



NATIONAL TRANSPORTATION SAFETY BOARD

Office of Aviation Safety
Washington, D.C. 20594

June 1, 2020

Group Chairmen's Factual Report – Attachment 1

Record of conversation with passenger witness

OPERATIONAL FACTORS/HUMAN PERFORMANCE

DCA20MA002

RECORD OF CONVERSATION

Eyewitness Steven Craig Ranney

Date: 10/19/2019

Location: Phone call

Participants: Sathya Silva, PhD - Human Performance, Dajuan Sevillian, PhD -Human Performance, Marvin Frantz: Operational Factors; NTSB

During the conversation, Mr. Ranney stated the following:

He was a commercial pilot and flew 135 air service operations for 20 years. He had single engine land and single engine sea ratings with an instrument rating. He had 15,000 hours total time and Part 135 experience was in Alaska. He had no experience flying to Dutch Harbor. Because it was his first time flying to Unalaska, he was very interested and following the flight closely. It was his first time on a SAAB 2000.

During the accident flight, he indicated that most of the approach was normal over the ocean. It was clear conditions over the water and cloud build up seemed to be mainly over the island. He noticed the wind gusts were hitting the water "hard." The turbulence was moderate after the bridge. The first approach to the runway did not go below 500 feet, then the pilot did a circle over the bay. He noticed that it looked like a heavy squall in the distance, with reduced visibility. He guessed that the reason the pilot broke off the first approach was because of reduced visibility. The second approach had moderate turbulence. After touchdown, which he "felt" was about a quarter of the way down the runway, he noted the midfield windsock was standing straight out. He estimated the wind was 20-30 knots straight off the tail. He felt the aircraft skid sideways to the right. They hit the fence and then went into the bay.

He was sitting in seat 4F. The person who was killed was sitting in the seat next to his. Mr. Ranney had moderate compression fractures and was taken to the hospital. He recalled that the "ceiling came down" and the propeller almost hit him. After the aircraft stopped, the passenger next to him was his main focus. Mr. Ranney untangled him and tried to lay him flat. A doctor began administering first aid. The activity with this passenger blocked everyone forward of his seat from exiting the aircraft. There was a student that called "fire" but he noted there was no fire and told everyone there was no fire. The forward exit was in the water. The people sitting forward of his seat and the flight attendant and pilots moved further forward to give the victim some space. He exited the aircraft after about 15-20 minutes and noted when he exited that the windsock was flat. He said it was clear from that observation that the winds were gusty. They had tried to drag the victim to the back of the aircraft to evacuate him, but the aircraft was at too steep of an angle. They knew the EMTs were coming, so they waited for them. The propeller had come in from the upper left of the aircraft.

Both approaches were to the same runway. He noticed long low approaches and the circle was a slow 360 with left hand turns. The conditions were VFR during the circle for the 2nd approach.

During the first approach, they were never over the runway, they broke off before then. Visibility was better on the second approach into Dutch Harbor. He noticed that during the landing the aircraft skid was to the right side of the runway. He indicated that from his seat, 4F he saw water coming at him. When asked why he thought the pilots broke off the first approach, he said that the turbulence wasn't severe and that it could have been because of the wind. He noticed on the touchdown the aircraft ballooned back up and that they were moving fast past the windsock. He felt immediate thrust reverse and braking but didn't feel the aircraft was decelerating. He felt the aircraft veer hard to the right and then begin sliding through the gravel. He believed they went off the end of the runway, not the side of the runway, and then started veering to the right. He stated it didn't feel like the pilot lost directional control.

There was no communication between the pilot and passengers regarding turbulence or winds upon landing, and there were no passengers that communicated any wind or turbulence issues. Steve indicated that he did not hear any flight deck alerts during the landing phase. Upon the aircraft landing, he went into brace position and he noticed that other passengers were in the brace position as well. When the aircraft landed, he noticed that the flight attendant was trapped in the forward part of the aircraft because of the position of the victim and was unable to assist in the evacuation. The flight attendant opened the forward emergency door. Most of the students on the aircraft were high school students and they opened the aft door and evacuated. When the aircraft landed, Dr. Becker immediately came on to the aircraft to aid passengers. Most of the passengers exited the aircraft quickly. There was some difficulty exiting since the forward door was over water and the aft door was up high since the aircraft was at such a steep angle. He waited until the EMT's strapped in the passenger that was near him to the carrier board and then exited the aircraft. He noted that the pilot told the passengers not to use the forward exit. He noted that if he was 2 inches over, he would have been killed. He noted that while he was assisting the victim, someone asked the pilots what happened, and one pilot said something like "the computer said we should be ok."

He noted that one of the students has a video of the touchdown and beginning of landing roll.