

## **Attachment 1**

NTSB Aviation Accident Final Report - Accident no. ANC15FA049

FAA Petition for Reconsideration to NTSB  
for  
NTSB case no. ANC15FA049



# National Transportation Safety Board Aviation Accident Final Report

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<b>Location:</b>	Juneau, AK	<b>Accident Number:</b>	ANC15FA049
<b>Date &amp; Time:</b>	07/17/2015, 1318 AKD	<b>Registration:</b>	N62AK
<b>Aircraft:</b>	CESSNA 207A	<b>Aircraft Damage:</b>	Substantial
<b>Defining Event:</b>	Controlled flight into terr/obj (CFIT)	<b>Injuries:</b>	1 Fatal, 4 Serious
<b>Flight Conducted Under:</b>	Part 135: Air Taxi & Commuter - Scheduled		

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## Analysis

The company flight coordinator on duty when the pilot got her "duty-on" briefing reported that, during the "duty-on" briefing, he informed the commercial pilot that most flights to the intended destination had been cancelled in the morning due to poor weather conditions and that one pilot had turned around due to weather. No record was found indicating that the pilot used the company computer to review weather information before the flight nor that she had received or retrieved any weather information before the flight. If she had obtained weather information, she would have seen that the weather was marginal visual flight rules to instrument flight rules conditions, which might have affected her decision to initiate the flight. The pilot subsequently departed for the scheduled commuter flight with four passengers on board; the flight was expected to be 20 minutes long.

Review of automatic dependent surveillance-broadcast data transmitted by the airplane showed that the airplane's flight track was farther north than the typical track for the destination and that the airplane did not turn south toward the destination after crossing the channel. Data from an onboard multifunction display showed that, as the airplane approached mountainous terrain on the west side of the channel, the airplane made a series of erratic pitch-and-roll maneuvers before it impacted trees and terrain. Postaccident examination of the airframe and engine revealed no mechanical malfunctions or anomalies that would have precluded normal operation. One of the passengers reported that, after takeoff, the turbulence was "heavy," and there were layers of fog and clouds and some rain. Based on the weather reports, the passenger statement regarding the weather, and the flight's erratic movement just before impact, it is likely that the flight encountered instrument meteorological conditions as it approached the mountainous terrain and that the pilot then lost situational awareness and flew into trees and terrain.

According to the company's General Operations Manual (GOM), operational control was delegated to the flight coordinator for the accident flight, and the flight coordinator and pilot-in-command (PIC) were jointly responsible for preflight planning, flight delay, and flight release, which included completing the flight risk assessment (FRA) process. This process



required the PIC to fill out an FRA form and provide it to the flight coordinator before flight. However, the pilot did not fill out the form.

The GOM stated that one of the roles of the flight dispatcher (also referred to as "flight coordinator") was to assist the pilot in flight preparation by gathering and disseminating pertinent information regarding weather and any information deemed necessary for the safety of flight. It also stated that the dispatcher was to assist the PIC as necessary to ensure that all items required for flight preparation were accomplished before each flight. However, the flight coordinator did not discuss all the risks and weather conditions associated with the flight with the pilot, which was contrary to the GOM. When the flight coordinator who was on duty at the time the airplane was ready to depart did not receive a completed FRA, he did not stop the flight from departing, which was contrary to company policy. By not completing an FRA, it is likely the total risks associated with the accident flight were not adequately assessed. Neither the pilot nor the flight coordinator should have allowed the flight to be released without having completed an FRA form, which led to a loss of operational control and the failure to do so likely contributed to the accident.

Interviews with company personnel and a review of a sampling of FRA forms revealed that company personnel, including the flight coordinators, lacked a fundamental knowledge of operational control theory and practice and operational practices (or lack thereof), which led to a loss of operational control for the accident flight.

The company provided no formal flight coordinator training nor was a formal training program required. All of the company's qualified flight coordinators were delegated operational control and, thus, were required by 14 *Code of Federal Regulations* Section 119.69 to be qualified through training, experience, and expertise and to fully understand aviation safety standards and safe operating practice with respect to the company's operation and its GOM. However, the company had no formal method of documenting these requirements; therefore, it lacked a method of determining its flight coordinators' qualifications.

In postaccident interviews, the previous Federal Aviation Administration (FAA) principal operations inspector (POI), who became the frontline manager over the certificate, stated that the company used the minimum regulatory standard when it came to ceiling and visibility requirements and that the company did not have any company minimums in place. He further stated that a cloud ceiling of 500 ft and 2 miles visibility would not allow for power-off glide to land even though the company was required to meet this regulation. When asked if he believed the practice of allowing the pilot to decide when to fly was adequate, he said it was not and there should have been route altitudes. However, no action was taken to change SeaPort's operations. The POI at the time of the accident stated that she was also aware that the company was operating contrary to federal regulatory standards for gliding distance to shore. A review of FAA surveillance activities of the company revealed that the POI provided surveillance of the company following the accident, including an operational control inspection, and noted deficiencies with the company's operational procedures; however, the FAA did not hold the company accountable for correcting the identified operational deficiencies.

If the FAA had conducted an investigation or initiated an enforcement action pertaining to the company's apparent disregard of the regulatory standard for maintaining glide distance before the accident similar to the inspection conducted following the accident, it is plausible the flight



would not have departed or continued when glide distance could not be maintained. The FAA's failure to ensure that the company corrected these deficiencies likely contributed to this accident which resulted, in part, from the company's failure to comply with its GOM and applicable federal regulations, including required glide distance to shore. The company was the holder of a Medallion Shield until they voluntarily suspended the Shield status but retained the "Star" status and continued advertising as a Shield carrier. Medallion stated in an email "With this process of voluntarily suspension, there will be no official communication to the FAA..." Given that Medallion advertises that along with the Shield comes recognition by the FAA as an operator who incorporates higher standards of safety, it seems contrary to safety that they would withhold information pertaining to a suspension of that status.

## Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be:

The pilot's decision to initiate and continue visual flight into instrument meteorological conditions, which resulted in a loss of situational awareness and controlled flight into terrain. Contributing to the accident were the company's failure to follow its operational control and flight release procedures and its inadequate training and oversight of operational control personnel. Also contributing to the accident was the Federal Aviation Administration's failure to hold the company accountable for correcting known regulatory deficiencies and ensuring that it complied with its operational control procedures.

## Findings

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Personnel issues	Decision making/judgment - Pilot (Cause)
	Situational awareness - Pilot (Cause)
	Decision making/judgment - Flight service personnel (Factor)
Environmental issues	Below VFR minima - Effect on operation (Cause)
Organizational issues	Adequacy of policy/proc - Operator (Factor)
	Training - Operator (Factor)
	Oversight of personnel - Operator (Factor)
	Oversight of operation - FAA/Regulator (Factor)



## Factual Information

### HISTORY OF FLIGHT

On July 17, 2015, about 1318 Alaska daylight time, a Cessna 207A airplane, N62AK, sustained substantial damage following an in-flight collision with tree-covered terrain about 18 miles west of Juneau, Alaska. The commercial pilot sustained fatal injuries, and four passengers sustained serious injuries. The flight was being operated as flight 202 by SeaPort Airlines, Inc., dba Wings of Alaska, as a 14 *Code of Federal Regulations* (CFR) Part 135 visual flight rules (VFR) scheduled commuter flight. (Wings of Alaska has been sold and is currently under different ownership.) Visual meteorological conditions were reported at the Juneau International Airport at the time of departure. A company flight plan had been filed, and company flight-following procedures were in effect. Flight 202 departed the Juneau Airport about 1308 for a scheduled 20-minute flight to Hoonah, Alaska.

On the day of the accident, the pilot arrived at the company office in Juneau about 1200. The accident flight was the pilot's first scheduled flight of the day. The company flight coordinator on duty at the time told the pilot that most flights to Hoonah were cancelled in the morning due to poor weather conditions and that one pilot had turned around due to weather. The flight coordinator said that the weather had started lifting around 1000 and that the first flight to Hoonah had departed at 1045. He suggested that the accident pilot talk with the pilot who had just returned. The dispatch group had a shift change between the time the accident pilot came on duty and when the pilot departed. The company flight coordinator on duty at the time of the accident only communicated with the pilot when she reported taxiing off the ramp for departure. No weather information was discussed, and no further radio communications were received from the pilot by the company.

According to Juneau Air Traffic Control Tower (ATCT) personnel, the pilot requested and received taxi clearance to depart for the 20-minute VFR flight to Hoonah at 1306. The flight was cleared for takeoff about 2 minutes later by the ATCT specialist on duty with no reported problems. About 15 minutes later, Juneau Police dispatchers received a 911 cell phone call from a passenger on board stating that the airplane had crashed.

During an interview with one of the surviving passengers, who was sitting directly behind the pilot, he stated that the pilot seemed normal during the preflight and briefing. After takeoff, the turbulence was heavy, and there were layers of fog and clouds and some rain. He had taken this flight numerous times and thought that the flight route that the pilot was taking was somewhat unusual. Before the impact, he thought that the pilot was trying to climb over the approaching mountain and skirt between a layer of clouds. He saw the trees coming at the windshield, and the pilot jerked back on the controls, and then he heard a "loud boom." The next thing that he remembered was sitting outside the airplane. He said that there were no unusual sounds from the engine and that the airplane appeared to be flying normally before the impact.

Automatic dependent surveillance-broadcast (ADS-B) data received by the Anchorage ATCT showed the following:



At 1308:09, the accident airplane took off from JNU.

At 1312:33, the accident airplane started a northwesterly turn around the west side of Portland Island at an ADS-B reported altitude of 825 ft mean sea level (msl).

At 1314:20, the accident airplane began a turn to a westerly heading at an ADS-B reported altitude of 825 ft msl.

At 1316:25, the accident airplane crossed the western shoreline of Admiralty Island at an ADS-B reported altitude of 675 ft msl and continued on a constant heading until the last ADS-B point was recorded.

The last ADS-B point was received at 1317:27, when the airplane was over Lynn Canal, about 1 mile from the eastern shoreline of the Chilkat mountain range at an ADS-B reported altitude of 525 ft msl. The last 30 seconds of the flight was missing from the ADS-B data.

#### PERSONNEL INFORMATION

The pilot, age 45, held a commercial pilot certificate with airplane single-engine land and sea, multiengine land, and instrument ratings. The pilot was issued a first-class airman medical certificate on April 9, 2015, with the limitation that she "must wear corrective lenses."

Company training records indicated that the pilot completed basic indoctrination on May 25, 2015, and initial ground training on June 2, 2015. Ground training curriculum was completed in two locations: Portland, Oregon, and Juneau. The pilot's most recent Part 135 proficiency checks (135.293 (a) (b) and 135.299) were completed in the Cessna 207 on June 12, 2015. Company records indicated that she had a total time of 840 flight hours.

The base chief pilot, who provided about half of the accident pilot's flight training, said that she was very good on systems but that she needed a few additional hours of flight training and initial operating experience before he was comfortable signing her off. He noted that the one thing that he really liked about her was that she wasn't afraid of turning around if she was uncomfortable. He did not notice any negative attitudes or habits with her flying.

The pilot's normal shift was the p.m. shift, which typically began at 1200 and ended at 2200. The pilot's flight and duty time records indicated that, the day before the accident, she flew 3.7 hours and then went off duty at 2200. The accident flight was the pilot's first flight of the day.

In June 2015, the pilot was on duty for 27 days, flew about 23 hours, and had 3 days off. In July 2015, the pilot was on duty for 11 days, including the day of the accident; flew about 41 hours; and had 6 days off. The pilot had not had a day off in the 72 hours preceding the accident flight. During that time, she flew a total of 19 flight segments, totaling 9.4 hours, not including the accident flight.

The pilot's roommates and family members reported no unusual activity in the 72 hours preceding the accident. However, in an interview with the pilot's sister, she said that the pilot had told her about an incident that had happened 2 or 3 weeks before the accident where she had gotten into a bad storm during a flight. The pilot said that she and her passengers were



praying together to get through the weather and that eventually she saw the runway and was able to land the airplane uneventfully. Other than this event, the accident pilot never mentioned to her sister any concerns about flying for the company for which she worked.

#### AIRCRAFT INFORMATION

The accident airplane, a Cessna 207A, N62AK, was manufactured in 1984. Before the accident flight, the airplane had logged a total time in service of 26,613.1 flight hours. The airplane was maintained under a 100-hour/annual inspection program, and the most recent 100-hour inspection of the airframe and engine was on July 6, 2015.

The airplane was equipped with a Continental Motors IO-520-F 285-horsepower reciprocating engine. The engine was factory rebuilt on June 16, 2015; installed on the airplane July 14, 2015; and had accumulated about 8.2 hours of operation before the accident flight.

#### METEOROLOGICAL INFORMATION

The area forecast issued by the National Weather Service Alaska Aviation Weather Unit (AAWU) at 1210 included an AIRMET for mountain obscuration due to clouds and precipitation, and the AIRMET was valid at the accident site at the accident time. The area forecast mentioned scattered clouds at 1,200 ft msl with broken to overcast ceilings at 2,000 ft msl with cloud tops to flight level 250 and an occasional broken ceiling at 1,200 ft msl with 5 miles visibility and light rain. Isolated instrument flight rules (IFR) conditions were also forecast with rain and mist. The AAWU weather charts produced at 1200 indicated that the accident site was on the boundary of marginal VFR to IFR conditions with isolated moderate low-level turbulence between the surface and 6,000 ft msl.

The closest official weather observation station is Juneau, which is located about 18 miles east of the accident site. At 1253, a METAR was reporting, in part, wind 110° at 14 knots; visibility 7 statute miles in light rain and mist; clouds and ceiling 200 ft few, 3,500 ft overcast; temperature 57° F; dew point 55° F; altimeter 30.24 inches of Mercury.

Numerous Federal Aviation Administration (FAA) weather cameras are located in the vicinity of the Juneau Airport. Images from several of the cameras closest to the pilot's flight route were obtained for the period from 1100 to 1600 on the day of the accident. Figure 1 shows an image that was taken about 5 minutes before the estimated accident time, facing the direction of the accident location. (Refer to the Meteorology Group Chairman's Factual Report in the public docket for further weather information and weather camera images.)





Figure. A video camera image showing visibility conditions at Juneau Airport about 5 minutes before the estimated accident time, facing the direction of the accident location.

No record was found indicating that the pilot used the company computer to review weather information before the flight nor of her having received or retrieved any weather information before the flight. The flight coordinator did not review weather camera images with the accident pilot before the flight and had no further communication with the pilot about the weather.

#### FLIGHT RECORDERS

The accident airplane was not equipped, nor was it required to be equipped with, a cockpit voice recorder or a flight data recorder.

#### WRECKAGE AND IMPACT INFORMATION

On-scene examination revealed that the airplane impacted a large spruce tree at an elevation of about 1,250 ft msl. After the initial impact, the airplane fuselage separated into two pieces. The forward section of the airplane, consisting of the cockpit and engine, separated just forward of



the main landing gear assembly and came to rest inverted about 50 ft forward of the initial impact point; the cockpit survivable space was severely compromised. The remaining section, consisting of the main cabin, wings, and empennage, came to rest inverted just below the initial impact point. The wreckage path was on a magnetic heading of about 215° and oriented uphill. The trees surrounding the accident site were on average over 100 ft tall.

The wreckage was recovered from the accident site on July 20, 2015, and placed in a secure hangar at the Juneau Airport. The National Transportation Safety Board (NTSB) investigator-in-charge (IIC), FAA IIC, a Textron Aviation air safety investigator, and a party representative from the operator examined the airplane on July 20 and 21.

The fuselage and engine compartment forward of fuselage station (FS) 65.33 was separated from the main fuselage and was found inverted 50 ft from the main fuselage. Both crew seats were observed in the forward fuselage. The engine remained in the forward fuselage. Both wings remained attached to the main fuselage. The left pilot's door had separated from the fuselage and was in the trees. The right passenger door had separated from the forward fuselage. The forward section of the cargo door remained attached to the fuselage. The aft section of the cargo door was separated from the fuselage. The empennage remained attached to the main fuselage and exhibited tree impact damage from FS 168.0 to 210.6. The outboard section of the right horizontal stabilizer from stabilizer station (SS) 54.4 outboard was not found. A section of the right elevator from SS 35.9 outboard was separated from the elevator and found at the main impact site.

The left wing had a large tree impact mark near wing station (WS) 56.53, which displaced the leading edge back to the main spar and displaced the main spar aft about 10 inches. The flap and aileron remained attached to the wing.

The right wing had a tree impact mark near WS 85.62, which displaced the leading edge back to the main spar. The leading edge was damaged from right WS 136.00 to the tip. The outboard section of the right wing from WS 172.00 to the tip and aileron were displaced upward. The flap and aileron remained attached to the wing.

The aileron direct cable to the left wing was found with the ball end pulled out of the control pulley. The cable was continuous out to the left aileron bellcrank. The aileron crossover cable was continuous to the right aileron bellcrank. The right direct cable was continuous from the right aileron bellcrank to a tension overload separation in the doorpost area.

The elevator cables were attached to the elevator torque tube and extended to about FS 95.33 where they exhibited a tension overload type separation. The elevator cables were attached to the aft elevator bellcrank and extended forward to about FS 95.33 where they exhibited a tension overload type separation. The elevator trim cables exhibited a tension overload type separation. The elevator trim tab actuator rod was observed extended the full length of the rod, and when slightly turned, the rod separated from the actuator.

Both rudder cables were attached to the rudder bars in the cockpit and exhibited a tension overload type separation near FS 59.70. The aft section of each rudder cable was attached to the rudder, and the rudder actuated when the cables were moved.



The flap actuator was observed in the "up" position. The flap follow up/indicator cable was stretched during the accident sequence. The indicator was observed in the "full flaps down" position, and the flap handle was in the "10°" position. The cables from the left wing to the right flap were attached.

The fuel strainer was removed from the airplane, and it contained fuel. A sample could not be obtained due to the position of the strainer in the wreckage. Air was passed through both the left and right wing vent systems. Both fuel caps on both wings were observed installed on their filler necks, and their seals were pliable.

The restraint systems of both crew seats consisted of compatible Cessna and Air Carriers Interiors, Inc., Kent, Washington, parts. Both of the crew seats remained partially attached to the seat tracks. The pilot's seat was equipped with an SEB07-5 Pilot and Copilot Secondary Seat Stop Installation.

All the passenger seats were separated from the seat tracks. Rescue personnel removed some of the seats from the airplane during the rescue. Several of the passenger seats exhibited damage to the seat base and attachment feet.

No preaccident anomalies were noted with the airframe that would have precluded normal operation.

#### MEDICAL AND PATHOLOGICAL INFORMATION

The State of Alaska Medical Examiner, Anchorage, Alaska, conducted an autopsy of the pilot. The cause of death for the pilot was attributed to "multiple blunt force injuries."

The FAA's Civil Aerospace Medical Institute performed toxicological testing on specimens from the pilot on September 9, 2015, which were negative for carbon monoxide and ethanol. The toxicological testing detected Valsartan in the pilot's urine and blood. Valsartan is a prescription medication used to treat high blood pressure. The pilot reported the use of this medication on her last application for an airman medical certificate.

#### SEARCH AND RESCUE

About 1336, the US Coast Guard (USCG) in Alaska received a 406-megahertz emergency locator transmitter (ELT) signal assigned to the accident airplane. At 1421, after being notified of an overdue airplane and after learning about reports of an ELT signal along the accident pilot's anticipated flight route, search and rescue personnel from the USCG Air Station Sitka began a search for the missing airplane. About 1650, the crew of a USCG HH-60 helicopter located the airplane's wreckage in an area of mountainous, tree-covered terrain. A rescue swimmer was lowered to the accident site and discovered that the pilot had died at the scene and that the four other occupants had survived the crash. The four survivors were hoisted aboard the HH-60 helicopter in two trips and then transported to Juneau.

#### SURVIVAL ASPECTS



All four passengers in the main cabin survived the accident. After the initial impact, the fuselage section, consisting of the main passenger cabin, fell straight down the trunk of the tree and came to rest inverted. The cabin's structure remained relatively intact with sufficient survivable space.

The pilot, who was in the cockpit, sustained fatal injuries. The forward fuselage and cockpit separated from the main fuselage and traveled about 50 yards forward before impacting in an inverted position. The survivable space in the cockpit was severely compromised.

## TEST AND RESEARCH

The engine was shipped to Anchorage, and on August 17, 2015, it was tested and run at the Alaskan Aircraft Engines facility. The engine was placed on a test stand with a replacement propeller.

Before the engine test, fuel was noted leaking from the fuel-metering plug retention screw on the fuel-metering unit when the electric boost pump was used to prime the engine. The fuel leak was not noticeable during the engine test, and further examination of the leak showed that the screw was likely fractured during the accident sequence.

The engine started on the first attempt with no hesitations or anomalies noted. The engine was run for about 8 minutes through various power settings, including full power, with no anomalies noted.

## ORGANIZATIONAL AND MANAGEMENT INFORMATION

At the time of the accident, SeaPort Airlines was operating 21 airplanes, of which 5 were based in Juneau. The company employed about 80 pilots and had bases in Juneau; Portland; Memphis, Tennessee; and San Diego, California.

### *Operational Control*

The FAA issued Operations Specifications Paragraph A008, "Operational Control," to SeaPort Airlines on January 21, 2011, and it stated, in part, the following:

#### *(1) Reference AJAA GOM [General Operations Manual] Section A and L*

SeaPort Airlines GOM section A, as referenced above, contains policies for Operational Control, but does not explain the procedures utilized for the initiation or conduct of flight movements. The policies contained in this section are a restatement of the certificate holder responsibilities listed on Operations Specifications Paragraph A008.

SeaPort Airlines GOM section L, as referenced above, contains the procedures for conducting flight locating, but does not contain procedures for the initiation or conduct of flight movements.

The SeaPort GOM, Section A, which described the company's organization, including its organizational chart, and the duties and responsibilities of managers, stated, in part, the following:

- SeaPort Airlines, Inc. operational control system includes a system of ensuring that SeaPort Airlines, Inc. has complete, effective, and sustainable operational control over each aircraft operated, and that no surrender or loss of operational control exists...
- Operational Control is the exercise of authority over initiating, conducting or terminating a flight. Operational Control includes, but is not limited to the following:

All flights operated by SeaPort Airlines, Inc. will be initiated, conducted or terminated only by those having been given operational control authority of SeaPort Airlines, Inc. as described in our General Operations Manual...Prior to any 135 flight or series of flight, at least the PIC [pilot-in-command] assigned must determine, whether the flight can be initiated, conducted, or terminated safely and in accordance with SeaPort Airlines, Inc. operation specifications, manuals, and regulations.

However, a review of the SeaPort GOM that was in effect at the time of the accident did not reveal any policies and procedures for initiation and conduct of flights.

A company representative stated that all the people listed in Flight Operations Bulletin 4-15, "Operational Control Personnel," were authorized to exercise operational control, including initiating or terminating flights. This list included the director of operations (DO), chief pilot, director of systems operation control (SOC), base and assistant base chief pilots, director and assistant director of maintenance, dispatchers (flight coordinators), and the company president; the list did not include PICs as approved operational control personnel.

The Flight Operations Bulletin and the Seaport GOM, Section A.2, stated, the following:

- Any of the above personnel may be responsible for the control of flight operations under FAR [*Federal Aviation Regulations*] 135.77 at any given time. These individuals are qualified through training, experience, and expertise (ref. 119.69(d)(1))

(Refer to the Operations Group Chairman's Factual Report in the public docket for further information regarding operational control.)

#### *Dispatcher (Also referred to as "Flight Coordinators") Duties and Training*

The GOM, Section A.4.10, stated the following regarding dispatcher training:

Operations personnel, as referred to in this manual, are also known as dispatchers. Prior to service, they must have received training and be knowledgeable of the General Operations Manual, Operation Specifications, Minimum Equipment List, and Operational Control policies and procedures of SeaPort Airlines, Inc.

Specific responsibilities and duties of the dispatcher include, but are not limited to, the following:



- Schedule flights and assist pilots in flight preparation by gathering and disseminating pertinent information for all stations regarding weather or runway conditions and any information deemed necessary for the safety of flight.
- Ensure that the pilot is qualified and current in the assigned aircraft.
- Monitor pilot flight and duty time records to ensure they are in compliance with FAR 135.263, .265, .267, as applicable.
- Monitor pilot status board to ensure pilots meet the requirements of FAR 135.293, .297, and .299, as applicable.
- Monitor pilot status board to ensure pilots' medicals are current.

In an interview, the flight coordinator that provided the accident pilot her "duty-on" briefing the day of the accident stated that there was no formal classroom training for flight coordinators and only on-the-job training, which consisted of shadowing a flight coordinator, followed by performing the duties while being observed.

In an interview, the DO stated that there was no formalized training program for flight coordinators but that it was a 4- to 6-week process, largely comprising on-the-job training. He also stated that he was unaware of there being any specific training documentation forms to keep track of training.

In an interview, the director of SOC stated that the flight coordinators in Portland were trained for Alaska-specific items, such as weather cameras, flight risk assessment (FRA) forms, and unique weather patterns, but that "at the end of the day, it's still Caravans or Cessnas flying up a canal." When asked about recurrent training for flight coordinators, he stated that, although they completed annual training, there was nothing documented at the time and nothing Juneau-specific.

The director of SOC later stated that he maintained dispatcher training records for the Medallion safety program and that the records were located in Portland. The NTSB received a copy of the dispatcher training forms on November 23, 2015. The records contained training certificate forms for the dispatcher that provided the accident pilot her "duty-on" briefing, the dispatcher on duty at the time of the accident, and several other dispatchers. Numerous training dates and certification signatures on the forms were inconsistent with information provided to the NTSB during interviews with SeaPort personnel. (Refer to the Operations Group Chairman's Factual Report in the public docket for further information regarding flight coordinator training and documentation.)

### *Flight Risk Assessment*

SeaPort Airlines implemented an FRA process for Alaska operations. The use of the FRA process was not elaborated upon in the GOM; however, the GOM assigned responsibility for the FRA to the PIC and director of flight control, which was changed to the director of SOC in Flight Operations Bulletin 4-15.



The SeaPort GOM, Section A.4.7, stated that one of the duties of the PIC was to complete an FRA, if applicable, before the flight to determine the risk level associated with the flight. To satisfy this requirement, pilots were to complete the FRA form during flight planning and to provide the completed forms to the flight coordinator before flight.

The FRA form applied numerical values to certain situations/circumstances, including, in part human, destination, and weather factors. According to the FRA form, risk values of 0 to 20 were considered a low risk factor and required only pilot and SOC concurrence. Risk values of 21 to 35 were classified as a risk factor of "caution," which required management notification. Risk values of 36 to 45 were classified as "medium risk," which required management approval. Risk values of 46 and higher were classified as "high risk," which required mitigation or flight cancellation. The pilot also had to complete a section listing the proposed true airspeed and altitude.

At the time of the accident, flight coordinators and PICs were required to sign off on the FRA form. The FRA form was part of the company's operational control and flight release system and was provided to the FAA, but it was not incorporated into the GOM, training program, or other company manuals. In an interview, the company president stated that the use of the FRA form was limited to Alaska and was used as part of the Medallion program. Although the form was not described in the GOM, it was intended to be used for every flight.

The flight coordinator who was on duty at the time of the accident stated that the PIC would complete the FRA form and fax it to the SOC. The coordinator's job was to just make sure the form "looked good." If management notification was required, he would sign that block on the form. He stated that he would only inform management if their approval was required as determined by a risk value between 36 and 45.

The flight coordinator who provided the accident pilot her "duty-on" briefing stated that, after a pilot completed the FRA form, sometimes the pilot would fax it to the SOC, and sometimes the form would be maintained in Juneau. If he saw one on the fax machine at the SOC, he would glance over it to determine if he agreed with the values and would hold onto it for his own records because he was not required to do anything specific with the forms. He further stated that he received no training on the use of the FRA form. The accident pilot did not submit an FRA form before departing on the accident flight.

The NTSB Operational Factors Group obtained three FRA forms dated June 9, 2015. This date was selected due to the existence of marginal VFR weather conditions in the Juneau area that day. A review of the forms revealed that all three of them were incomplete or incorrectly completed. Three of the forms were not signed off by the flight coordinator. Two of the forms did not follow the guidance at the top of the page that stated the lowest total for any section could be 0 and that no negative values could be entered. Also, the same two forms required management notification; however, there was no notation indicating that management was notified.

The NTSB Operational Factors Group also obtained 11 FRA forms dated August 20, 2015. Three of the forms were incorrect or incomplete. A review of one of the forms revealed that it was incomplete and that it listed a proposed altitude of "1000 hopefully" for a flight requiring the crossing of a channel about 2.5 nautical miles wide at the narrowest point. Additionally, the



pilot entered a negative value for the section labeled "destination factors" and omitted a 2-point value from the human factors section titled "ADO and ACP not on duty," which every other pilot who completed an FRA that day applied to their score. The pilot assessed a total risk value of 17. However, when the omitted 2-point value was added and the negative "destination factors" value was removed, the total risk value was 21, which would have required management notification.

Another FRA by the same pilot who filled out the three incorrect or incomplete forms discussed above also contained assigned values inconsistent with the guidance provided at the top of the page. Also, for proposed true airspeed and altitude, a question mark was entered. (Refer to the Operations Group Chairman's Factual Report in the public docket for further information regarding FRAs.)

### *FAA Oversight*

FAA Order 8900.1, Volume 3, Chapter 25, Section 5, 3-2029, K, stated, in part:

Only approved persons may exercise operational control on the certificate holder's behalf.

The certificate holder must have adequate controls in place to ensure that officials in a position of authority over flights conducted under the certificate do so safely, and in compliance with the regulations, OpSpecs, GOM, as applicable, and accepted or approved procedures.

Management of operations should never be inattentive, distracted, or careless. Hands-off management is not a legitimate excuse for failing to maintain operational control.

The FAA front line manager responsible for the SeaPort Airlines certificate was the principal operations inspector (POI) for SeaPort Airlines until January 2015. During postaccident interviews, when asked if he knew the ceiling and visibility requirements for Part 135 flights over open water, he stated that SeaPort Airlines 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. Cloud ceilings of 500 feet and 2 miles visibility would not allow for power-off glide to land, 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 practice of allowing the pilot to decide was adequate, he said it was not and there should have been route altitudes.

Title 14 CFR 135.183, "Performance Requirements: Land Aircraft Operated Over Water," stated, in part, the following:

No person may operate a land aircraft carrying passengers over water unless it is operated at an altitude that allows it to reach land in the case of an engine failure, or it is necessary for takeoff or landing.

A chart located in the Pilot's Operating Handbook of the accident airplane titled *Maximum Glide* showed that following an engine failure, the altitude required to glide 3 miles is about 2,000 ft. No record of enforcement action was located during the investigation related to this regulatory deviation.



The POI assigned to the certificate at the time of the accident was located in the Portland Flight Standards District Office and was assigned to the certificate in January 2015. She had been employed with the FAA for about 7 years at the time of the accident.

She stated in an interview that, in addition to SeaPort Airlines, she was the POI for a Part 135 air ambulance company and a Part 135 operator considered high risk. The POI was also assigned oversight of a designated pilot examiner, and she was the only inspector in the office qualified for tailwheel and turbine operations. She stated there probably should have been assistant inspectors, but they did not have the resources in the Portland FSDO.

The POI added that, although legally operating in the Juneau area under VFR, the company did not respect the environmental challenges and proactively increase company weather minimums. She also questioned if there was enough oversight from company management of pilots new to flying in Alaska.

When asked if the company's minimum altitudes changed when flights were operated over water, the POI replied that SeaPort was operating at 500 ft with 2 miles visibility over a 3-mile-wide channel. She stated that 500 ft would not provide 3 miles of gliding distance. The POI added that, while conducting surveillance in the operations center for SeaPort in September 2015, she observed an airplane making 360° turns; she told the flight coordinator that they should call the pilot and tell him to turn back. The flight coordinator tried to call the flight back to JNU but was unable to make radio contact with the pilot. The airplane descended to 800 ft above the channel, and radio contact still could not be established. The POI called it a loss of operational control and a risk that needed to be mitigated. She thought a letter needed to be sent from the FAA to the company, but it was being held by the FAA Alaska Regional Deputy Division Manager. She stressed to an NTSB investigator that the findings needed to go to the company but that they were still going through the process.

Title 14 CFR 119.69, "Management Personnel Required for Operations Conducted Under Part 135," stated, in part, the following:

That anyone in a position to exercise control over operations conducted under the operating certificate must be qualified through training, experience, and expertise, and to the extent of their responsibilities, have a full understanding of the following material with respect to the certificate holder's operation; aviation safety standards and safe operating practices; 14 CFR Chapter I (Federal Aviation Regulations); the certificate holder's operations specifications; all appropriate maintenance and airworthiness requirements of this chapter (e.g., parts 1, 21, 23, 25, 43, 45, 47, 65, 91, and 135 of this chapter); and the manual required by Sec. 135.21 of this chapter; and discharge their duties to meet applicable legal requirements and to maintain safe operations.

When asked how the requirements for persons exercising operational control in accordance with 14 CFR 119.69 were met, the POI stated that they are trained but that she had never observed the training. As for prerequisites, she said there were none because they did not need to be pilots or certified dispatchers.

The previous POI for the company stated that Part 119 required operational control personnel to be knowledgeable in certain subjects. He said that the flight coordinators were trained and



that it was documented that they had certain training, but there was no approved training program.

### *Medallion Foundation*

According to the Medallion Foundation Shield Program website, the purpose of the Shield Program was to create and maintain a higher level of safety through the use of system safety and safety management system principles. An applicant needed to earn a "star" in each of the following categories to earn a shield:

- Controlled flight into terrain (CFIT) avoidance
- Operational control
- Maintenance and ground service
- Safety
- Internal evaluation

To earn a star, an applicant organization had to complete specific training classes, produce a required manual, and undergo an external audit to determine if the company had incorporated the information into its corporate culture. Following the initial audit, annual independent audits were to be conducted.

According to the Medallion website, the benefits of being a Shield carrier "include reduced insurance rates, cross promotional marketing of Shield carriers and recognition by DOD [Department of Defense], OGP [Oil and Gas Producers] and the FAA as an operator who incorporates higher standards of safety than required by regulations."

On March 25, 2016, the company provided a document to the NTSB dated March 23, 2009, titled "client access website for Medallion Foundation," which established a Shield Program award date of May 23, 2008, for SeaPort Airlines. The document indicated that SeaPort Airlines, doing business as Wings of Alaska Airlines, held the following stars: CFIT avoidance, operational control, safety, internal audit, and maintenance and ground service.

Documents and emails provided to the NTSB by SeaPort Airlines indicated that the company met with Medallion staff on April 21, 2015, in Juneau to discuss the status and necessary revisions to maintain a Medallion Shield. On May 6, 2015, SeaPort Airlines sent an e-mail to the Deputy Director of the Medallion Foundation that contained an attached letter outlining the changes to the Medallion program manuals and a timeline for audits and revisions. The letter of intent was dated May 5, 2015, and Seaport Airlines provided a draft copy to the NTSB.

On May 8, 2015, Deputy Director of the Medallion Foundation sent an e-mail to the President of SeaPort Airlines responding to the letter of intent. In the e-mail, the Deputy Director stated that, after discussions with the Executive Director, two options were available to SeaPort Airlines regarding the Medallion Shield.

The e-mail noted that the first option would be a voluntary suspension of Shield status by SeaPort Airlines. The e-mail stated that Wings of Alaska would be removed from the list of Shield Carriers on the Medallion Foundation website but Medallion would not remove the status of the stars. It further stated, "With this process of voluntary suspension, there will be no



official communication to the FAA, nor will we retain any records within the Medallion files kept on the participating members." The e-mail stated that the second option would be an involuntary suspension of Shield status by Medallion. In this case, Medallion Foundation would "have to go through a paperwork trail, including official notification made into Medallion files." The email did not explain the reason for the suspension.

Review of the documents provided by SeaPort Airlines indicated that SeaPort voluntarily suspended its Medallion shield on May 15, 2015. The documents also showed the company was allowed to maintain the status of its stars but was removed from the list of Medallion Shield Carriers.

On June 29, 2015, the Executive Director of Medallion sent a letter to the President of SeaPort Airlines expressing concern about how the Medallion Foundation was managing each operator's fulfillment of the CFIT avoidance program. The executive director requested a copy of SeaPort's CFIT avoidance program, pilot roster, and CFIT avoidance training records. SeaPort's July 10, 2015 (which was 7 days before the accident), response letter indicated that the accident pilot and three other pilots had not completed initial CFIT avoidance training but that eight other trainees had completed the training.

According to the CFIT avoidance training records that the company provided to Medallion, no minimum training time was required, and pilots were trained to proficiency. Of the 12 training records provided, all 12 of the trainees completed the training for flat light recognition, whiteout recognition, deteriorating visibility, and inadvertent IMC training in 1 hour. SeaPort Airlines also submitted a copy of its CFIT Avoidance Training Manual, which contained policies and procedures for the dispatch and conduct of flights. These policies and procedures were not contained in the FAA-accepted GOM or the FAA-approved training program. There is no regulatory requirement for compliance with the Medallion program manuals. (Refer to the Operations Group Chairman's Factual Report in the public docket for further information regarding Medallion Foundation.)

## ADDITIONAL INFORMATION

### *Integrated Display Unit Recorded Data*

The accident airplane was equipped with two Chelton integrated display units (IDU). The IDUs are identical part numbers and are configured to operate as primary flight displays (PFD) or multifunction displays (MFD). Using sensors, including a solid-state air data and attitude heading reference system and ADS-B technology, the PFD displayed aircraft parameter data including altitude, airspeed, attitude, vertical speed, and heading. The MFD displayed navigational information on a moving map, and glide distance was indicated by a ring around the airplane that changed size and shape based on aircraft altitude and wind.

The IDUs recorded valid data for the entire accident flight. The IDU flight route was consistent with the initial ADS-B data. However, the data showed the airplane altitude slightly higher than the ADS-B data with the airplane crossing Admiralty Island about 1,100 ft msl and then beginning a constant descent from about the western shore of the island until about 30 seconds before impact when an abrupt climb was initiated. The airplane continued in a westerly direction before making a series of erratic pitch-and-roll maneuvers. The highest altitude



reached during the accident flight was 1,220 ft msl, which occurred just before impact. The last data point was recorded at 1318:10.

### *Terrain Awareness and Warning System*

The FlightLogic electronic flight instrument system (EFIS) IDUs includes a terrain awareness and warning system (TAWS) that provided color-coded warnings of terrain on the MFD and, when enabled, aural alerts. The IDU provided Technical Standard Order-C151b TAWS functionality. As part of the TAWS, the PFD was capable of providing a profile view of terrain ahead of the aircraft ("synthetic vision"). The system features integrated Class C TAWS or, depending upon aircraft configuration settings and external sensors/switches, the system is configurable as a Class A, B or C TAWS or a Class A or B Helicopter TAWS.

The Class C TAWS provides the following functions:

1. Terrain display: Displays terrain and obstacles on the PFD and MFD.
2. Forward looking terrain awareness: A warning function that uses a terrain and obstruction database to alert the pilot to hazardous terrain or obstructions in front of the aircraft.
3. Premature descent alert: A warning function that alerts the pilot when the aircraft descends well below a normal approach glidepath on the final approach segment of an instrument approach procedure.
4. Excessive descent rate alert (ground proximity warning system [GPWS] Mode 1): A warning function that alerts the pilot when the rate of descent is hazardously high compared to height above terrain (for example, when descending into terrain).
5. Sink rate after takeoff or missed approach alert (GPWS Mode 3): A warning function that alerts the pilot when a sink rate is detected immediately after takeoff or initiation of a missed approach.

The Chelton system included a TAWS inhibit switch that could be used to manually inhibit TAWS alerting functions. The switch was of the latching type and gave an obvious indication of actuation (that is, a toggle switch). The TAWS inhibit switch was connected directly to the EFIS IDU. Data recovered from the accident airplane's IDU showed that the TAWS alerting function was set to the "inhibit" position at the time of impact. The toggle switch was found in the "inhibit" position in the wreckage, and a digital image from a passenger's personal electronic device showed that the switch was in the inhibit position during the flight.

## **History of Flight**

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Enroute-cruise

Controlled flight into terr/obj (CFIT) (Defining event)

## Pilot Information

Certificate:	Flight Instructor; Commercial	Age:	45, Female
Airplane Rating(s):	Multi-engine Land; Single-engine Land	Seat Occupied:	Left
Other Aircraft Rating(s):	None	Restraint Used:	3-point
Instrument Rating(s):	Airplane	Second Pilot Present:	No
Instructor Rating(s):	Airplane Multi-engine; Airplane Single-engine; Instrument Airplane	Toxicology Performed:	Yes
Medical Certification:	Class 1 With Waivers/Limitations	Last FAA Medical Exam:	04/09/2015
Occupational Pilot:	Yes	Last Flight Review or Equivalent:	06/12/2015
Flight Time:	845 hours (Total, all aircraft), 48 hours (Total, this make and model), 158 hours (Last 90 days, all aircraft), 4 hours (Last 24 hours, all aircraft)		

## Aircraft and Owner/Operator Information

Aircraft Manufacturer:	CESSNA	Registration:	N62AK
Model/Series:	207A	Aircraft Category:	Airplane
Year of Manufacture:		Amateur Built:	No
Airworthiness Certificate:	Normal	Serial Number:	20700780
Landing Gear Type:	Tricycle	Seats:	6
Date/Type of Last Inspection:	07/16/2015, AAIP	Certified Max Gross Wt.:	3803 lbs
Time Since Last Inspection:	1 Hours	Engines:	1 Reciprocating
Airframe Total Time:	26613 Hours as of last inspection	Engine Manufacturer:	CONT MOTOR
ELT:	C126 installed, activated, aided in locating accident	Engine Model/Series:	IO-520-F
Registered Owner:	WINGS AIRLINE SERVICES INC	Rated Power:	285 hp
Operator:	Sea Port Airlines, Inc	Operating Certificate(s) Held:	Commuter Air Carrier (135)
Operator Does Business As:	Wings of Alaska	Operator Designator Code:	AJAA



## Meteorological Information and Flight Plan

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Conditions at Accident Site:	Visual Conditions	Condition of Light:	Day
Observation Facility, Elevation:	PAJN, 16 ft msl	Observation Time:	1253 AKD
Distance from Accident Site:	20 Nautical Miles	Direction from Accident Site:	86°
Lowest Cloud Condition:	Few / 200 ft agl	Temperature/Dew Point:	14°C / 13°C
Lowest Ceiling:	Overcast / 3500 ft agl	Visibility	7 Miles
Wind Speed/Gusts, Direction:	14 knots, 110°	Visibility (RVR):	
Altimeter Setting:	30.24 inches Hg	Visibility (RVV):	
Precipitation and Obscuration:	Light - Rain		
Departure Point:	JUNEAU, AK (JNU)	Type of Flight Plan Filed:	Company VFR
Destination:	HOONAH, AK (HHH)	Type of Clearance:	None
Departure Time:	1308 AKD	Type of Airspace:	Class G

## Wreckage and Impact Information

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Crew Injuries:	1 Fatal	Aircraft Damage:	Substantial
Passenger Injuries:	4 Serious	Aircraft Fire:	None
Ground Injuries:	N/A	Aircraft Explosion:	None
Total Injuries:	1 Fatal, 4 Serious	Latitude, Longitude:	58.335278, -135.066944 (est)

## Administrative Information

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Investigator In Charge (IIC):	David S Williams	Adopted Date:	04/19/2017
Additional Participating Persons:	David Keenan; Federal Aviation Administration, AVP-100; Washington, DC Andrew Hall; Textron Aviation; Wichita, KS Nicole Channon; Continental Motors; Mobile, AL Peter Baker; Sea Port Airlines; Portland, OR		
Publish Date:	04/19/2017		
Note:	The NTSB traveled to the scene of this accident.		
Investigation Docket:	<a href="http://dms.nts.gov/pubdms/search/dockList.cfm?mKey=91583">http://dms.nts.gov/pubdms/search/dockList.cfm?mKey=91583</a>		



## **Attachment 2**

*Alaska Dispatch News* Article. “NTSB Alaska welcomes new investigators”

FAA Petition for Reconsideration to NTSB  
for  
NTSB case no. ANC15FA049



# NTSB Alaska welcomes new investigators

Author: **Colleen Mondor**

Published **December 29, 2014**

After a competitive search involving more than 150 candidates, the National Transportation Safety Board -- the federal agency tasked with investigating major accidents in the U.S. -- has hired two new investigators for the Alaska Aviation Safety Office. Shaun Williams and Millicent Hoidal have diverse aviation experience and bring the Alaska staffing back to full-strength for the first time in almost three years. Williams was formerly with the Federal Aviation Administration in Alaska, where he was responsible for the initial certification of commuter carriers, which includes charter and air taxi operators. Prior to that, he was a captain for Air Wisconsin where he gained many hours operating in cold weather environments. Williams graduated from the University of North Dakota and is an airline-transport certified pilot. He also holds a flight instructor certificate.

The move from the FAA to NTSB will allow Williams to explore different facets of the aviation environment and, as he said in a recent interview, "get more into the why and how" of aviation accidents. He's keen to promote safety in different ways to Alaska pilots.

"As an example," he said, "during hunting season Alaska often suffers a number of accidents. We would like to get information out to pilots on the common causes of those crashes and how to mitigate them."

Hoidal has been with the NTSB since working as an intern in Washington, D.C. and the Southwest office in Texas. Most recently she worked as a duty officer with the agency's Response Operations Center. She has degrees from Louisiana Tech University and Texas State University and is working toward a graduate degree in commercial aviation. Hoidal also is a certified commercial pilot and flight instructor. She is the first female aircraft accident investigator assigned to Alaska.

Even as a newcomer to the Anchorage area, Hoidal is keenly aware of the state's unique relationship with aviation.

"Aviation permeates every level of the community and people's lives," she said. "Everyone has airplanes here and the wide range of environments they fly in are so different, from the Interior to Southeast and everywhere else. There is a great adventure opportunity to work in this office and so much to learn; the aviation community is much different from the rest of the country and presents a chance to learn both from the other investigators here and the places I will go on the job," she said.



According to Alaska Region Chief Clint Johnson, there were many "wonderful candidates" for the Alaska openings.

"As chief, adding Shaun and Millicent to our office brings a wealth of valuable operational experience, and I feel very blessed with the team we've assembled," he said. "The NTSB's trademark is to carry out and deliver thorough, in-depth accident investigations, and the addition of these new investigators to the Alaska office will help us to deliver on that pledge. Simply put, I feel we owe it to the flying public here in Alaska."

Both Williams and Hoidal will continue NTSB accident investigation training for the next year. They will also have to attend the NTSB's training academy in Washington, D.C., and are now working alongside Alaska's two "journeymen" investigators, Chris Shaver and Brice Banning, as well as other investigators assigned to the Western Pacific region.

Alaska's NTSB investigators handle an average of 100 aviation accidents a year and also travel to assist on investigations Outside when needed.



## **Attachment 3**

Excerpts from Attachment 1 to the NTSB Operations Factual Report – Interview Summaries of FAA Inspectors

FAA Petition for Reconsideration to NTSB  
for  
NTSB case no. ANC15FA049

SeaPort Airlines  
Juneau, AK  
July 17, 2015  
ANC15FA049

**NATIONAL TRANSPORTATION SAFETY BOARD  
WASHINGTON, D.C.**

ATTACHMENT 1

Interview Summaries

38 Pages



**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 Bartauskyy, 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. Bartauskyy 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. Bartauskyy 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. Bartauskyy 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 (Bartauskyy) 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. Bartauskyy 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. Bartausky 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.