the new format. Included was a letter from the PMI advising the authorization for GXPA to use a Fairchild SA26 was valid for 30 days or until new OPSS were issued. Draft OPSS, Part D, Additional

Maintenance Requirements, were included with the letter. We couldn't find the new OPSS being issued authorizing the use of the SA26 and the 30 days had long since lapsed. We felt this to be one of the more important projects to accomplish. Prior to blindly issuing OPSS authorizing the use of the SA26, a partial evaluation, for use under 14 CFR Part 135, of the aircraft was determined appropriate. During this evaluation, it was determined that either GXPA had misrepresented the aircraft, or Detroit FSDO had erroneously projected the installed engines overhaul interval on the Part D OPSS. A 5400 hour overhaul interval was listed on the draft OPSS. Our maintenance record review established that the engines were only eligible for a 3600 hour overhaul interval and that interval since last overhaul had been exceeded. In addition, we were unable to verify several Airworthiness Directive compliance's and installed equipment. We advised GXPA that we could not proceed with the issuance of OPSS authorizing the use of the aircraft under Part 135. Subsequently, GXPA elected to use and list the aircraft on its other Part 135 Certificate still held by Detroit FSDO.

At the same time, we determined that one of the PA60 Aerostar's had a wrong model, per TCDS, engine installed.

During the Spring and Summer of 1999, the CLE FSDO CMT continued surveillance/certification and catch up activities. At this time, Mr. Warren Shoemaker was selected by the Company as Director of Maintenance. Mr. Shoemaker was based at the Louisville, KY (SDF) facility. Mr. Shoemaker had prior military experience and part time employment with GXPA. A week was spent by the PMI and PAI at each of the GXPA PBO and Louisville, KY maintenance facility. Lengthy letters describing areas and items deficient toward compliance and acceptable practices were addressed to GXPA following those visits.

At the same time, the POI was discovering irregularities with pilot records, crew qualifications, flight/duty times, training and flight records. The PMI and PAI were simultaneously finding aircraft being operated in an unairworthy and unsafe condition. Conditions found included missing/illegible/incorrect required placards and markings, windshield de-lamination/damage, wing leading edge and engine inlet dents, tire wear, fuel leaks, all beyond manufacturer's recommended maximum allowable. During this period, GXPA experienced frequent and numerous engine failures due to FOD and other unexplained causes.

Upon each occasion, when mechanical discrepancies, technical and actual unairworthy conditions were brought to the attention of GXPA, they were remedied. Follow up surveillance activities continued to find the same, similar/identical conditions of other same make/model aircraft, and some repeat conditions on the same aircraft that had been permitted to recur.

In July/August, 1999, during maintenance record reviews, it was determined that on at least two occasions, GXPA had failed to accomplish the additional maintenance requirements, engine test flights after flame outs/maintenance, specified/referenced in their OPSS Part D, Additional Maintenance Requirements. Simultaneously, while

reviewing flight/maintenance records, it was determined that GXPA was experiencing frequent/numerous interruptions to flights, due to mechanical origins, and not reporting them i/a/w 135.415 & .417. The first enforcement actions were initiated towards all of these situations. It was during the course of these investigations that I began to realize: GXPA apparently did not understand the content or meaning of their Part D OPSS or additional maintenance requirements. Their understanding seemed to be that they were only obligated to perform the maintenance/inspection requirements contained in their AAIP's. I'm confident this mis-understanding included Mr. Cheema. The one issue of non-accomplishment with the GE recommended critical altitude flight test, in the GE Maintenance Manual, after engine change or in-flight flame out on the HFB's was addressed by Mr. Cheema whipping a Flight Log entry for an in-flight air start procedure. The two recommendations, critical altitude and air start, had no relationship. Mr. Shoemaker was oblivious to both until we directed him to the Maintenance Manual.

About this same time the DOD/CARB permanently placed GXPA in a non-use category, due to their inability to meet their safety and quality standards.

Concurrently, is was determined that GXPA had enjoyed a Continuous Airworthiness Maintenance (CAM) program, instead of a traditional Hot Section and Overhaul program, for the Allied Signal Garrett Airesearch TPE331 engines on the Fairchild SA226 aircraft. This option, rather than set overhaul intervals, is offered by the manufacturer. However, it was determined that GXPA had not, did not, and could not meet the utilization requirements recommended by the manufacturer under that option. The CHDO, along with Regional Specialists and Counsel, initiated an Emergency OPSS Part D amendment towards those affected engines, deleting that option. Literally, as the amended OPSS were being presented to the operator, AGL201 recalled the inspectors and OPSS. They were never issued. Subsequently, the OPSS Part D were amended, listing each engine, by serial number, affected by the CAM, with a calendar time compromise equivalent to the recommended utilization. The agreement was, as these affected engines passed through this landmark, they would return to the traditional overhaul interval and manufacturer's primary recommended additional maintenance requirements.

In addition, GXPA had obtained, from the Detroit FSDO, and still enjoy engine overhaul interval time escalations, on OPSS Part D, way beyond those recommended by the engine manufacturer and allowed by a PMI in FAA Order 8300.10. Worse, there appeared to be no documentation or substantiation in the files as to how these escalated overhaul intervals, 6000 to 8400 hours for GE CF700 engines, 1800 to 2400 hours for Lycoming engines, and Continuous Service for some Garrett engines, were justified or authorized. The saving grace, rarely has GXPA operated an engine to the manufacturer's recommended overhaul interval, let alone the escalated interval they had approved for themselves.

At about this same time, it was discovered that similarly, GXPA also enjoyed, rather that adhering to manufacturer's recommended component overhaul/replacement interval, a Component Continuous Airworthiness Procedure (CCAP). These were contained in the AAIP's and permitted GXPA to do some bench checks, rather than overhaul, certain

components, at various intervals. The Company documents looked rather impressive and appeared to be based upon a MSG-3 Maintenance Program Development document guidelines. Unfortunately, their airplanes were not eligible for the MSG-3 concept, there was no documentation that any of these procedures, documents and work cards had any consultation or approval outside of GXPA and the DTW FSDO which had approved them as a part of the AAIP's years ago. This was one of may items listed to Mr. Shoemaker in September 2000, but was never resolved.

During the Fall of 1999, it became apparent that GXPA had been operating their HFB 320's with twice the useful load permitted, as they were equipped, in the AFM. Also, it was becoming an issue that GXPA had not been adhering to the overhaul/life limits schedule of maintenance and inspections contained in their HFB Approved Aircraft Inspection Program (AAIP). In November, 1999, with no notice, explanation, or fanfare, GXPA requested that their entire HFB320 fleet, 7 total, be deleted from their OPSS for use under Part 135. We never did know what we were about to discover.

Beginning in August, 1999, through present, GXPA has made several requests and motions to relocate and transfer parts and their total operation to another FAA Region and Districts. The most significant has been their declarations of operating a Main Maintenance Base separate from their PBO. Being, that they have been keeping their aircraft's permanent maintenance records at a location other than their PBO, away from the CHDO (CLE FSDO) for approximately the last year.

Between August, and November, 1999, a new POI, Mr. Walter Moor, was assigned to the GXPA CMT.

During the Fall of 1999, several issues between GXPA and the CHDO started to come to a head. GXPA enlisted the services of several different legal firms as initial contact points in FAA business concerns. These being the issues of their Chief Pilot candidate, Enforcement Actions that had been initiated by the CHDO, and other issues being GXPA's requirement that their pilot's perform preventive/maintenance functions on their aircraft, a request for a HFB320 Ferry Permit, and GXPA operating Fan Jet Falcons contrary to an Airworthiness Directive and a subsequent request and resolution for an Alternate Means of Compliance for that AD, and GXPA's inability to make available Load Manifest Records.

During the summer of 1999 and on into 2000, the PMI and PAI struggled for a point of contact within the company for maintenance issues.
Mr. Shoemaker frequently voiced his displeasure with the Company's Toledo Maintenance Operation. He preferred the SDF location as being declared the principal maintenance base and spent little time in Toledo. When we were at Toledo conducting records and ramp inspections, we would hear Mr. Shoemaker being paged, but rarely would he contact us. For the most part, our primary contact was Mr. John Bucknell, Chief Inspector.

All attempts and consideration towards the company operation was given during ramp/records/etc. inspections. So as not to totally disrupt the daily operation, aircraft which were not immediately on line, or were in for maintenance, were selected. During the course, Mr. Bucknell or a maintenance associate generally accompanied the PMI and PAI. At the conclusion of each activity, or the day's activities, those company personnel were debriefed of the findings and concerns. Show and tell was conducted between the PMI/PAI and company personnel. The Company took notes/entered discrepancies on MDL's in their own words/terms/descriptive narrative. Records questions and concerns were usually handled by Mr. Tom White, GXPA Records Specialist. Mr. White proved to be invaluable to us. He was quite proficient with the unique record keeping system GXPA employed. Mr. White could usually locate the record in question, and/or concur that a problem existed and warranted further investigation.

We did notice that every time we entered a management person's office, D of O, D of M, Records, Chief Inspector, they would immediately perform some mouse maneuvers with their computer. We later heard that these maneuvers activated an audio/video surveillance system so that our conversations and actions were recorded. We never did confirm that rumor.

By now, it was becoming apparent that little progress was being made with the Company towards pro-active maintenance. Chronic conditions affecting the airworthiness of the aircraft had been substantiated. The same/similar conditions findings were becoming routine on the same make/model, frequently the same aircraft. Flight crews were expressing appreciation towards our efforts. Even though anonymous and authored Emails, telephone, and Aviation Safety Hot Line Complaints were still being received, some progress was being made. Flight crews were also becoming more liberal in their recording of in-flight maintenance discrepancies. Although, corrective action was traditionally along the order of, 'Ground Check OK,' 'Could Not Duplicate,' 'Check Connections, Ground Check OK.' The Company record keeping system made it difficult to track individual components as they were swapped from airplane to airplane. The flow was something like: One reported inoperative component would be removed from an airplane. It would disappear for a while. Then re-appear with a "Yellow" Grand Air tag on it describing it as serviceable, signed by one of the A&P Mechanics. Then it would be re-installed, probably in the airplane from which it was first removed due another pilot discrepancy. Then remain in service for a brief period until another pilot discrepancy. It was like the components kept revolving around and around internally, without anything ever being sent out for repair. With this, and other record keeping irregularities, enforcement action was initiated towards individual A&P Mechanics, including the Director of Maintenance. The investigations were initiated anticipating No Action or Administrative Action toward the individuals. Hopes were that if they felt their certificates were on the line, they'd take a stand with the Company. Part of the maintenance, and pilot, problems included that the turnover was rampant. Except for a few, personnel would stay for a few months, until they began asking questions. Depending upon the answers they received, or further questioning, they'd either leave on their own, or be dismissed.

Other Company operational observations: Whenever a trip would be initiated, a klaxon would sound in the hangar, the loud speaker would announce the launch of the airplane within the next few minutes. Ground and maintenance crews would position the airplane, complete the re-fueling, preparation, pre-flight, and APU connection, and occasionally engine start. The crew would arrive, race across the hangar, leap into the airplane, shut the door and away they'd go. Quite dramatic and impressive. Also, a sign was posted in the hangar. It announced that for the preceding day, x number of launches had been completed with y number of maintenance delays/returns. The ratio's were seldom complimentary of success. I never understood the philosophy, if it was intended to be a positive or negative motivational device.

Also during the Fall of 1999, GXPA attempted a Voluntary Self Disclosure. This was a result of one of the DOD CARB recommendations. The recommendation was that GXPA verify their maintenance personnel FAA Certificates. Since Mr. Shoemaker was located in SDF, he worked with the SDF FSDO, leaving CLE out of the loop. In early September, 1999, Mr. Shoemaker learned that one of their mechanics did not hold any FAA Mechanic Certificate, yet had been signing MDL's, approvals for return to service, utilizing "A" and his SSN. GXPA conducted an internal investigation, all of the MDL's during the time the individual worked there were reviewed, all which he had signed were re-inspected and re-approved for return to service, and the mechanic fired. On October 19, 1999, Mr. Shoemaker called his initial notification. This was discussed between the PMI and Great Lakes Regional Counsel, AGL7H. Counsel advised to initially deny the Self Disclosure, initiate enforcement action towards the Company and individual, and the course of action would later be determined.

In January 2000, a series of letters, concerning these issues, from these legal representatives were directed towards the CHDO PMI, Manager, Airworthiness Unit Supervisor, and FAA Great Lakes Regional Counsel. These raised the issues and displeasure of Grand Aire Express, Inc. with the handling and issuance of a HFB320 Ferry Permit in 12/1999, the situation of lost Load Manifests, the issue of pilot's being required by the company to perform maintenance/preventive maintenance on the aircraft they piloted, operating Fan Jet Falcons' contrary to an AD and the AMOC procedure for that AD.

In the Spring of 2000, the first brief opportunity to witness a GXPA freight load was afforded to us. This prompted my immediate concern. I felt that the GXPA STC'd freight configured aircraft were missing the key/critical components, FAA Approved freight containment and restraint devices. With that, 12 boxes of archived STC drawings, schematics, and blue prints were obtained and reviewed. I also attempted assistance from Great Lakes Regional Specialists and AFS 330. Throughout the rest of the year research, review, etc. was conducted towards "FAA Approved Cargo Containment/Restraints." By Fall 2000, when GXPA Cargo Loads were again observed and documented, I had determined that GXPA did not fulfill regulatory requirements, "approved devices" for carrying cargo. During the same time, GXPA enjoyed OPSS E96, Approved Weight and Balance Procedures. The OPSS specified that all weight and balance procedures would be per the GXPA Weight and Balance Manual. I repeatedly asked all GXPA Key

Management Personnel for a copy of their Approved Weight and Balance Manual. All I was ever offered was each individual aircraft's Airplane Flight Manual (AFM) Weight and Balance Section. Since GXPA could neither produce this document, nor appeared to use other than actual weights and AFM loading/balance, during another OPSS amendment, I deleted E96 and advised them accordingly. This went without Company protest until late 2000 when one of their legal counsel made this an issue in one their formal complaints against me.

In the Spring/Summer of 2000, the first press releases and Toledo Blade articles describing pending Enforcement Actions/Civil Penalties were released/published. This caused/created a tremendous amount of interest, tension, and pressure. Companies which did business with and for GXPA were interested/concerned as to their contribution, if any, to the investigations and concern, since they operated similar aircraft, that they also had not entered into non-compliance. Subsequently,
Mr. Cheema did lodge a formal complaint towards me for divulging FOUO information. Ms. Tammi McGivern, FAA Security, investigated the allegations.

In Spring-Summer of 2000, other issues arose and continued. These being the Aerostar inflight loss of the emergency exit window and the company's inability to provide pilot-in-command (Mr. Cheema's) vital information. Finally, in July, 2000, repeatedly postponed informal conferences involving 6 EIR's were held at the FAA GLRO.

During this time GXPA initiated several claims and maneuvers to designate the SDF facility as their Principal Maintenance Base. This resulted in all their aircraft maintenance records being re-located to SDF. This not only created a hardship for the CLE FSDO, but also the company. Eventually the records were returned to Toledo.

The rest of the Summer of 2000 was relatively quiet. Other projects superseded Grand Aire Express, Inc. surveillance, the end of the year and accomplishment of NPG, reduced travel budget funds, kept us away from the Company.

The beginning of FY2001, October 2000, started surveillance activities anew. This afforded the first opportunity to inspect loaded Grand Aire Express, Inc. aircraft. This opportunity also refreshed the cargo containment/restraint project that had been started in February, 2000. In a November 2000, Mr. Jim Qureshi, GXPA GM, was reminded of all these concerns.

Just as the new NPG started, it was announced that Grand Aire Express, Inc. was scheduled for a RASIP inspection the end of November, 2000. The RASIP initially called for about 12 inspectors and a 2 week duration. At the last minute, AGL201 announced the team and duration would be cut in half. Immediately prior to and post RASIP, little, if any NPG surveillance activities were conducted until the final RASIP report was received 01/29/01. Subsequent that, any visits were in pursuit of addressing the RASIP findings.

During this Winter 2000/2001, Grand Aire Express, Inc. and AGL7 were in negotiation towards CP settlement of the previous EIRs. No agreement or settlement was reached.

Late December 2000, GXPA announced the closing of their SDF facility. Another location, Sellersburg, IN was declared the new Principal Maintenance Base. Mr. Shoemaker left the Company. With that,
Mr. Mohammad Tariq was appointed as Director of Maintenance. We had worked closely with Mr. Tariq for 6 months or so prior his selection. There was some concern as to whether or not Mr. Tariq met the regulatory experience requirements to hold such position. Since most of his experience on his resume was obtained in Saudi, Pakistan, and defunct U.S companies, it was unverifiable. However, at face value it satisfied the regulatory requirements, we were comfortable with
Mr. Tariq, at the time he was the best GXPA had to offer, we concurred with the Company selection.

Late December, 2000, and January, 2001, Grand Aire Express, Inc. renewed their efforts, with consolidation of the previous letters of concern, into a formal complaint towards the CLE FSDO PMI oversight/surveillance/enforcement activities. These complaints were directed towards the CLE FSDO Manager and AGL200. There were 8 issues/items of complaint, being the HFB320 Ferry Permit, Aerostar Emergency Exit Window inflight loss project, press releases, RASIP findings, post-RASIP visit, and enforcement action involving the Director of Maintenance. The complaint request involved an immediate reassignment of a PMI and transfer of the Air Carrier Certificate to GL23.

February and March, 2001, was spent documenting, justifying, and supporting the FSDO actions that were subjects of the 8 items of complaint with AGL230 specialists.

In March, 2001, AGL200 met with Mr. Cheema, Grand Aire Express, Inc. President. On March 28, 2001, AGL200 announced that CHDO Responsibilities reassignment "...is in the best interest of the FAA." The transfer would be between CLE FSDO and DTW FSDO. Subsequent, to date, 04/09/01, efforts have been concentrated on RASIP findings close out, technical transfer of CHDO responsibilities in FSAS VIS, NVIS, and OPSS, assembly of CLE FSDO GXPA Office files, manuals, etc. and the physical transfer of such anticipated to transpire the week of 04/09/01.

Throughout the past two years while CLE FSDO was the GXPA CHDO, constant and chronic airworthiness issues arose. Those issues included the physical airworthiness status of the aircraft. Conditions in question included technical areas, missing, illegible, incorrect markings and placards, obsolete Airplane Flight Manuals, safety concerns in the operation of aircraft with excessive and beyond manufacturer's recommended wear, damage, and leaks. Administrative/management issues of records availability, completeness, execution, retention, accuracy, accountability, currency/completeness and usefulness of company manual systems, and two complete turn overs in company management personnel were additional concerns. The company demonstrated bandaid

corrective action towards airworthiness issues. Corrective action was initiated as a reaction, there was never any evidence of company proactive and/or preventive efforts. Attempts and efforts were initiated towards revising the company MEL's and AAIP's. The revised product's quality was never at an acceptable level. It was demonstrated that the company management personnel were either incapable, inexperienced, unqualified, or they were prevented to direct, initiate, affect, and complete decisions and changes.

The GXPA PMI assignment was quite challenging, was easily a full time job, and afforded tremendous opportunities, experiences, and learning situations. I dare say there is no other 14 CFR Part 135 operation in the nation with a fleet of HFB 320's, as many sub-bases, line stations, and such a cultural diverse roster as Grand Aire Express.

Major issues left unresolved at the time of this CHDO transfer include: Revisions to the AAIP's and MEL's.
Resolution of the MMB location.
Escalated Engine TBO intervals.
Validity of the inclusion of MSG-3 Logic in the AMD AAIP for components.
The absence of: "Approved" cargo containment/restraint devices, cargo handling/loading training, and cargo loading/handling/restraint procedures and practices.

Proof of GXPA performance standards during the past two years are reflected in their numerous reported inflight mechanical interruptions and reliability, occurrences, incidents, accidents, and enforcement report activity. Not reported are constant Fan Jet Falcon engine changes due to ground detected FOD, which is a separate indicator of a poor kept operation.

This is not a safe, nor compliant motivated operation. All the indicators and comparison factors, predicting a major catastrophic event in this operator's future, are glaringly evident.

If safety is the FAA's primary concern, the recent decision to transfer CHDO responsibility for GXPA appears to be poorly made for all the wrong reasons.