

SeaPort Airlines
Juneau, AK
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**NATIONAL TRANSPORTATION SAFETY BOARD
WASHINGTON, D.C.**

ATTACHMENT 1

Interview Summaries

38 Pages

Interview: Shane Mitchell, Pilot and Roommate of Accident Pilot, SeaPort Airlines, Inc.
Date: August 10, 2015
Location: Telephonic Interview
Present: Chris Shaver – NTSB
Shaun Williams – NTSB
Dave Keenan – FAA
Peter Baker – SeaPort Airlines, Inc
Bob Richmond – Legal Counsel, SeaPort Airlines, Inc.

Mr. Mitchell was a 34 year old, Juneau qualified pilot who was hired May 18, 2015. He was qualified on both the Cessna 206 and Cessna 207 airplanes. He possessed a commercial pilot certificate with airplane single engine land, multi-engine land and instrument airplane ratings. He had just less than 1,000 total flight hours.

During an interview conducted on August 10, 2015, Mr. Mitchell stated the following:

He described his normal duties and responsibilities as being a pilot-in-command (PIC). He would arrive at work to preflight the airplane, check the fuel and oil amounts, weather depending, and check the weather.

Mr. Mitchell stated that he had flown to Hoonah numerous times. The route to take was up to the pilot to decide, but the quickest route was direct over the top of the terrain. He said going out, he would prefer 2,000 – 3,000 feet and an additional 500 feet for the return flight, all weather depending.

When asked to describe weather minimums for initiating a flight, he stated that he needed either 1000 and 3 or 500 and 2. He explained that if the cloud ceiling was 1,000 feet, 3 miles visibility was required and if the ceiling was 500 feet, then 2 miles visibility was required. He would rather have the visibility than the ceiling. He said there was no company ceiling or visibility requirements and the company guidance was “you are the PIC, use your judgement.” There were also no minimum enroute altitudes

He further stated that he did not take gliding distance into account, as about 2,000 feet was required to make the trip from Juneau to Hoonah while remaining within gliding distance to land.

He stated that in order to make and justify go/no-go decisions, a risk assessment was utilized before a round trip departed. The pilot would complete the risk assessment and fax it into dispatch. If the risk level required management notification or approval, that was handled by dispatch and the pilot had to wait for the signature before departing.

When asked about training, he said they utilized a simulator in the top of the hanger to work on getting out of boxed canyons. During training flights in the airplane, he said the instructor would put him under foggles¹ for the entire return flight.

When asked to describe a typical schedule, he said that for the afternoon shift, he would arrive at the airport about 1100 or 1200. His last flight would arrive back at Juneau around 2120 and he would be home about 2200. He would get to bed between 2300 and midnight and be up again around 0800.

Mr. Mitchell stated that he had been roommates with the accident pilot since June, 2015. His interactions with the pilot in the 72 hours preceding the accident included eating together and watching

¹ Foggles are a type of view limiting device designed to simulate flying in instrument meteorological conditions.

movies. He said he was up before her on the day of the accident around 0800 and he was unsure of what time she went to bed the night before.

When asked about the pilot pay at SeaPort as compared to other companies in the area, he said he was unsure of other pay scales, but that turning down a flight had no effect on pay. He said he was paid by the day, regardless of any flying.

End of Interview

Interview: James Caldwell, Pilot and Roommate of Accident Pilot, SeaPort Airlines, Inc.
Date: August 11, 2015
Location: Telephonic Interview
Present: Chris Shaver – NTSB
Shaun Williams – NTSB
Dave Keenan – FAA
Peter Baker – SeaPort Airlines, Inc
Bob Richmond – Legal Counsel, SeaPort Airlines, Inc.

Mr. Caldwell was a Juneau qualified, Cessna 206 pilot who was hired May 18, 2015. He possessed a commercial pilot certificate with airplane single engine land, multi-engine land and instrument airplane ratings. He was also a flight instructor and an instrument flight instructor and had about 1,100 total flight hours.

During an interview conducted on August 11, 2015, Mr. Cutler stated the following:

He had been flying about eight years and started in Colorado at Ames Community College. Prior to his employment with SeaPort, he had never flown in Alaska.

He described his normal duties and responsibilities as being a pilot-in-command. He would arrive at work about 45 minutes early to preflight the airplane, check the fuel and oil amounts and thoroughly check the weather. He utilized the National Oceanic and Atmospheric Administration website, along with the FAA weather cameras and Foreflight® to gather preflight weather information. When the preflight routine was complete, he would load bags and then the passengers.

Mr. Caldwell stated that he had flown the accident route before and said the company minimum altitude was 500 feet, his personal minimum altitude was 1,000 feet, and 1,500 feet was needed to maintain gliding distance to land.

He stated that in order to make and justify go/no-go decisions, a risk assessment was utilized to some degree. He said a higher number meant more risk and required more thought analysis, but the decision was still up to the pilot in command. At a certain level, around 46 or so, management would need to be notified.

When asked to describe a time management approval was needed for one of his flights, he said they discussed the weather and what it was like. He said it was pretty windy with a little turbulence, but he had just returned from the same location and felt comfortable. The manager gave his approval and the flight departed without a delay. This conversation took place entirely over the phone.

He said the Capstone equipment was utilized on the Cessna 206 as well as the Cessna 207. He said he felt “pretty good” about using it and that training on the system was “pretty good and thorough.” An entire day was spent learning about the equipment.

When he was hired, he said he completed controlled flight into terrain (CFIT) and inadvertent instrument meteorological conditions (IMC) training in a simulator.

Although roommates, he never observed the accident pilot’s flying skills. He said she seemed knowledgeable during conversations. When asked about any hazardous attitudes when it came to flying, he said that she loved flying and had no ego about it; she was extremely cautious and “one of the most

cautious of all of us.” He stated that on a previous flight, after departure, she turned around due to weather.

Mr. Caldwell stated that he could not remember any specific interpersonal conflicts in her personal life, except that while conducting training, the instructor was tough on the accident pilot.

He stated that although not sure how the pay at SeaPort compared to that of other companies in the area, he said he made less than a flight instructor in Colorado. Morale at the company before the accident was pretty good, according to Mr. Caldwell, but following the accident it was pretty low.

When asked to describe the company’s approach to managing safety, he said that it was the #1 core value and it permeated throughout the entire organization. He always felt supported when turning down a flight due to weather. He said standardization and SOP adherence among the SeaPort pilots was pretty good.

When asked to describe his relationship with the accident pilot, he said they had met in ground school and sat together everyday. When they both went to Juneau, they decided to move in together with another pilot. He said they had breakfast and dinner together everyday. The accident pilot was described as “maybe a little more introverted” than extroverted, but overall middle of the road.

On the day of the accident, the flight was supposed to be operated by a Cessna 206, but due to the number of passengers, it was switched to a Cessna 207 about an hour before the flight departed. Also, the flight had been scheduled to depart at 1345 Alaska daylight time, but was changed to 1245 Alaska daylight time.

When asked to describe his conversations with dispatchers, Mr. Caldwell stated that some days they only spoke when he would duty on or duty off. Other days they would be on the phone more often. He said that since the accident, there has not been any push back from the dispatchers regarding weather decisions, but prior to the accident, he would receive some pushback questioning which weather cameras he was looking at and what weather. When asked about their preparedness or training, he stated that they were not pilots and not in Alaska. He said the cameras could only provide a general idea of the weather conditions.

He stated that the pilots in Alaska were careful about the weather as it “is not something to play with.”

End of Interview

Interview: James Murawski, Dispatcher, SeaPort Airlines, Inc.
Date: October 8, 2015
Location: SeaPort Airlines Headquarters, Portland, OR
Present: Chris Shaver – NTSB
Shaun Williams – NTSB
Patrick Hempen – FAA
Peter Baker – SeaPort Airlines, Inc.
Bob Richmond – Legal Counsel, SeaPort Airlines, Inc.

Mr. Murawski is a Juneau qualified dispatcher with a date of hire at SeaPort of February 2, 2015. He held a commercial pilot certificate with multi-engine land and instrument ratings. He was not the Juneau Dispatcher on duty the day of the accident, July 18, 2015.

During an interview conducted on October 8, 2015, Mr. Murawski stated the following:

Initial dispatcher training consisted of spending two weeks shadowing a dispatcher, followed by two weeks of performing dispatcher duties while being observed. If the dispatcher would be assigned to the Juneau desk, an additional four weeks of training was required in the same format as initial training.

There was no formal recurrent training for dispatchers. On a monthly basis, they reviewed Federal Aviation Regulations, the company GOM, duty time requirements, and weather. Asked about any additional weather training, he said that they were taught how to read aviation weather charts.

Asked what weather products dispatchers used, Mr. Murawski said that they used the FAA weather cameras, aviationweather.com, surface charts, wind charts, and they also called outstations to get weather reports from the ground. Asked if the dispatchers printed or sent a weather packet to the pilots, he said no. Asked if the dispatchers interfaced with Flight Service Stations, he said no.

A normal day consisted of coming on duty and familiarizing himself with that day's operation. He received a pass-down briefing from the previous dispatcher regarding the current situation, the plan for the rest of the day and the week ahead. After the pass-down, he assumed control and began dispatching for the rest of his assigned shift.

When asked about any differences between the handling of Alaska flights versus flights in the rest of the country, he stated that more of the operation in Alaska was fluid, meaning more on demand flights. The rest of the country had more scheduled flights. Constant communication with the crews was important and the same in either part of the operation. They would discuss the flights and weather for the day when each pilot dutied on and before each departure from a base. They very rarely spoke with the pilots at an out station. He described the initial daily conversation with the pilots as discussing which aircraft was assigned to the flight, the passenger loads and any special requirements such as cargo or mail. They touched on weather, talked about the weather cameras, pilot reports and forecast or known icing.

Asked if the dispatchers received and disseminated pilot reports, Mr. Murawski said that if they did receive one, they would pass it along to other company pilots, but they would never file an official pilot report with the FAA.

He stated a formal risk assessment was completed before every Alaska flight with the pilot inputting the numbers and totals before sending it to the dispatcher via fax. The dispatcher would review what was marked down for weather and check the number, sign it and send it back to the pilot with any notes

that may be applicable. He stated this was the process prior to the accident and a pilot could not depart without the dispatcher's signature on the sheet.

With regards to training received on the risk assessment, he was taught how to analyze it and what the different sections meant. With a risk value above 21, signifying some risk, management approval was required. He would notify management, discuss the weather with the pilot, signoff the management notification and return it to the pilot. On a normal, low risk day, his signature on the form was a confirmation of receipt, not a concurrence of the values selected.

Asked if he felt the risk assessment adequately captured risks associated with a flight, he said that he believed it did, that it followed the IMSAFE checklist.

Asked if the dispatchers had the authority to cancel a flight, Mr. Murawski said, yes they could. Asked if he had ever been pressured to tell a pilot to fly, he said no.

When asked about any experiences with the accident pilot, he stated that he had worked with her a few times. When the weather was low or deteriorating, she would not fly. While dispatching for the Juneau desk, there was one or two times that she took off and later decided she was not going to continue due to the weather, and turned around back to Juneau.

End of Interview

Interview: Tim Cutler, Dispatcher, SeaPort Airlines, Inc.
Date: August 6, 2015
Location: Telephonic Interview
Present: Chris Shaver – NTSB
Shaun Williams – NTSB
Dave Keenan – FAA
Peter Baker – SeaPort Airlines, Inc
Bob Richmond – Legal Counsel, SeaPort Airlines, Inc.

Mr. Cutler was a Juneau qualified dispatcher who was hired in September, 2014. He was not an FAA certified dispatcher, but did possess a commercial pilot certificate with about 230 hours of total flight time. He was the Juneau dispatcher on duty at the time of the accident on July 18, 2015 and only spoke with the accident pilot when she radioed in her “off” time. For the purpose of standardization, “off” time was when the engine was running, the radio master switch was turned on and the pilot was preparing to leave the ramp area.

During an interview conducted on August 6, 2015, Mr. Cutler stated the following:

There was no formal classroom training or syllabus and no training records existed. Initial dispatcher training consisted of shadowing a dispatcher, followed by performing dispatcher duties while being observed. Training lasted about a month and consisted of the systems utilized, flight tracking, emergency operations and weather products. He stated there was no recurrent training; they adjusted as things changed.

Mr. Cutler said his duties included scheduling, creating and cancelling flights based on weather, the economy or safety. Regarding safety, he said he would check maintenance information to ensure the aircraft was safe. He would also manage the flights/aircraft utilized based on passenger loads. He reported to the SOC manager and the Director of Operations. Each day following a 30-45 minute transition between morning and afternoon dispatchers, he would brief the DO.

Mr. Cutler usually worked the afternoon shift and described his normal day as follows:

- Arrive shortly before 1300 Pacific time
- Observe the previous dispatcher to familiarize himself with the operations of the day
- Review the turnover log, weather, flight following, daily issues and which pilots were working

When assigned to dispatch for the Juneau operation, he would remain with the Alaska desk for the entire shift, whereas other desks could change.

He described the difference between the Alaska operation and the rest of the operation as Alaska was more fluid. He said the Juneau operation was constantly changing, more so than the lower 48 flights.

As the dispatcher assigned to the Juneau desk on the afternoon of the accident, he watched the accident pilot walk to her airplane across the ramp via cameras that are monitored by the dispatcher in Portland. He said she called “off” with four passengers and stated that she was going “up over the top to get to Hoonah.” He said the weather was lower, but nothing out of the ordinary. He did not discuss the weather with the pilot as that was a discussion that only took place when the pilot began their duty day unless “there is something to discuss.” He would only update pilots on the weather when there was a change or concern. He said if the weather was not looking good on the camera, he would call the pilot. Also, the station would sometimes call to voice a weather concern, at which point he would contact the

pilot. He stated that one pilot had just returned from Hoonah, but did not speak with them before the accident pilot departed. One weather camera was cloudy, but he said it was usually cloudy.

The weather products Mr. Cutler said he used were METARs, TAFs, weather cameras, radar, Aviation Digital Data Service and pilot reports (PIREPs). When asked to expand upon the PIREPs, he said there were no official PIREPs and he kept no record of any PIREPs he received. He said there was no training on weather when he began work at SeaPort, but he had completed two college courses pertaining to weather.

Regarding the accident pilot, Mr. Cutler stated that he had worked with her when she was in ground school at SeaPort. His opinion was that she was a "sharp girl." He said she was always very cautious and communicated more about weather than anyone else. He recalled that she had cancelled a flight due to weather previously and also once she called that the weather was not looking good and she was going to hold for a while. At no point did she ever make a safety decision that gave him cause for concern. During his interactions with the accident pilot, she would say that she loved the AK flying and it was not the same as the south.

He had worked with the accident pilot a few times prior to the accident. Since she worked the afternoon shift and he worked the morning shift, it was usually just the duty on briefing. He had never really spoken with her in a conversation besides for work.

When asked if he felt that pilots respected his input regarding weather and a go/no-go decision, he stated that he had never received any pushback and never had anyone question the decision.

He said flights are tracked using CRABS. The display is on the tv monitor at all times, but did not recall watching the accident flight. He said he was not afraid to voice his opinion if he saw something that was not safe.

He stated that a formal flight risk assessment is completed by the pilots and faxed to the dispatcher or maintained in Juneau. He received no training on the use of the risk assessment, and it was a process that was transferred from Juneau to the Portland SOC when the oversight of flights was combined in Portland. He said it was never made to be an official thing and more for their awareness. It was only utilized in the Alaska operation and not for any of the other operations conducted by SeaPort.

The role of the dispatcher regarding the risk assessment was to glance over it to see if they agreed. Mr. Cutler would hold onto it and keep it for his records and said he was not required to do anything with it.

When asked what operational control was, he said that he could create and ground flights along with management, specifically the DO, and the pilot. He said maintenance personnel could ground flights. When asked how operational control was performed, he said the DO only wanted to know of significant issues and did not want to know about all of the weather cancellations. The DO was available 24/7 but if he could not make contact with him, then any Chief Pilot could be called. The DO was located in Memphis, but online most of the day. He stated that if the flight was on schedule with no obvious reasons not to depart, then the decision was on the pilot and unless someone saw something they did not like, no conversation between him and the pilot was necessary.

Mr. Cutler stated that he is supervised by the SOC manager, and above him was the DO. He could not recall the last time his work had been sampled, but said it occurred more when he was new.

When asked if he had ever been observed by the FAA performing dispatcher duties, he replied that he had seen the POI in the SOC twice since the accident, but had never been asked any questions.

End of Interview

Interview: Chris Nilsen, Dispatcher, SeaPort Airlines, Inc.
Date: August 12, 2015
Location: Telephonic Interview
Present: Chris Shaver – NTSB
Shaun Williams – NTSB

Mr. Nilsen was a Juneau qualified dispatcher who had been at the company since the Juneau operation began; almost two years. He was the holder of neither a pilot certificate nor a dispatcher certificate from the FAA. He had a 4 year degree in Aeronautics from Embry Riddle Aeronautical University. He was the Juneau Dispatcher on duty the day of the accident, July 18, 2015, and spoke with the accident pilot when she dutied on for the day.

During an interview conducted on August 12, 2015, Mr. Nilsen stated the following:

There was no formal classroom training for dispatchers. Initial training consisted of shadowing a dispatcher, followed by performing dispatcher duties while being observed. Training lasted about a month, with the trainee scheduled to work 0900 – 1700 so they could observe both the morning and afternoon shifts.

He stated his duties included performing flight following, tracking flight times, tracking minimum equipment list maintenance items, auditing pilot flight and duty times and discussing weather with the pilot in command. This discussion would take place once per day when the pilot came on duty and if there were any changes throughout the day. Normally flights and weather was discussed with pilots only once per day, not on a trip by trip basis.

Mr. Nilsen usually worked the morning shift and described his normal day as follows:

- Began work at 0430 Pacific time
- Turned on the computers and redid passenger loads, checked weather, maintenance, pilot flight and duty times and pilot medical certificates to verify validity dates
- Spoke with pilots to discuss the daily plan
- Flight followed during the day
- Lunch break at 0800 when a relief dispatcher could cover from another desk.

When assigned to dispatch for the Juneau operation, he would remain with the Alaska desk for the entire shift, whereas other desks could change throughout the day.

He described the difference between the Alaska operation and the rest of the operation as Alaska was “more of a taxi service.” The dispatcher had to constantly monitor passenger loads.

As the dispatcher assigned to the Juneau desk on the morning of the accident, he spoke with the accident pilot when she came on duty to provide her daily briefing, but was relieved about 40 minutes before the accident flight departed. During the briefing, he told her which aircraft she would be flying, the passenger load and the weather. He informed her that every flight in the early morning to Hoonah, Alaska had been cancelled. He told her to discuss the weather with a pilot who had just returned from Hoonah, Mr. Taylor Phillips. The accident pilot voiced no concerns about conducting the flight. He did not look at the weather cameras with the accident pilot. She told him that she would go look at them prior to departing.

When asked to describe the Alaska operation and weather on the day of the accident, Mr. Nilsen stated that the weather was "a little low" and they could only get to Skagway. Most of the Hoonah flights had cancelled with one pilot turning back due to the weather. The weather started lifting around 1000 and the first flight to Hoonah departed at 1045. The pilot returned when Mr. Nilsen was leaving for the day.

The weather products Mr. Nilsen said he used were METARs, TAFs, weather cameras and he would obtain information from the Aviation Weather Center. There was no training on weather when he began working at SeaPort besides reviewing icing charts.

When asked if weather was printed for the pilots, he said the DUATS report, to include NOTAMs, was printed off when he visited the Alaska operation for 10 days. The printed weather information should have been signed off per the Medallion program, but only the pilots would signoff on the information. It was usually placed on the wall in the operations area but never sent to the dispatchers for verification.

He had worked with the accident pilot a few times prior to the accident flight. Since she worked the afternoon shift and he worked the morning shift, it was usually just the duty on briefing. He had never really spoken with her in a conversation besides for work.

When asked if he felt that pilots respected his input regarding weather and a go/no-go decision, he stated that dispatchers were part of the decision process. He said the dispatcher made the decision to delay or cancel a flight or to let the flight depart.

All flights were tracked using real time information contained in the CRABS system.

He stated that a formal risk assessment was completed by the pilots and faxed to the dispatcher. It is only utilized in the Alaska operation and not for any of the other operations conducted by SeaPort. The dispatcher role was just to "make sure it looks good." The dispatcher did not complete a risk assessment. If no risk assessment was received, he said he would do everything in his power to make sure the flight did not depart until one was submitted. He said that if the risk value indicated management notification was required, he would sign that line. He would only notify management if management approval was required. He would contact management for approval, but when asked if management would discuss the risk assessment with the pilot, he said no. If management approved the flight, he (Mr. Nilsen) would call the pilot back and let them know the approval had been received.

Regarding operational control, Mr. Nilsen defined it as the method for initiating, diverting or terminating a flight. He said the SOC, Vice President, Chief Pilot and Director of Operations had operational control. When asked about the dispatcher, he stated that the dispatcher on duty had operational control.

He said he would see the Chief Pilot every day, and if the Vice President was in Portland, he would walk through the SOC.

He said he was supervised by the Director of SOC and Director of Operations. He said his work was never sampled by management, only if help was needed. He only had interaction with the FAA one time for a total of about 15 minutes.

End of Interview

Interview: Shaun Hewitt, Director of Systems Operation Control (SOC), SeaPort Airlines, Inc.
Date: October 8, 2015
Location: SeaPort Airlines Headquarters, Portland, OR
Present: Chris Shaver – NTSB
Shaun Williams – NTSB
Patrick Hemen – FAA
Peter Baker – SeaPort Airlines, Inc.
Bob Richmond – Legal Counsel, SeaPort Airlines, Inc.

Mr. Hewitt was the Director of SOC. He held a private pilot certificate with an airplane single-engine land rating. He had been the Director of SOC intermittently since February, 2015. He was at home at the time of the accident.

During an interview conducted on October 8, 2015, Mr. Hewitt stated the following:

His duties included managing the dispatchers, creating general reports and auditing pilot times and duty records.

According to Mr. Hewitt, in the previous 1-2 years, the most significant change to the operation was the relocation of the Juneau dispatch functions from Alaska to Portland, OR around September, 2014. All dispatching was accomplished from the Portland SOC remotely. Cameras were installed in Juneau that overlooked the entire operation and streamed to the SOC in Portland. One Dispatcher moved from JNU to PDX to assist in the transition. The Dispatchers in PDX were trained for Alaska specific items such as weather cameras, risk assessment forms and unique weather patterns. He stated "At the end of the day, it's still Caravans or Cessnas flying up a canal."

He had a good working relationship with the FAA. The Principal Operations Inspector had conducted inspections several times. Frequently, when ASAP meetings took place, she would stop by the SOC. The most recent visit was 3 weeks prior to this interview, and the inspection was focused on the Alaska operation. It was a very positive and constructive outcome. Recommendations resulted from the inspection, but he believed they were geared towards the wrong department and they were mostly for pilots or maintenance. He could not remember the specific recommendations.

Regarding the performance of Operational Control, he stated that from the dispatcher perspective, operational control would be considered the ability to delay, hold or cancel a flight as necessary. From the SOC standpoint, the dispatchers had the ability to cancel a flight. The decision was always discussed with the pilot. Regardless of what the pilot wanted, SOC had the ability to cancel the flight if it was not legal to depart.

Prior to the accident, a Flight Risk Assessment (FRA) was required to be submitted by the pilot of an AK flight. If the risk value was low, the dispatcher would file them away. If the risk value was elevated, pilots were not allowed to depart without a signed copy from the SOC or management.

Since the accident, a FRA was required to be completed by the pilots, faxed to the SOC, signed by the dispatcher and received by the pilot prior to departure. The pilot completed the FRA and sent it to the dispatcher. They would then write notes on the FRA and send it back to the crew. The signature was an acknowledgement that the dispatcher had received the form. When asked to elaborate, he stated that the signature said they agreed with the numbers. The notes were not necessarily limitations, but "here are our notes giving the permission to turn around." Without the notes, the pilots could still turn

around. If the pilot had traveled outside radio range and was holding for weather, it was more so they knew they could turn around without further approval. Pilots were required, post-accident, to receive a signed copy of the FRA prior to departure and no pilots had departed without it.

He felt the form encompassed the risks that had significant weight to them. The only reason it was used, was because it was a form or tool used in the medallion operations. The other operations (lower 48) did not use the form because the dispatcher could always contact the pilot through tower or center. Also, the AK flights were conducted VFR as opposed to IFR in the rest of the operation. The only change he would make to the FRA would be to add a box and notes for the dispatcher.

When asked who had responsibility for operational control, he stated that ultimately, as the FAA sees it, the decision in a Part 135 operation will always come down to the PIC. When on the ground discussing the flight information, it was a 50/50 give and take. The SOC had the ability to stop the pilots from departing. 100% of the time, the pilots agreed with the decision. He had minimal pushback from the pilots. When it did occur, the Chief Pilot was brought in and the decision went into mitigation.

The role of the dispatcher, aside from operational control, was to be an information hub. No new information was generated from the SOC, rather it was obtained and distributed. Dispatchers and pilots would debrief some weather or other concerns after a flight, but Mr. Hewitt stated "We refrain from giving an opinion," but would just give facts. The dispatcher was responsible for dutying on and off pilots, auditing maintenance forms, auditing pilot and crew duty time, coordinating the schedule for the day and assigning pilots to flights.

Dispatcher training consisted of a minimum of two weeks of company documents and form review provided by him. The dispatcher then spent two weeks standing behind an active dispatcher before 2-3 weeks being the active person on the desk with the primary person behind them providing guidance until they were ready to take on the role. It was a joint decision between the dispatcher and him as to "when they are ready to take the reins and given operational control of SeaPort."

There were no prerequisites for being a SeaPort Dispatcher. He was unsure how many were FAA certificated Dispatchers. Several had pilot's licenses and several had both.

When asked what he would do if he saw a pilot doing something unsafe on the flight tracking software, he stated that he would contact them on the radio and find out what was going on. A pilot circling in JNU may mean something different than in the lower 48. It could mean they were looking for a safe altitude. Flight management would be involved anytime the pilot was not receptive to their conversation. Anytime they see a pilot deviate from their called in flight plan, they would make contact. He said it was rare that they would see something unsafe. Communication with the pilots was accomplished by IP based radio. Communication was maintained with the airplanes as far north as Haines, AK.

When asked if dispatchers were aware of the requirement for aircraft to maintain gliding distance to land, he stated that they were aware that the aircraft must be within gliding distance. They were not trained on minimum route altitudes as that is ultimately up to the pilot and taught in pilot ground school.

End of Interview

Interview: Peter Baker, Director of Safety and Security, SeaPort Airlines, Inc.
Date: November 4, 2015
Location: Telephonic Interview
Present: Chris Shaver – NTSB
Shaun Williams – NTSB
Bob Richmond – Legal Counsel, SeaPort Airlines, Inc.

Mr. Baker was the Director of Safety and Security for SeaPort Airlines, Inc. at the time of the accident. He held a commercial pilot certificate with an airplane single-engine land, multi-engine land and instrument rating. Also he held a certified flight instructor certificate with an airplane single engine rating and he was an FAA certificated dispatcher. He was hired as the Director of Safety in April, 2015.

During an interview conducted on November 4, 2015, Mr. Baker stated the following:

He began his airline career in 1992 as a ramp agent before leaving to acquire the remainder of his commercial pilot ratings and his flight instructor certificate in 1996. After flight instructing in Seattle for a couple of months, he returned to Horizon Airlines as an instructor for ground operations and F-28 aircraft systems. He remained at Horizon for 15 years teaching ground systems for the F-28 and CRJ-700, eventually becoming the turbojet lead ground instructor. From January, 2014 – April, 2015, Mr. Baker was in Hawaii as the manager of pilot training for Island Air.

He described his normal duties and responsibilities as wearing two hats: safety and security. He had one person who reported directly to him and that person administered the drug and alcohol program. At the time of the interview, his current job on the safety side was to evaluate safety programs that were relevant to being implemented at SeaPort, administer all the safety incentive programs and ensure stations were holding monthly safety meetings. From the security standpoint, he ensured compliance with TSA directives, responded to letters of investigation from the TSA and updated security training materials under mandate from TSA. The time spent between safety and security was estimated about equal.

Mr. Baker stated that when he first arrived at SeaPort, he was very impressed with the safety culture. He said SeaPort had a very active safety incentive program for reporting, including an aviation safety action program (ASAP). He stated that safety was one of the core values and cornerstones the company was built upon. At no point did he feel like he was being brought in to fix something, but rather to build upon what was already in place.

At the time of the accident, he was not involved in trying to make any major changes to the operation. He was in the process of updating the safety manual because he said it was critical to undertake regular reviews of safety policies and the manuals that guided it. He found nothing that he said needed “major surgery,” but things that needed updating.

Following the accident, Mr. Baker held a series of meetings and conducted a series of evaluations while spending time in Juneau. He concluded the procedures in place were not sufficient, but did not elaborate.

When asked what changes he implemented following the accident, he replied that no specific changes had been implemented other than requiring safety meetings. He said they were not taking place at the local level when he was hired, but also his implementation of the safety meetings was not a direct result of the accident. Safety meetings were under his directive and followed a prescribed format. The individual stations would complete paperwork on the safety meetings and then send that

documentation to him. He said he would make a point to get out on the road periodically and would only attend the safety meetings if they were scheduled when he was visiting the area. Pilots were always invited to attend, based on their schedule, as it affected their duty time. He said duty time included any company activity, including the safety meetings. He said they had to be very careful that the pilots were invited and they would have to track the times if they participated.

Mr. Baker stated there was never a safety stand-down or safety meeting where all the pilots were required to attend; rather information was disseminated through the chief pilot's office. They never had all the pilots in the same room. Following the accident, flight operations in JNU were suspended for one or two days for a safety stand-down.

At the time of this interview, Mr. Baker stated that the JNU operation was officially shut down and SeaPort Airlines was no longer operating in the state of Alaska. When asked if a risk mitigation plan was being implemented in the rest of the operation, he stated that it was being handled by Max, the director of operations. Mr. Baker had been a party to a number of the meetings where they discussed issues brought forward for considerations, and he said at least some of them were being considered for adoption.

When asked if he thought the flight risk assessment (FRA) was sufficient, he said he had not been around the operation long enough to know all of that. He did not know that he would have a fully formed opinion in 90 days. He further stated that he had no input into changes to the FRA since the accident. He knew they changed it from being completed prior to the 1st flight of the day to every trip. He said they discussed it and Max implemented it and he agreed with it.

Mr. Baker stated that he was not delegated operational control. Regarding his line of authority to make corrective action, he stated that reported directly to the CEO and had director access to Max, Noel and Shaun. If he saw something that was an immediate safety concern, it was his job "to raise the red flag to those people." He did not have the authority to stop an operation; he would have to go through someone else. He had observed dispatchers exercising operational control, but not for any prolonged period of time. He said he had never conducted a formal safety observation of the SOC.

Prior to the accident, Mr. Baker's relationship with the FAA was limited to his participation in the ASAP meetings once per month. He stated that once an ASAP report is filed, by either a pilot or mechanic, a flow chart was utilized to determine the action required. If the issue was systemic, they would look at policy changes and if not, it would be dealt with on an individual basis.

Mr. Baker said that prior to the accident, he met with one of the directors or assistant directors of the Medallion Foundation in advance of a Medallion audit. He described the meeting as a pre-audit meeting to look at things in advance of the audit so they knew what to expect and what would be audited. SeaPort was preparing for a full annual audit, but it was not completed because he said it became clear that would be divesting the Alaska operation, so at that point it became unnecessary. At the time, he was about ½ way through the process of reviewing all the Medallion manuals.

When asked if he thought the Alaska pilots were given the adequate tools to operate safely, Mr. Baker stated that he knew their level of training was adequate and he was impressed with conversations with David Williams regarding flight training. He further stated that he was very impressed with their level of communication and his observations were that the pilots made very good use of the information and resources available to them. He never sat through the entire pilot training curriculum, only portions and never flight training. He observed several hours of ground school at SeaPort and he was very impressed with it.

Regarding the accident pilot, Mr. Baker stated that he was only familiar with her in passing. He only met her on two occasions; first when he handed her a company ID and then again when he sat through a portion of her ground school training.

When asked to describe the company's approach to managing safety, he stated that he took it very seriously and he was the SeaPort approach to managing safety with the exception of his boss, the CEO. His perception was that he was in an industry that demanded his attention. They were very upfront about the fact that they took it seriously and they wanted to know when there were hazards in the workplace. He said they practiced a "just" culture. There had never been a time during his tenure with SeaPort where there was any retribution of any kind for safety reporting.

Mr. Baker said that if an agent did something unsafe and told him about the situation and the action taken, he would take a hard look at the systems in place and address it if they found they were placing their people in certain situations. He said he had the blessing of his boss to address those situations and that was something that impressed him when he started at SeaPort and he was happy to embrace that philosophy.

He stated he could not be the single point of contact to "put the brakes on the operation," but that he could be the person to raise the flag. He said fellow leadership at the table listened to him. Mr. Baker believed if he thought he needed to put the brakes on the operation, there would be a discussion at the table and if they agreed, they would put on the brakes.

When asked if SeaPort monitored trends in operations or maintenance, Mr. Baker stated that the only trend monitoring was accomplished through ASAP reports. He said that it was his opinion that they had nothing to lose and everything to gain from implementing a safety management system (SMS) at SeaPort. He said the main driver and what would come out of an SMS were data points. It was not in place at the time of the accident and also was not in place at the time of the interview. He stated that it was a large undertaking.

When asked if he ever received pushback from other management officials about safety related changes, he stated that he had. He said it was never anything of an immediate situation and he never felt the need to walk in and put the brakes on the operation. He had not been put in that situation. The issues were less of an immediate concern and he thought the pushback was healthy. He said it forced him to reinforce his position and come up with relevant data to support his view. No one ever stood in his face and said no, they were not going to do something.

End of Interview

Interview Summary

Interview: David Williams, Base Chief Pilot (Juneau), Seaport Airlines
Representative: Bob Richmond (Attorney)
Location: Seaport Offices, Juneau, Alaska
Time/Date: 1400 ADT / July 20, 2015
Present: Chris Shaver (NTSB), David Keenan (FAA AVP-100)

During the interview, Mr. Williams stated the following information.

He stated that he held an Airline Transport Pilot certificate, with commercial privileges for single-engine land and sea, and he was also a flight instructor. He had about 8,500 hours of flight time with about 6,500 hours flying in Alaska. He started working for Wings of Alaska in April 2004. He started as a line pilot, then became assistant director of operations, and in 2014 became the base chief pilot for the Juneau base. He said that his normal duties were basically to train, hire, and fire pilots. And depending on the time of year, he would also fly the line.

He said that he was working the afternoon shift on the day of the accident. Most of the flights were running late because of the weather. He flew a trip to Skagway and Haines, and said that the weather wasn't good, but it wasn't bad either. He stated that he had been flying around the area long enough that the weather didn't bother him as long as he had legal minimums. He recalled the weather on his flights to be about 1,000 foot ceilings with more than 3 miles visibility. He said that the accident pilot departed about 10 minutes after he did. He did not speak with her before departure, and didn't recall any conversations about the flight or the weather. On his return leg to Juneau, he started hearing other airplanes talking on the radio about looking for a downed airplane. When he landed at Juneau, the company emergency response plan had already been activated.

Asked about how he made go/no-go decisions, Mr. Williams stated that the FAA weather cameras are what they relied on the most, but they still looked at METARS and forecasts as well. The company also had a basic flight risk assessment form from the Medallion Foundation that they had incorporated into the operations. He said that it was used as a blunt tool. If you scored over a 46 on the form you were supposed to cancel the flight, but there was an option to wave that with management approval. He and Dave Sandberg were able to give management approval at the Juneau base, but Dave was not an operational control delegate.

Asked to elaborate on the flight risk assessment, Mr. Williams said that the risk assessment was considered part of their operational control procedures. He said that the pilot was supposed to fill out the form for every flight and then fax the form to the operational control center (SOC) in Portland, Oregon. He said that the pilot did not have to hear back from the SOC for normal operations, but they did have to wait to depart if management approval was needed. He said that when he gets a call for management approval of a flight, he usually focuses on how the pilot feels about the flight and tried to listen to the tone of how they are feeling about the flight when making the decision to approve or not. He stated that the accident pilot did not fill out a flight risk assessment for the accident flight, and he was not sure why she didn't. He also wasn't sure why the SOC didn't catch that she didn't fill out the form prior to departing.

Asked about the pilot's general view on the risk assessment, he stated that it was an extra piece of paperwork. He thought the newer pilots saw a benefit in it, but the higher time pilots tended to be worse. Asked if pilots were disciplined for not completing risk assessment forms, he said that they would at least be talked to about it and he had done that in the past.

Asked about weather minimums to launch, he said that they use the basic Part 135 minimums of 500 foot ceilings and 2 miles visibility, with the caveat of needing gliding distance to shore when flying over the water. He said that the altitude required to go from Barlow to Point Howard was 1,200 to 1,400 feet msl, and about the same to go from Point Howard to Sisters Island. He said that they do not do any point to point GPS flying, and that he didn't want to see their pilots doing that because it could get them in trouble.

Asked if the company taught cue based training, Mr. Williams said that they don't officially, but they do informally teach cue based with the Chelton using the range rings to determine visibilities.

Asked how operational control is performed, he said that he is responsible for operational control in the Juneau base. When he is not on site, that function goes to Dave Sandberg. Asked who operational control is delegated to, he said that the director of operations delegates it to him. He was not sure if he could delegate it or not, and he wasn't sure what the manual said. He stated that after departure, most of it falls on the pilot because there is usually such a difference in conditions in-between destinations.

Asked about pilot selection and training, Mr. Williams said that when he was hired everyone had at least 2,000 hours, but as the industry has tightened they are now hiring with the basic VFR part 135 minimums. He said that he and Dave Sandberg did most of the flight training in Juneau and they also had another check airman. Flight training was usually 3 to 5 hours with one hours of Capstone training. He said that they focus a lot on making sure that the pilots can handle the winds. He said that the ideal training days were the worst weather days. They do perform a CFIT avoidance maneuver, but it is not described in the CFIT training manual. Asked if he completed the accident pilot's flight training, he said that he thought he completed about half of it. He thought that she was good on systems, but needed a little work on stick and rudder skills, which was common for a 700 hour pilot. He thought that the accident pilots completed about 14 hours of IOE, which was a little more than the other pilots. He said he remembered that the extra IOE was because he didn't like some of her descent planning and pattern entries, as well as some of her airport communications. He said that she had come a long way since the start of training and he felt that she was competent when he signed her off. One thing that he really liked about her was that she was not afraid to turn around if she was not comfortable.

Asked about a typical duty day for pilots, he stated that they had split shifts, a morning and an evening group. The morning group dutied on at 0400 and were done by 1400. The evening group started at 1000 at the earliest, but normally around 1200, and finished no later than 2200. They try and have the pilots on a 5 day on, 2 off schedule. They also try to avoid pilots doing both morning and evening shifts in the same week. He said that the accident pilot worked mostly evening shifts. Mr. Williams was responsible for managing pilot scheduling.

Asked to describe the company's approach to managing safety, Mr. Williams said that safety was one of their core values. At the end of the day, safety is all that matters. He felt that standardization and SOP adherence among the pilots was very high. He said that he didn't want "cowboy" pilots, and he told pilots to do what they can do predicated on a successful outcome. He felt that he did not pressure his pilots to take flights.

Mr. Williams said that his top safety concern prior to the accident was that they had a lot of new people, most of which were seasonal, which meant that there was less resources available to the pilots. If he would have had higher time pilots, there would be more resources, more mentors, for the newer pilots to go to.

Asked about his interactions with the accident pilot, he stated that he had flown with her on the night of the 16th, and also did her IOE. He said she was a very pleasant, smart person. She was organized, methodical, but a bit slow procedures-wise. She was making good progress though. He did not notice any negative attitudes or habits with her flying.

Interview: Noel McDermott, Chief Pilot, SeaPort Airlines, Inc.
Date: October 9, 2015
Location: SeaPort Airlines Headquarters, Portland, OR
Present: Chris Shaver – NTSB
Shaun Williams – NTSB
Peter Baker – SeaPort Airlines, Inc.
Bob Richmond – Legal Counsel, SeaPort Airlines, Inc.

Mr. McDermott was the Chief Pilot for SeaPort Airlines, Inc. He held a Commercial Pilot certificate with single engine land, multi-engine land and instrument ratings. He was hired in February, 2009 and became the Chief Pilot March 6, 2012.

During an interview conducted on October 9, 2015, Mr. McDermott stated the following:

Although he had completed ground school for the Cessna 206 and 207, he has had no flight training in the aircraft. He had about 7000 total flight hours, but said he had nothing to speak of in the Cessna 206 or 207.

He described his normal duties as training and providing guidance and support to pilots, and working with the FAA over the training program, FAA Order 8900.1 guidance and prudent safety matters.

The only significant change to the operation in the last 2 years was the fleet changeover in the lower 48 from Pilatus PC-12's to Cessna 208's. Staffing changes had resulted from the passage of FAR 117. Pilots used to stay 1-3 years and now some did not stay for a full year before leaving. The Alaska operation had a core group of pilots that had been around for several seasons and then each year, newer pilots were added for the season.

He described the relationship with the FSDO as good although there had been points of contention due to timeliness of the FAA. A new POI was appointed in January 2015 when the former POI was promoted. Response time from the FAA slowed significantly on the operations and airworthiness side since the new POI was appointed. They waited four months for a single line item change to an MEL that he stated was a gross safety issue.

He thought the last time training was observed by the FAA was in October or December, 2014 with the previous POI while in Memphis. He could not recall a training observation in 2015. He believed there more activities in Alaska, but would have to search through email records for specifics.

He described operational control as the authority to initiate, divert, or terminate a flight. He stated it was essentially the authority to direct the operation of the aircraft and crew to ensure the operation is in compliance with the operations manual. The pilot could terminate a flight, but not initiate, whereas he could initiate a flight as Chief Pilot. Operational control was a tiered approach, starting with the Director of Operations, then him, followed by the Director of the SOC. It was accomplished primarily by the SOC. They would work in close harmony with the flight crew on the legality of operations.

When asked if he ever sampled the work of the pilots from the SOC, he said that he did not often make it a specific point. The SOC was usually his first and last stop of the day. He would stop by each desk to see how things were going.

He was not as involved with the Alaska pilot group as he was the rest of the operation. He said there was different equipment and operating characteristics. He worked with the base Chief Pilot to ensure

training was given and in compliance with FAR and FAA Order 8900.1. He retained authority to train locally.

He had not visited the Alaska operation in 10 months when he went in late July. In previous years, he would go to Alaska every 6-8 weeks during the summer.

When asked how he audited training in Alaska, he said that he would make it a point to go out and fly with the crewmembers. Other audits were completed through the base Chief Pilot and instructors. He described himself as a paper auditor. He audited training records before they could move on to the next stage of training.

He conducted a majority of the training for the lower 48 operations and had given a majority of all ground training for new hire ground schools for the preceding 3 years.

SeaPort normally ran two Alaska classes per year, one towards the end of March and one in mid-April. In 2015, 5 people from the May 18th ground school went to Alaska. They completed basic indoctrination ground school in Portland before going to Juneau for Alaska supplemental training and they completed the remainder of their training in Juneau. The accident pilot was part of that group.

Training in Alaska had more focus on emergency operations, seat installation/removal and VFR weather patterns local to the region. Addendums for the LOA and Chelton training took up a "lion's share." The Chelton training was conducted in the classroom and simulator. Also there were guided worksheets, lecture and video.

The training systems were separated because they were different. There was no IFR enroute system to speak of in the Alaska operation. The base Chief Pilot focused heavily on the Chelton system. They completed a lot of simulated instrument work. Due to the location of the closest ILS, conducting this training in the aircraft was not practical.

When asked about inadvertent IMC training, he stated that it was a required training maneuver. They taught a 180 degree turn with the Chelton system for VFR only pilots. This was not taught in the lower 48 since they did mostly IFR flying.

He described CFIT avoidance and EGPWS training as a focus of the training program, especially with Southeast Alaska. EGPWS training was required training. They taught pilots to perform a Vx maximum power climb but then do an immediate turn away from what was shown on the displays or what had been visually acquired outside the aircraft.

In order to clarify the requirement, he was asked if both were mandatory. He stated EGPWS escape maneuver and IMC escape maneuvers were both required. They were in addition to and in close coordination with CFIT and EGPWS. It was the same training module, system wide.

Regarding altitude selection over open water, he stated that the pilots were trained to meet the FAA requirement to not be beyond glide distance. They need to be about 1,600 feet AGL across Burner's Bay and 1,500-1,800 feet over the water. He said the Chelton unit computed drift down, but was unsure how the Air Data Computer derived its numbers. Weights were not inputted into the system and they did not input fuel on board. Also, he stated that to his knowledge, these altitudes were not documented anywhere in the training program, but rather discussed in ground school and training.

When asked about "1000 hopefully" appearing on a Flight Risk Assessment (FRA) form, he stated that he would want to speak with that pilot and find out the reasoning for "hopefully." He said that Skagway or

Haines would be the only destinations feasible at 1,000 feet. He said that dispatchers were aware of the altitudes.

When asked if the pilots were trained on the FRA, he stated that they were as a portion of the medallion program and medallion stars. He said that when a flight was operated IFR, the go/no-go decision is made for you by the regulations. When operating VFR, the pilots were required to fill one out before each flight and then send it to the SOC. Depending on the value, some required signoffs by management. It should have been done before every flight, but said he would have to go back and review the medallion information, but he believed every flight. If the value was low risk, SOC was to contact the pilot and acknowledge receipt of the form and "off the pilot goes." Most receipt confirmations were done by phone. If the value derived resulted in a moderate risk, and management notification was required, it could be sent in by fax or taking a picture of the FRA and sending it via email. The confirmation was just verbal that it had been received and a manager had looked at it.

When he had seen a moderate risk level in the past, he called the crew. He asked if the pilot had operated in those conditions and if they felt comfortable operating in those conditions and the flight load on board.

He stated that overall he believed the FRA was adequate and useful. If he would change anything on it, he said there was no need to change the values, but would have the pilot complete the FRA for all 5 airports as opposed to just the destination airport in the event of a diversion.

Mr. McDermott stated that he had the sole authority to make changes to the training program. He would advise management of the intent to change it, but no approval was needed. There were funds available for enhancement and quality of training.

He described the Medallion program as something that was a primary focus in Alaska. Besides a mention in ground school, David trained the pilots in the Medallion programs. Medallion provided guidance within the training aspect. It covered CFIT, scenario based training on IMC, EGPWS, FRA and the dynamic nature of weather in SE AK in their operating area. He said that a lot of their Medallion programs gave supplemental information and helped give pilots answers to the "why" they did things.

He could not recall any time that a representative from Medallion observed any of the training. He stated that the Medallion program was more of a safety program than a training program and therefore it was largely held under the safety umbrella.

Mr. McDermott stated that before an audit of the Medallion program was accomplished, an individual from Medallion would travel down for a "pre-audit" where they went through the records and get them ready to present for the audit, so the team could be there for less time and access the information easier.

When asked about knowledge of the accident pilot, Mr. McDermott said that he met her for 2 weeks during ground school, but did not do her interview. When the 2 weeks was over, she went to Alaska.

The feedback he received about her was that she was a very detail oriented individual. Her flying skills were good and decision making was solid. Familiarity with the operation was taking longer however. The pace of the ground operations was fast and she had difficulty adjusting. Memorizing some of the VFR reporting points contributed to her longer IOE. She received more IOE than what would normally be given in Alaska. He stated that it was not unusual for longer IOE, as all 5 pilots from the lower 48

received more IOE than the minimum 5 hours. The pilot only received 3 days of Alaska specific ground training.

He stated that the rest of the accident pilot's training was on par and the same number of hours as everyone else. It was not a competency issue in the airplane, but rather familiarity with the operation.

End of Interview.

Interview: Max Griffin, Director of Operations, SeaPort Airlines, Inc.
Date: October 8, 2015
Location: SeaPort Airlines Headquarters, Portland, OR
Present: Chris Shaver – NTSB
Shaun Williams – NTSB
Patrick Hempen – FAA
Peter Baker – SeaPort Airlines, Inc.
Bob Richmond – Legal Counsel, SeaPort Airlines, Inc.

Mr. Griffin was the Director of Operations for SeaPort Airlines, Inc. He held an Airline Transport Pilot certificate with single engine land, multi-engine land and instrument ratings as well as Advanced Ground Instructor and Instrument Ground Instructor certificates and five aircraft type ratings. He had just less than 12,000 hours of total flight experience. He was hired May 27, 2014 as the Director of Operations.

During an interview conducted on October 9, 2015, Mr. Griffin stated the following:

He described his normal duties and responsibilities as performing the normal duties of a FAR 119 certificate. He was in charge of the SOC, and of scheduling flying and pilots, in addition to being the point of contact for the Federal Aviation Administration (FAA). He also oversaw a majority of the maintenance activities at SeaPort. The company was on the fourth Director of Maintenance (DOM). After Mr. Griffin began working for SeaPort, DOM duties began being delegated to him. When asked to describe the delegated duties, he stated that day to day oversight of the maintenance department and anything that required his concurrence, he would consult the official DOM. Mr. Griffin had no maintenance background, but was an instructor and taught in a maintenance school.

SeaPort operated 21 total aircraft, which included 5 airplanes based in Juneau, Alaska. Mr. Griffin stated there were about 80 pilots and he did not know the number flying in Alaska. He said the operation slowed down a lot in the winter and SeaPort had a significantly reduced schedule, typically beginning September 15. After the reduction, pilots were given the opportunity to bid by seniority of positions in the lower 48. Since the season had ended for 2015, all pilots were gone from Juneau. He said some transferred and some left the company. He was unsure of the number. In addition to the pilots, he stated there was an Director of the SOC and he thought seven dispatchers.

When asked if there had been any significant changes in the nature of the operation within the last two years, he said, generally no. There had been a reduced schedule in the mid-south that he attributed to a "nationwide pilot shortage." He stated that SeaPort was in the process of starting a tour operation in Hawaii. It would be a separate part of SeaPort and operated under an entirely separate operating certificate. The president of the company, Rob McKinney was the only person in Hawaii at the time.

When asked about significant changes in training for pilots or dispatchers, he said there had not been any significant changes for pilots, but minimal changes for dispatchers. The changes were not in writing, but he wanted a more formalized training program for dispatchers in general. He said the changes had not evolved enough to put them in writing and there was no regulatory requirement to do so, therefore there was no formal dispatcher training program in the next training program revision.

Mr. Griffin stated that SeaPort Airlines, Inc., operated under scheduled FAR Part 135 commuter regulations at the time of the accident. They also conducted charter flights in Alaska and the lower 48. Chartered flights accounted for less than 5% of the total operations in the lower 48, but in Alaska they made up 15-20% of the operations during the summer and about 10% of the total operations in the winter.

When asked about operational control, Mr. Griffin stated that he had ultimate operational control decision making over the entire operation. Rob McKinney, President, had operational control as delegated by Mr. Griffin. Immediately under Mr. Griffin was the Chief Pilot, Director of the SOC, dispatchers, then base Chief Pilots. He said a current list of operational control delegates was contained in the GOM, section A3 or A9 and he maintained the list.

When asked how company management supervised delegates with operational control he stated that he received a briefing from the SOC seven days per week, typically around 0900CST from the dispatchers assigned to the lower 48 desk and then from the Alaska desk. He also would call the SOC an additional 1-2 times daily at random to get an idea of what was going on in the operation. He said that he would test the dispatchers by quizzing them on routing, pilot qualifications or maintenance status of airplanes while having the aircraft routing day plan and aircraft status page on his personal computer. There was no record of this quizzing. He stated that there were challenges maintaining operational control with the bases, to include Alaska. One of the challenges was ever changing weather and the frequency in which it changed, especially during the winter. Sometimes last minute aircraft changes were made based on necessity. An example was given such as weight and load dictating an upgrade from a Cessna 207 to a Cessna 208. The dispatcher would make that decision and choose the aircraft and pilot since they would have operational control. Only if the change had an impact on the operation would he be notified. He said he was on duty seven days per week and personally made more than 95% of the operational control decisions.

Mr. Griffin described the role of the dispatcher as being involved with the flight from the beginning to the end. He said they assigned aircraft based on maintenance status and forecast and assigned a crew based on legality and availability. The pilots would call the dispatcher when they began their duty day and were given the information and weather briefing for the trip for that day. They informed the pilots about all factors at hand that may have affected the flight to include weather, NOTAMS and maintenance restrictions such as MEL items. He stated that the go/no-go decision was ultimately up to the PIC. The dispatcher could say that in their opinion and based on their training that yes, they thought the flight could go, but that it was still up to the PIC. He said they "never, ever force anyone to go when they are not comfortable." The pilot can say no, and if they did, they would typically call him to discuss the decision. They would not always call, but it depended on the situation. During flight, he stated that the dispatchers had the ability to contact the flight over internet radio and track the flight using flight tracking software. He believed the ability to maintain contact with the aircraft covered the entire route structure.

When asked about the training of the dispatchers, he stated that it was not a required position. Training was largely OJT. The Director of the SOC or other dispatcher would sit with them and teach them every aspect of the operation. The process could take 4-6 weeks and various senior dispatchers or managers would shadow the trainee before they were released to do things on their own. He stated that he was trying to make it a formalized ground school and more like a training program that pilots would complete. At the time, he said that he was responsible for anything related to the SOC. Mostly, the Director of the SOC would provide the training, but that he could do some policy related training.

He said there was no formalized recurrent training, but that dispatchers would receive additional training all the time. He said it was more ongoing training for various reasons to include a new city being added.

When asked about training documentation, he stated that there were no specific forms he was aware of to keep track of the training. He said it was a grey area since they were not required to have dispatchers.

When questioned on the qualifications for dispatchers, he said the job description contained the list for qualifications. He said an aviation background, dispatcher license was preferred but not required and knowledge of Part 135 would certainly be helpful. He said the Director of the SOC may have had something, but he did not see it. He said if a dispatcher was not doing well in training, then the Director of the SOC would contact him. He said he trusted the judgement of the Director of the SOC.

Mr. Griffin stated that pilot in command minimum requirements were 1200 hours total flight time, there was certain night, cross country and actual instrument requirements. He said the Alaska pilots were different since they were day VFR only. They preferred 500 hours total flight time, and typically the pilots had about 200-300 more hours. They were typically hired around 700 hours of total flight time. In 2015, they had a class of new hire pilots specifically for Alaska and then during a large class in May, they asked for volunteers to go fly in Alaska.

Mr. Griffin stated that pilots in the lower 48 had a different training schedule than pilots that were going to be based in Alaska. Pilots in the lower 48 attended a 2 week, 80 hour ground school before flight training in the airplane. Following the flight training, they completed an oral exam, a checkride in the airplane and then began initial operating experience (IOE). There were two check airmen in Alaska to conduct the checkrides. Alaska based pilots completed the same basic ground school plus three additional days related to Alaska geography, weather, Capstone and the Juneau Letter of Agreement. The additional training was conducted in Juneau. All flight training for Alaska based pilots was completed in Juneau, to include the checkride and IOE. He stated there was a minimum amount of IOE, as contained in the FAA approved training manual, but was not sure of the number of required hours.

When asked what was done as a company to ensure pilot proficiency in areas such as emergency procedures and equipment failures, Mr. Griffin replied that the training would be included in the emergency training in the training program and that they had an emergency checklist for scenarios. SeaPort did not conduct simulator training. Although the company had a simulator, it had not yet been integrated into the training program.

When asked about CFIT training and inadvertent IMC training, he stated that they tried to do CFIT training, but not always. It was not required and not a formal part of the training program. When it was completed, it took place in a simulator at the Civil Air Patrol in Juneau that had visuals but no motion. He said it was a part of the Medallion program, but not always completed. Mr. Griffin said he had been through the Medallion CFIT training and was qualified to give the training, but that providing training was the responsibility of the Chief Pilot. He said SeaPort did not use cue based training with the pilots in Alaska. As for training on the Chelton unit, he stated that it was completed with a classroom set up unit simulator and in the actual airplane. The initial training on the Chelton unit predated his arrival at the company and he had not personally completed the training.

Mr. Griffin said safety was the highest priority and more of a culture for the company. He took the approach that it could always be better. When asked about an accountable manager, he replied "Yes. All of us are. Ultimately, I am from an operational standpoint." There was a formal safety policy that had been enhanced since the arrival of Peter Baker, Director of Safety. The policy was located on the safety page of the employee website.

Mr. Griffin was then asked about risk assessments. He replied that they were a part of the Medallion program and covered human factors, geography, etc. He said the forms were only completed for the Alaska operation and not in the lower 48. In Memphis, the risk assessment was not as important as San Diego or Portland and though there had been discussions about implementing the form in the other

areas, it had not taken place. He stated that the pilot came up with a score that correlated to a range of scores and ultimately manager notification and manager approval. If the score exceeded the limit for management approval, he would not allow the flight to depart at that time. He said the pilot completed the assessment and sent it to the dispatcher. If it required management notification or approval, about 95% of the time, he was the person notified. The notification or approval could also be completed by the Chief Pilot or base Chief Pilot. He said the actual form predated his arrival at the company and believed it was created by Medallion. There had been no changes to the form since his arrival. Although he had never filled one out himself, he felt it was an adequate form. There had been no changes to the form following the accident, but it was re-emphasized that the form was to be completed before every flight in Alaska. Also the Director of the SOC was to ensure the dispatchers knew the scoring system and what it meant. When asked to elaborate on the "every flight" requirement, he said especially if it required approval. He would personally go track down the risk assessment if the weather was poor in Alaska. He then said technically the flight could still go, but strongly recommended that it did not depart. He said typically he would be notified if someone did not complete the form and follow-up would take place.

When asked about the relationship between SeaPort and Medallion, he stated that had personally spoken with people from Medallion, but had never met any of them. He said he was proud of the Medallion Shield. At the time of the interview, he was in the process of enhancing the relationship and getting documents "up to speed." He did not know when the last Medallion audit took place.

Mr. Griffin was asked about any policies for flight over water and how it related to gliding distance to shore. He replied that the flight must be within gliding distance of "land." He used air quotations with the word "land." He stated that the land might not be suitable for landing purposes, but as a policy they stayed within gliding distance to land per the regulation. He said typically they had minimum altitudes for certain routes and it depended on a particular flight. Ultimately, he said, it was the pilot's decision. If the weather dictated otherwise, then the pilot could do something different. He said they had to make the decision between maintaining VFR and maintaining gliding distance. He was unaware of the specifics of the altitude training for gliding distance or to cross the water.

End of Interview.

Interview: Rob McKinney, President/CEO, Seaport Airlines
Representative: Bob Richmond (Attorney)
Location: Seaport Offices, Juneau, Alaska
Time/Date: 1700 AKD / July 29, 2015
Present: Chris Shaver (NTSB), David Keenan (FAA AVP-100)

During the interview, Mr. McKinney stated the following information:

He was an ATP rated pilot with about 7,500 hours total flight time. He had an extensive career in aviation as a pilot, FBO manager, and currently the CEO of SeaPort airlines. He was approached by Seaport in September 2007 and asked to start their certificate. They ended up purchasing in the Wings of Alaska certificate in in April 2008, and started flying in June 2008. He stated that in his current position, he was responsible for the overall health of the company. Since he has the depth of operational experience, he still flies the line on occasion.

He stated that system wide, SeaPort operated 22 airplanes. Normally, six airplanes were based in Juneau during the summer months, and that number went to five during the winter. Asked about pilot staffing, he said that there were in the high 60s system wide, and that they would need around 80 pilots to be fully staffed. He said that didn't know the exact numbers for Juneau, and that the base chief pilot would be able to answer that. He thought that there were 6 flight coordinators in total, and they were all based in Portland.

Asked to describe the nature of the work at SeaPort in Alaska, he said that the summer months were a blend of scheduled operations and air tours. They flew passengers, mail, and cargo. In the Alaska operation they were also authorized to carry HazMat. He said that the Alaska operation is all single pilot VFR, where their operations in the lower 48 were all two-pilot IFR operations.

Asked if there had been any significant changes to the operation in the last two years, he said that there had been no changes in the nature of the operation. There had been some changes in management with a new Director of Operations and new Director of Maintenance. There had been some minor differences in training, but nothing substantial. They had made some big changes in their reservations programs.

Mr. McKinney stated that the relationship with the Portland FSDO was very hands on. He had been the director of operations at two different points and had been very vocal about his disagreement with some of the FSDO choices, specifically not responding to correspondence in a timely manner and interviewing employees without notice. He said that they had also had manual changes that had been in process for over a year. The POI has new to their certificate, and he thought that someone from the FSDO visited the Alaska operation quarterly. The SeaPort certificate was moved to the Portland FSDO from the Juneau FSDO in 2012. Seaport wanted the certificate to stay with Juneau, but they were told that the Juneau FSDO no longer had the manpower to effectively manage the certificate. He said that through his meetings with the FSDO personnel there had been some marginal improvement. Mr. McKinney also stated that the majority shareholder of SeaPort had acquired a Part 121 certificate and that they were working on that project.

Asked about SeaPort's operational control procedures, Mr. McKinney stated that the director of operations is ultimately responsible for operational control of the airline. He said that he can be designated by the DO to perform operational control functions, but it is not part of the normal flow. The DO does allow flight followers to exercise limited operational control, and that pilots are not allowed to

initiate flights. He said that the pilot and flight coordinator usually make the operational control decisions to release a flight on a flight by flight basis. That decision is not documented on a piece of paper, it's all discussion between the pilot and flight coordinator. He said that the DO maintains a list of all operational control delegates. He said that the DO is very hands on and keeps good tabs on the operation as a whole.

Asked if the company used a flight risk assessment, Mr. McKinney said that they do use one as part of the Medallion Foundation program, but only in the Alaska operation. The assessment is not described in the GOM. It is supposed to be used on a per flight basis, but he thought that been used more sparingly.

Mr. McKinney said that there was no formal training program for the flight followers.

Asked about pilot selection and training, Mr. McKinney said that up until recently they had always required pilots to meet Part 135 IFR minimums, but with the pilot shortage that had to start hiring using VFR minimums. He thought that they had hired pilots with less than 750 hours. He said that most pilots attend ground school in Memphis or Portland and that they might do one Alaska specific ground school. After ground school, Alaska pilots do their flight training in Alaska. He said that Norm McDermott, the Chief Pilot is responsible for pilot training. Asked what SeaPort does to ensure pilot proficiency in emergency procedures, he said that the PTS standards are strictly adhered to. He said that some pilots don't make it through training. The VFR pilots go through the same training as the IFR pilots. They don't do the full blown IPC, but the get inadvertent IMC and CFIT training.

Mr. McKinney stated that he was an Alaska on the day of the accident. He was getting another individual a tour of the operations and station visits. The accident pilot had flown them on two different legs the day before. They had taken a flight to Hoonah that morning and arrived about 1045. The weather on the flight was typical Southeast Alaska weather, as high as 1300 feet and as low as 900 feet during the flight. Skies were clear in Hoonah. They were scheduled to come back in the early afternoon but got stuck due to weather. He said they were having lunch in Hunan on the phone rang and Mr. Sieber reported that they had an aircraft down. He said that he did not have the emergency response plan in front of him, and his first call was to the director of safety. He spent the rest of the day making phone calls in Hoonah until he could get back to Juneau. He ended up chartering a coastal helicopter to get back to Juneau and arrived about 1925.

Mr. McKinney recalled observing the pilot's performance when she flew him the day before the accident. He stated that she was very methodical, and he realized that it was probably intimidating for her to be flying the CEO of the company. He said that she went line by line down the checklist, and did everything required on the preflight briefings. He said that it was refreshing because sometimes in Alaska the folks tend to lose some of that attention to detail. He stated that he would consider her flying as "by the book."

Asked to describe the company's approach to managing safety, Mr. McKinney said that safety is the number one core value of Seaport. He said that safety starts at the top with him. He said he picks the people that he works with and picks the people that have his same philosophy. He stated that no one has ever been forced to fly on his watch ever, and that no one has ever been reprimanded for turning around. He thought that having a safety manager showed some of that dedication to safety. He was extremely proud of the culture at Seaport and that everyone was dedicated to safety. He stated that the company had a formal safety policy and at the director's safety was the accountable manager. He said that the company has an anonymous safety reporting system and that he had watched it grow from just

a few reports a month to dozens now. Asked how the company makes use of that information he said that they put things in the pilot read file, then turn them into GOM amendments. He stated that the company uses WBAT software to monitor trends in operations and maintenance. The company communicates safety information to its employees through a pilot read file, company newsletter, and monthly and quarterly safety meetings. He said the company also incentivizes employees monetarily for safety reporting. He also said that people don't usually use anonymity because of the non-punitive culture.

Interview: Dee Rice, Principal Operations Inspector, FAA
Date: October 7, 2015
Location: FAA FSDO, Portland, OR
Present: Chris Shaver – NTSB
Shaun Williams – NTSB
Patrick Hempen –FAA
Howard Martin – Legal Counsel, FAA

Ms. Rice was the FAA Principal Operations Inspector assigned to SeaPort Airlines, Inc. at the time of the accident. She had flown 28 accident free years in Alaska before being hired at the FAA in September, 2008. She spent six years working for the Anchorage FSDO before she transferred to Portland in May or June, 2014. She was assigned as the POI for Seaport in January, 2015.

During an interview conducted on October 9, 2015, Ms. Rice stated the following:

The CMT for Seaport Airlines, Inc. was comprised of three inspectors – POI, PMI, PAI. She stated there probably should be assistant inspectors, but they did not have the resources in the office. At the time of the accident, her assigned operators consisted of SeaPort, a FAR 135 air ambulance company, a FAR 135 operator considered high risk, a designated pilot examiner, and she was the only inspector in the office qualified for tailwheel and turbine operations.

Ms. Rice stated that SeaPort received the most attention by her out of all the operators to which she was assigned. They were a busy operator and Alaska was considered high risk, requiring her to make visits to Juneau. She said she spent a week in Juneau to get a feel for all aspects of the carrier. She was able to observe new hire pilot training, recurrent training and basic ground school.

When asked to describe what specific oversight duties a POI should perform or ensure are performed on this type of operator during the course of a year, she stated “more than normal considering the operation.” She believed this was a time when pilots acquired their flight time with a carrier like SeaPort and move on. This created a risk by requiring the operator to constantly train new pilots. Most of their other operations were conducted using Cessna Caravans and flying IFR. In Juneau, the operation included Cessna 207 airplanes being operated single pilot. She stated that she tried to focus on enroute inspections, how the completed flight following, how they looked at weather, risk assessments, and if the pilots were adequately trained for the areas in which they flew. She stated that with the new safety assurance system (SAS), their work program was set for them. Beyond the items dictated by SAS, she could add items to allow her to look at things previously reviewed.

Ms. Rice stated that from the time she took over the FAA assignment of SeaPort from her predecessor, the relationship between the company and the FAA was very adversarial. She stated that working with the Chief Pilot and Director of Operations went well, but from her view, the CEO of the company liked to be in control of things and had a very adversarial relationship with the FAA. As an example, she said that following the accident, she worked with the DO updating risk assessments and mitigation plans but when the time came for him to turn it in to her, he was unable to do so because in her words they (CEO) was so afraid of litigation from the accident that they did not want to make the change. She said the DO was trying to get change but the CEO was blocking the change.

She expressed concern about while although legally operating in the Juneau area VFR, the company did not respect the environmental challenges and proactively increase company weather minimums. The flight following was originally accomplished from Juneau, but was changed to the SOC in Portland. She questioned if there was enough oversight by company management. She stated that there was an

Assistant Chief Pilot in Juneau when she was there previously and believed the accident could have been prevented by proper company oversight. She said the accident pilot was new to Alaska and in her opinion, should have more oversight than normal.

When asked to describe the SeaPort training program, Ms. Rice stated that it was a good program. She observed training by the Assistant Chief Pilot in Juneau. She recommended building scenarios to get the pilots thinking about how to handle situations when they were flying single pilot. She stated that training could not be the only tool in the tool bag. She said they relied on it as “we have this really good training.” She believed they needed stronger oversight.

When asked about CFIT training, she stated that they did what was included in the training program. She said they had a Medallion Star for CFIT, but they had not had an audit and did not keep up the program. SeaPort did not utilize cue based training and believed the training program would be better if they went beyond it. She said SeaPort let the CFIT training lax with the constant influx of new pilots, but believed that is when it was needed the most. Following the accident, she said the DO made everyone complete the training and they were not allowed to fly until it was completed. Since the accident, all pilots in JNU only were using Medallion CFIT training. Prior to the accident, they were not. It continued to be AK only training. She said the company continued to advertise as a Medallion Shield carrier, although they let the certification lapse

When asked if the training was adequate, she said it was as far as the training program requirements, but they should have been going beyond the requirements with Medallion. She said they mentioned they had a Medallion simulator, but high turnover did not allow them to keep up with the training. When the dispatchers were pulled out of JNU, all the pilots quit. She said they had warned management. She believed the pilots liked the additional oversight from the dispatchers being in JNU. There was nothing like someone who knew the AK area. It was different than IFR work in SAN or PDX.

When asked what she would change, she said she told management that something needed to be done. The FAA regional office would not do anything because there was not a history. She continued: “There is history, there’s been an accident. What more history do you need?”

Ms. Rice stated there was an estimated 14 or 15 people authorized to exercise operational control on behalf of SeaPort. She said it was very widespread. When asked who in the organization was authorized to exercise Tier 1 operational control as defined in FAA Order 8900.1, she said a lot of the people in the SOC are listed. She stated that the last time she performed an inspection on the operational control at SeaPort was September 16, 2015. She said it was interesting. She went with another inspector due to previous adversarial contacts. She said they had a good setup with separate screens for SAN, MEM, PDX and a whole AK area that took up a good part of the room. While she was conducting enroute inspections in August, one of the pilots told her the people in Portland did not know where they were. She asked the SOC about reporting points, but they did not know where the points were, but they could say the pilot was near a “long skinny island.” They knew the reporting points near JNU, but not up north towards Skagway. Once a plane goes down, they were no longer visible on the displays. The SOC manager told her the dispatchers had communication with the pilots all the way up the channel but she was skeptical. Once when she was in the SOC conducting surveillance, the weather was poor in JNU and the flights had been on a weather hold in the morning. There was one flight enroute and one preparing for launch to Hoonah. The enroute flight was going north. In order to make gliding distance from one end to the other of Berners Bay, the planes must be about 1,600 feet. After witnessing the airplane making 360 degree turns, she told the dispatcher that they should call the pilot and tell him to turn back. The dispatcher tried to call the flight back to JNU but was unable to make radio contact with the pilot.

The plane descended to 800 feet over the channel and radio contact still could not be established. She said that answered the question about communications. She called it a loss of operational control and a risk that needed to be mitigated. She said SeaPort needed to devise minimum enroute altitudes to ensure the FAA they could maintain gliding distance and clear terrain. She said safety was the biggest concern and the attitude of the company had to be owned by the company and not by the FAA. She thought a letter needed to be sent from the FAA to the company but it was being held by Deek Abbott, FAA Alaska Regional Deputy Division Manager. She stressed that the findings needed to go to the company but they were still going through the process.

Ms. Rice stated she had never observed dispatcher training. As for prerequisites, she said there were none as they did not need to be pilots or certified dispatchers. She stated the Director of the SOC was in the process of getting his instrument rating. She said the SOC was having the same personnel retention problem as the pilot group. People were leaving for bigger and better opportunities.

When asked how the requirements for persons exercising operational control (FAR 119.69) are met, she stated that they are trained.

She stated that SeaPort did utilize a flight risk assessment (FRA) and she had reviewed the form. She said it was only utilized in the AK operation but she would have liked for it to be used regularly throughout the system and not only as needed in the GOM. In her opinion it seemed to be adequate. She said she liked it over doing nothing. When she was in the SOC, she saw a FRA filled out with a weather hold in the morning. There was a statement on the form "the weather is below forecast, will evaluate enroute." She said there went the risk assessment, "going to take a look enroute and going anyway." She stated that at best, prior to the accident, it was completed on the first flight of the day, not every flight. It was signed by the pilot with no concurrence by the SOC. She said they should have been required to sign off that they reviewed it and concurred.

When asked if the FRA was part of the operational control procedures, she said no. The DO made them fill it out and they had to have it. In the GOM it was very loosely stated and she said that would be addressed.

She stated that SeaPort had six check airmen and instructors and she approved these individuals and conducted surveillance on them performing their duties. She stated that she observed them giving an oral and flight check, and she has been accused of being extremely thorough. With new candidates, she followed the FAA guidance and gave them a checkride first to ensure that they could personally fly the airplane and then she would observe them conducting a checkride.

When asked to describe the role of the Medallion Foundation with the SeaPort operation, Ms. Rice stated that she requested in a letter for a Medallion audit to bring the company back up to speed. Without the audit, she said they were just going to hang the plaque on the wall.

When Ms. Rice was asked how she felt about the procedures SeaPort had in place to manage weather related risk, she stated that if they were using them, it would have been helpful. She believed it would have helped the day of the accident, from a pilot standpoint.

Ms. Rice was then asked if their minimums changed when the flights were operated over water, to which she replied that they could develop minimum enroute altitudes for their routes. She stated that the SOC manager agreed with her. Ms. Rice said that they were operating at 500 feet and 2 miles visibility over the three mile wide channel. She wanted gliding distance assured. She said 500 feet would

not give three miles of gliding distance. SeaPort had no specified minimum altitudes for their routes. She said they must prove gliding distance and terrain clearance could be maintained.

Ms. Rice stated that since the accident, surveillance of the company had been increased. With a joint effort from the Juneau FSDO, SeaPort was receiving a lot of attention and “not the kind you want.” She said that until they came forward and started mitigating the risk, the certificate management part of the oversight was on hold. All the time they had was being spent on surveillance. Formal requests for changes to the operational control procedures had been submitted to the company and were contained in the correspondence file. The risk mitigation strategy was to be a part of a scheduled meeting with Deek Abbot from the FAA.

End of Interview.

Interview: Ty Bartausky, Frontline Manager, FAA
Date: October 7, 2015
Location: FAA FSDO, Portland, OR
Present: Chris Shaver – NTSB
Shaun Williams – NTSB
Patrick Hempen –FAA
Howard Martin – Legal Counsel, FAA

Mr. Bartausky was the FAA Frontline Manager (FLM) assigned to SeaPort Airlines, Inc. at the time of the accident. Immediately prior to becoming the FLM, he was the assigned Principal Operations Inspector for SeaPort from 2009-2015. Prior to being hired at the FAA in 2007, he flew as pilot-in-command under 14 CFR 121 and 14 CFR 135.

During an interview conducted on October 9, 2015, Mr. Bartausky stated the following:

His primary duty was to provide oversight and guidance to his unit of employees. His unit consisted of four POI's, one new hire operations inspector, one aviation safety technician and one aviation safety assistant. In addition to the oversight and guidance, he was also responsible for managing day to day activities, engaging in situations that arose, reviewing work and files before they left the office, internal audits and reviewing office processes.

He stated that a three person certificate management team (CMT) was sufficient for an operation the size of SeaPort if focus could be appropriately managed. Ideally he would have preferred to reduce the workload on the POI so she could have focused more on SeaPort, but the FSDO had staffing issues and was unable to do so. He said given the staffing situation, she was managing the best she could. He would have liked for her responsibility to have been decreased so she could provide greater focus on the certificate.

When asked to describe the working relationship between the FAA and SeaPort, Mr. Bartausky stated that from his standpoint, it was difficult to quantify at that time. He said it was adversarial, but there was mutual respect. He attributed degradation in the relationship to the circumstances. Prior to the accident, SeaPort was more open to making changes and since the accident; they are faced with pressures from different sources. The accident was when he saw the shift and there was less of a willingness to mitigate the safety risk, in his opinion. He said that prior to the accident, if the FAA brought something to the attention of SeaPort, there would be some pushback, but they would still correct the issue. There was more pushback than from some other operators, but it still did not rise to the level of pushback they received after the accident. As an example, he said that in Jackson, TN, the local FAA completed a facility inspection and found no record of scale calibration. There was nothing in the manuals, but the guidance for requesting the calibration was in FAA Order 8900.1. The FAA sent a letter that requested the calibration and SeaPort responded that since the regulation did not require calibration, they were not going to comply with the request.

When asked if he knew where the pushback was coming from, he said it was from Rob McKinney, President of SeaPort Airlines, Inc. The Director of Operations, Max Griffin was very willing to work with the FAA, but he (Bartausky) thought Mr. McKinney was limiting the DO in what he could do. He thought that Mr. McKinney believed that by making changes, it was admitting fault, and maybe he was getting that advice from legal counsel.

Mr. Bartausky said that when a POI made changes to manuals, if they were administrative and he had a high level of trust with the POI, then he would only accomplish minimal review. If there was a significant

change, there would be a lot of dialog with the POI and an exchange of information prior to an approval letter getting to his desk. He might have done a cursory review, but not in depth like the POI.

He stated that he would try to review PTRS activity codes and comments periodically. With the implementation of SAS (safety assurance system), inspectors had a complete inspection plan. Certain assignments were auto assigned for every operator, similar to "R" items in the national work program. The inspector had the ability to build plans, which the FLM would have to resource. He would have to resource the items and then complete a data review once the items were entered into the system. He said SAS required more engagement and increased the FLM workload, but did not have as much of an impact on him as it did inspectors. He said the jury was still out on the manageability of SAS.

When asked if prior to the accident he was familiar with the SeaPort flight risk assessment, he stated that he was familiar and it was his impression they did it, although he was not sure how consistent. He said there was no formal procedure in the operations manual that required it to be completed. He thought it was voluntary and part of Medallion. Beyond that, said he did not know the specifics or to what level they were engaged. He also was unsure if the form had been modified from the way it was when he was POI.

Mr. Bartauský was asked how SeaPort performs operational control to which he replied that it was an inspector's job. Based on his knowledge, he said they have "dispatchers" (he used air quotations) that made assignments. There was an assignment board in Portland that would be kept current with pilot assignments. The Chief Pilot of management would provide updated information for due checkrides or medicals so the dispatcher would know who was available. The company would publish a schedule for who could be called. The dispatcher was delegated operational control to initiate and release a flight. The GOM did give them operational control.

He stated that the dispatchers were trained but there was no approved training program. 14 CFR 119 required operational control people to be knowledgeable in certain subjects. He said looking back it was documented that they did have certain training.

When asked his general view of the SeaPort certificate, he said it had changed. His view of the company used to be higher, but he always had concerns for the safety culture. He was under the impression that they did not push the weather or take unnecessary risks. He thought they met minimum regulatory standards. He asked them to take additional steps to mitigate risk, which they had not accomplished. He said the FAA had done what it could to express their concerns and transfer the risk back to the operator and conduct surveillance. He believed the change probably happened before the accident.

When he was the POI, he "had a lot of confidence in the guys in Juneau." He said they have been good at pulling the wool over his eyes and believes a pilot shortage may have led to more pressure. He thought it was probably something that had happened more gradually and he had more confidence in the company a year ago that he did that day, but he was unsure when the shift took place. He would have always felt comfortable boarding one of their flights. When he was POI, he felt they were a safe operator. He did not think it had anything to do with the changing of POIs as SeaPort had been given a high degree of oversight.

When asked to comment on whether the FAA oversight was adequate prior to the accident, he stated that it was the best they could do and it was hard to define adequate. He would have liked to have given them more focus and attention, but was not able to due to staffing and other certificates. He stated he was the FLM for between 60-70 certificates. He hired several aviation safety inspectors on the operations side. He stated that following the accident, there had been no significant changes to the

oversight of SeaPort. They were still looking at their options moving forward. They were trying to focus on SeaPort, but they were unable to change the workload of the POI.

When asked about the oversight of the entire operation, he stated that geographic oversight was critical. They used geographic oversight as much as they could, particularly the Juneau and Memphis FSDO. Normally he was not aware of when geographic surveillance took place, only if there were problems. The only way he would know of satisfactory surveillance would be by reviewing data in the SPAS database.

When asked if he knew the ceiling and visibility requirements for 135 flights over open water, he stated that SeaPort used the minimum regulatory standard and did not have company minimums in place. He said that in reference to power-off gliding distance to shore, there was a regulatory standard that had to be met. 500 foot ceilings and 2 miles visibility would not allow for power-off glide to shore, but that they had to meet the regulation. He stated that it was a changing number and up to the pilot to decide. When asked if he believed the pilot decision was adequate, he said it was not and there should have been route altitudes.

Mr. Bartausky stated there was no risk mitigation plan in place that the operator had made the FAA aware of. He said maybe one was internal, but not visible to the FAA. He was aware of a meeting between Deek Abbott, Deputy Division Manager, Alaska Regional Flight Standards and SeaPort. There had been no contact between him and the Alaska Regional Office about a meeting with an operator based in Portland. He thought maybe the office manager had scheduled something, but no one had spoken to him about the meeting.

He said the FAA was going to hopefully utilize the new compliance procedures with SeaPort. He would like for SeaPort to take action and make change without having to write an enforcement action against the company. He stated that before SeaPort could do anything new or different, they would be required to have a plan in place. He said they were focusing on surveillance and putting the risk back on the operator. If the FAA found a concern or issue, they were going to try to use that information to get something in return, but if they needed to, they would submit enforcement action against SeaPort.

On September 16, 2015, the POI found a noncompliance issue and drafted a letter to SeaPort, which was sitting on Mr. Bartausky's desk for review. He said he wanted to see what SeaPort would do to change before sending it.

When asked if he felt he was given the tools and authority to affect change on operators, Mr. Bartausky replied that to the greatest extent possible, he did. He said that staffing was always a challenge in general aviation. He would like to spend more time with the operators. He felt supported every step of the way and supported the people in his unit. He they did not make decisions in a vacuum.

End of Interview.

Interview: Michelle Ramsey
Date: August 12, 2015
Location: Telephonic Interview
Present: Chris Shaver – NTSB
Shaun Williams – NTSB

Ms. Ramsey was the sister of the accident pilot, Farah Peterson. She spoke with her sister at least once per week, with the last communication being the morning of the accident via text message.

During an interview conducted on August 12, 2015, Ms. Ramsey stated the following:

Her sister wanted to go into flying since attending Auburn University in 1988, although flying had been a lifelong dream and passion since about the age of 5.

In 2001, after hearing about a Delta scholarship, Ms. Peterson enrolled at Western Michigan University to pursue her flying dream and graduated in 2003. While working in the finance field, she continued to build flight time by flying airplanes that were owned by friends. In 2013, the accident pilot resigned from a lucrative finance career to become a flight instructor in Vero Beach, FL.

Ms. Ramsey said that towards the end of May he sister moved to Alaska for a position with SeaPort Airlines. She walked away from a six figure salary to do what she loved, but due to her knowledge of finance, was financially stable.

When asked if her sister got along with her colleagues, she stated that Ms. Peterson told her everyone was very nice and she liked the people with whom she worked.

Ms. Ramsey stated that about 2-3 weeks prior to the accident, he sister told her she had encountered a bad storm on a flight. She said that her and her passengers were praying together to get through the weather. Eventually she saw the runway and was able to land. Other than this event, the accident pilot never mentioned to her any concerns about the flying for the company for which she worked.

When asked to describe the daily habits of her sister, Ms. Ramsey stated that she was unsure of a normal time to go to bed, but the latest they spoke was about 2200. She said Ms. Peterson was very versatile, but probably a morning person and described her as a “good sleeper.”

When they last spoke on the phone the weekend before the accident, Ms. Peterson seemed very happy and in a good mood.

Ms. Ramsey stated that her sister took blood pressure medication, but never mentioned any side effects. It was being used to treat hypertension that ran in the family. She said tobacco products were not used by her sister and alcohol consumption was socially at most. She stated that there were no changes to the pilot’s health or fitness within the past year.

Regarding SeaPort Airlines, Ms. Ramsey said her sister liked the company and planned to stay with them and move to the Memphis base in September, 2015. She had stated that she was pleased with and enjoyed the training at SeaPort.

End of Interview