Aviation Safety

Federal Aviation Administration

Petition for Reconsideration

to the

National Transportation Safety Board

NTSB Accident no. ANC15FA049

SeaPort Airlines *dba Wings of Alaska* Flight 202
Cessna 207; N62AK
Juneau, Alaska; July 17, 2015

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1.0 Introduction

Pursuant to 49 Code of Federal Regulations (CFR) § 845.32, the Federal Aviation Administration (FAA) petitions the National Transportation Safety Board (NTSB) to reconsider and modify its findings and determination of probable cause for NTSB accident no. ANC15FA049 involving a fatal airplane accident near Juneau, Alaska. The accident occurred on July 17, 2015, when a Cessna 207A, operating as flight 202 by SeaPort Airlines, Inc., doing business as (dba) *Wings of Alaska,* collided with mountainous terrain.

The NTSB's final report[1] determined that a contributing factor to the probable cause of this 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."* The FAA requests that this factor be removed from the probable cause statement, along with the verbiage in the final two paragraphs of the analysis section of the report associated with this factor.

As discussed in this petition, the FAA asserts the NTSB report misconstrues statements made by two FAA inspectors and erroneously finds that the FAA was aware of regulatory deficiencies prior to the accident yet did nothing to prompt the company to correct those deficiencies. This analysis is based solely on incomplete, erroneous, and misleading excerpts from NTSB's written summaries of two FAA inspectors.

49 CFR § 845.32(a)(3) states, in part: *"Petitions must be based on the discovery of new evidence or on a showing that the Board's findings are erroneous."* The regulation also states that petitions based on new evidence must identify such evidence, and petitions based on a claim of erroneous findings shall set forth in detail the grounds relied upon. The FAA asserts this petition is based on both the presentation of new evidence *and* erroneous findings.

2.0 Background of Accident and Investigation

On July 17, 2015, about 1318 Alaska daylight time, a Cessna 207A airplane, N62AK, collided in flight with tree-covered terrain about 18 miles west of Juneau, Alaska. The commercial pilot sustained fatal injuries and all four passengers sustained serious injuries. The flight was being

[1] See Attachment 1, NTSB Aviation Accident Final Report, Accident no. ANC15FA049. This report is posted on the NTSB web site here: https://app.ntsb.gov/pdfgenerator/ReportGeneratorFile.ashx?EventID=20150718X04523&AKey=1&RType=HTML&IType=FA.
The public docket of supporting materials can be found on the NTSB's web site for docket materials at this link: https://dms.ntsb.gov/pubdms/search/hitlist.cfm?docketID=58281&CFID=1423462&CFTOKEN=bef8ff5eba4fe709-11274E42-B31C-312D-A3693ADFBBC2CA44

operated as flight 202 by SeaPort Airlines, Inc., dba *Wings of Alaska*[2] as a 14 CFR Part 135 visual flight rules (VFR) scheduled commuter flight. Visual meteorological conditions (VMC) 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 International Airport about 1308 for a scheduled 20-minute flight to Hoonah, Alaska.

The investigation of this fatal scheduled air carrier accident was conducted as a general aviation (GA) field investigation by staff from the NTSB's Alaska Regional Office in Anchorage, Alaska. The NTSB investigator-in-charge (IIC) was assisted by an investigator trainee, Shaun Williams, who had been hired into the NTSB Alaska Regional Office a few months prior to the accident.[3] The trainee was assigned as the Operations Group Chairman responsible for conducting formal interviews of the then-current and previous FAA principal operations inspectors (POIs) of SeaPort Airlines. The Operations Group Chairman (trainee) was then given the additional assignment as the NTSB IIC after the original journeyman IIC resigned from the NTSB later during the investigation to pursue a career as a pilot.

The then-current POI and previous POI for SeaPort Airlines were separately interviewed by the NTSB Operations Group Chairman trainee about *three months after* the accident.[4] In accordance with agency policy, the FAA's Accident Investigation Division (AVP-100) dispatched a senior aviation accident investigator from Washington DC to participate in the interviews as a party member of the NTSB Operations Group. However, as explained later in this petition, the FAA investigator was not provided draft summaries of the interviews by the NTSB for review until 18 months later when the summaries had already been incorporated into the final drafts of both the Operations Group Chairman's Factual Report and the overall NTSB Final Accident Report. Excerpts from each of the NTSB's written summaries of these two interviews[5] represent the only evidence relied upon to support the contributing factor attributed to the FAA.

3.0 Current Probable Cause Statement

On April 19, 2017, the Board adopted the SeaPort Airlines accident report -- via its delegated authority[6] -- and then released the report to the public on the NTSB's website five days later on April 24, 2017.[7] The entire probable cause statement is cited below, with the contributing factor underscored to highlight the sentence that the FAA requests to be deleted:

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[2] *Wings of Alaska* and SeaPort Airlines no longer exist.

[3] See Attachment 2, *Alaska Dispatch News.* "NTSB Alaska welcomes new investigators" by Colleen Mondor. December 29, 2014.

[4] See Attachment 3, Excerpts of Attachment 1 to the NTSB Operations Group Chairman's Factual Report – Interview Summaries. These excerpts include the summaries of interviews of the then-current and previous POI.

[5] See Attachment 3, Excerpts of Attachment 1 to the NTSB Operations Group Chairman's Factual Report – Interview Summaries. These excerpts include the summaries of interviews of the then-current and previous POI.

[6] The SeaPort Airlines accident report and probable cause were reviewed and adopted by the NTSB's Director of the Office of Aviation Safety under the Safety Board's delegated authority. *See* 49 CFR § 800.25(c).

[7] Page 20 of the NTSB Aviation Accident Final Report (see Attachment 1 of this petition) indicates that the "publish date" was April 19, 2017. However, the report was not made public until five days later on April 24, 2017. As discussed later in this petition, the SeaPort Airlines report was cited in another NTSB report of an Alaska aviation accident involving Promech Air that was presented in a formal Board Meeting the following day on April 25, 2017.

The National Transportation Safety Board determines that 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.

4.0 Overview of the Petition

The FAA has reviewed all evidence presented and contends that portions of the report narratives for the NTSB's factual, analysis, and probable cause are erroneous and should be modified accordingly. Specifically, the FAA petitions the Board to revise the report by deleting the final sentence of the probable cause/factor statement and the verbiage in the final two paragraphs of the analysis narrative associated with it. The FAA asserts that the contributing factor is based on an erroneous analysis that the FAA was aware of "known regulatory deficiencies" prior to the accident yet took no action. The following provides details to demonstrate why the FAA believes the Board's findings are erroneous, and to present new evidence that supports FAA's assertions.

5.0 NTSB Analysis Narrative Relied Upon to Support Contributing Factor

The final two paragraphs of the "Analysis" section on pages 2 and 3 of the NTSB Aviation Accident Final Report[8] present the justification for the contributing factor regarding the FAA's "failure." The FAA petitions the NTSB to delete this verbiage from the final report. These paragraphs are presented verbatim as follows:

> 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.

[8] See Attachment 1, NTSB Aviation Accident Final Report, Accident no. ANC15FA049, pages 2-3.

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."

6.0 Factual Information Relied Upon to Support NTSB's Analysis

The FAA conducted a review of the factual sections of the accident report and the entire NTSB public docket to determine what facts were available to support the final two paragraphs of the analysis. The review revealed three sources of information: (1) Interview summary of the then "current POI," Ms. Dee Rice; (2) Interview summary of the "previous POI," Mr. Ty Bartausky; and (3) excerpts of the Cessna 207A Pilot Operating Handbook regarding over water operation. Each of these sources is contained in the attachments to this petition, and cited verbatim below:

6.1 Interview Summary Excerpts of Inspector Dee Rice (Current POI)

Source: NTSB Operations Group Chairman's Factual Report - Attachment 1[9]

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?"

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….

[9] See Attachment 3 of this petition, Excerpts of Attachment 1 to the NTSB Operations Group Chairman's Factual Report – Interview Summaries, for the entire NTSB interview summary of Inspector Rice.

… 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 [sic] 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 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.

6.2 Interview Summary Excerpts of Frontline Manager Ty Bartauksy (Previous POI)

Source: NTSB Operations Group Chairman's Factual Report - Attachment 1[10]

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….

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.

[10] See Attachment 3, Excerpts of Attachment 1 to the NTSB Operations Group Chairman's Factual Report – Interview Summaries, for the entire NTSB interview summary of Inspector Bartausky.

6.3 Information from the Cessna 207A Pilot Operating Handbook

Source: NTSB Final Report[11] – Factual Narrative - page 14

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.

No other factual information — such as correspondence between FAA and SeaPort, FAA surveillance records, or follow-up interviews — can be found in the NTSB report and/or docket to support the references to FAA oversight in the analysis narrative or probable cause statement.[12]

7.0 FAA Review of NTSB Analysis Statements

The FAA reviewed each statement of the final two paragraphs of the analysis section of the NTSB Final Aviation Accident Report and presents the following explanations as to why each statement is erroneous while also providing new evidence in support of the FAA's assertions:

NTSB Analysis Statement no. 1:

"In postaccident interviews, the previous Federal Aviation Administration (FAA) principal operations inspector (POI), who became the frontline manager over the certificate, 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."

Analysis Statement 1 was used by the NTSB to support the conclusion that the FAA contributed to the cause of the accident. That conclusion rests on the assumption the previous POI was aware — *prior* to the accident — that SeaPort Airlines was not following its operating requirements for glide distance. That assumption, however, is inaccurate. The previous POI, Mr. Ty Bartausky, did not infer or state during the interview that he was aware of, or condoned, any pilot flying at the minimum altitude of 500 feet above the surface if the aircraft was beyond the glide distance required under 14 CFR § 135.183. Upon reading the interview summary after its public release,

[11] See Attachment 1 of this petition, NTSB Aviation Accident Final Report, Accident no. ANC15FA049, p. 14.

[12] The SeaPort Airlines accident that is the focus of this petition is similar to another Part 135 fatal Alaska aviation accident involving Promech Air, which occurred about 3 weeks before the SeaPort accident. Both accidents involved controlled flight into terrain (CFIT) during daytime VFR operations. In the Promech Air final report, despite citing concerns with FAA surveillance with supporting documents, references, and narratives entered into the public docket of factual evidence, the Board *did not* conclude the FAA was culpable in any aspect of the accident.

Inspector Bartausky did not concur with all that the NTSB had written. In a sworn declaration[13] supporting this petition, he stated that he "had no information or evidence that pilots of SeaPort Airlines were conducting flights at lower altitudes in reduced ceilings and visibility contrary to the Federal Aviation Regulations," and that he did not "recall ever having any suspicions of such non-compliant conduct by SeaPort Airlines prior to the accident." He also stated that his comments regarding SeaPort were "based on what I had learned about the accident flight" and that the NTSB "did not publish a fair or accurate summary of what I told them during the interview."

The NTSB Report also mischaracterized the previous POI's statement by misstating the regulatory requirements. The "*500 ft and 2 miles visibility*" is not "*a cloud ceiling*" and is not related to the "*power-off glide*" rule for over water operations — these are three separate sections found in Part 135 and the pilot is required to comply with each section. *See* 14 CFR § 135.203 (minimum altitude is 500 feet above the surface), § 135.205 (flight visibility is at least two miles), and § 135.183 (altitude that allows airplane to reach land in the case of engine failure). A fourth FAR is also applicable: 14 CFR § 91.155 (clear of clouds in class G airspace, the least restrictive requirement).

NTSB Analysis Statement no. 2:

"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 FAA agrees that Inspector Bartausky stated that pilots should not decide when to fly, and that he personally believed established route altitudes would be a benefit. However, the next sentence with the phrase "*no action was taken…"* implies that he was aware that SeaPort was not following its operational control procedures prior to the accident. Again, that is an erroneous conclusion based on an inaccurate assumption. In his declaration, Inspector Bartausky stated that he "did not believe there was information or evidence that any pilot of SeaPort was violating the FARs or failing to follow the General Operations Manual."[14] This is significant because the NTSB report and/or docket contain no additional information to corroborate what the NTSB provided in its interview summary regarding any known deficiencies.[15]

NTSB Analysis Statement no. 3:

"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."

As with the interview summary of the previous POI, the NTSB Report misconstrues the statements of the then-current POI, Inspector Dee Rice. The NTSB interview summary states: *"Ms. Rice said*

[13] See Attachment 4, Declaration of FAA Inspector Ty Bartausky.

[14] See Attachment 4, Declaration of FAA Inspector Ty Bartausky.

[15] The FAA notes the NTSB's docket for this investigation does not contain the numerous surveillance records demonstrating frequent and appropriate surveillance of SeaPort Airlines prior to the accident. Before the accident, between November 2014 and June 2015, the FAA conducted 30 "R" item inspections, sent letters, initiated enforcement investigations, and held several meetings with SeaPort Airlines. A comprehensive timeline of these surveillance activities is summarized on page 10 of this petition, along with the dates of the investigative activities conducted by NTSB. This timeline, and the supporting documents for each entry (see Attachment 6 of this petition), show no evidence was discovered by FAA to warrant an enforcement investigation or extra surveillance of SeaPort Airline's operations in Alaska. The FAA considers these records as new evidence for the Board's review.

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." The NTSB analysis statement takes this one interview summary excerpt and, again, draws an inaccurate, unsupported assumption that Inspector Rice was aware —*prior* to the accident — that Seaport was in violation of FAA rules.

Inspector Rice did not state she was aware of any instance *prior* to the accident that SeaPort Airlines was operating contrary to the gliding distance rule. Instead, she was reflecting on what she believed likely occurred *during* the accident flight — a reflection that occurred three months after the accident when the NTSB interviewed her. In her sworn declaration[16] supporting this petition, Inspector Rice stated:

> "… I had no personal knowledge of any violation … by SeaPort Airlines or its pilots involving 14 C.F.R. § 135.183 (operation at an altitude that allows an airplane to reach land in the case of an engine failure). Also, I had not received any reports of FAR violations by SeaPort Airlines or its pilots involving 14 C.F.R. § 135.183. Information gathered following the accident of SeaPort Airlines flight 202 was the first indication of a possible violation by the accident pilot; there was no evidence of a FAR violation by SeaPort Airlines itself."

She also stated: "To be clear, the NTSB final report and related documents do not contain a fair or accurate summary of what I told the NTSB investigators during the interview."

NTSB Analysis Statement no. 4:

> *"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."*

This statement is apparently drawn from the NTSB's interview summary of Inspector Rice.[17] Specifically, the NTSB interview summary states, in part:

> She stated that the last time she performed an inspection on the operational control at SeaPort was September 16, 2015. … She 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 Deek [sic] 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."

While it is correct that Inspector Rice did conduct surveillance "following the accident" and discovered a potential deficiency with SeaPort's operational procedures, the NTSB's analysis statement claims that the FAA did nothing to attempt to address this alleged deficiency. This is inaccurate.

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[16] See Attachment 5, Declaration of FAA Inspector Dee Rice.
[17] See Attachment 3 of this petition, Excerpts of Attachment 1 to the NTSB Operations Group Chairman's Report.

Specifically, Inspector Rice had drafted a letter citing the operational control issue she observed on September 16, 2015, and that letter was sent to Inspector Bartausky.[18] Inspector Bartausky told the NTSB that he had the letter "for review" and that "he wanted to see what SeaPort would do to change before sending it." While the report provides no indication that the NTSB investigators followed up with the FAA to determine what eventually was changed with SeaPort following the event, or what actions Mr. Bartausky took following his review of Inspector Rice's concerns, the NTSB erroneously concluded that no action was taken. In reality, a letter of surveillance findings was sent by Inspector Bartausky to SeaPort Airlines on October 9, 2015, conveying many of Inspector Rice's concerns. This letter and other associated correspondence -- which the FAA is attaching[19] as new evidence for this petition -- addressed SeaPort Airlines' deficiencies with operational control issues, flight risk assessment completion, and minimum safe operating altitudes.

In his attached written declaration (See Attachment 4), Inspector Bartausky stated that findings "were not ignored," and that "there was insufficient evidence to demonstrate a non-compliance with the regulations, and the FSDO continued to monitor SeaPort's risk mitigation. Shortly thereafter, on October 12, 2015, SeaPort Airlines notified FAA of its intention to cease operations in Alaska effective October 16, 2015." His statement is corroborated with an email that the FAA is providing as part of the supporting documentation of the timeline mentioned above.[20] The email was received by the FAA from the airline on October 12, 2015, and it conveyed their intent to cease Alaska operations at the end of the business day October 16, 2015. Thus, approximately 30 days after Inspector Rice observed an event that was documented and brought to the attention of the airline, the airline stopped operating in Alaska.

NTSB Analysis Statement no. 5:

> *"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."*

As explained above, this statement is inaccurate and unsupported by the facts. Additionally, there is no logical connection between the violation of an open water glide-distance rule and a CFIT accident (because the pilot failed to remain in VMC). Evidence of any disregard for regulations by SeaPort Airlines was not "*apparent"* or known to FAA prior to the accident despite the agency's frequent and appropriate surveillance. The only evidence supporting this statement in the NTSB's report are the previously cited misinterpretations of interview summaries. Moreover, the use of words *"if"* and *"plausible"* to justify the FAA as a contributory factor in a fatal air carrier accident necessitates unwarranted speculation.

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[18] The NTSB also erred in its interview summary of Inspector Rice by stating a letter was "being held by Deek [sic] Abbott, FAA Alaska Regional Deputy Division Manager." At no time did Deke Abbott ever receive a letter from Inspector Rice (See Attachment 7). The SeaPort Airlines operating certificate was controlled by the FAA's Northwest Mountain; therefore, as the acting Alaska Regional Deputy Division Manager (Deke Abbott) would not have been involved. The fact is that Inspector Rice drafted the letter for her frontline manager, Inspector Bartausky.

[19] See Attachment 7 of this petition, FAA Emails and Correspondence regarding Post-Accident FAA Actions.

[20] See Attachment 7 of this petition, FAA Emails and Correspondence regarding Post-Accident FAA Actions.

NTSB Analysis Statement no. 6:

"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."

As previously stated, with support from inspector declarations and FAA surveillance records attached to this petition, no "deficiencies" were known to the FAA prior to the accident for the FAA to correct. Therefore, this NTSB analysis statement is erroneous.

8.0 Timeline of FAA Surveillance Actions and NTSB Investigation Events

The following provides a timeline summary of FAA surveillance activities prior to and following the SeaPort accident.[21] NTSB activities are depicted in blue italics for context.

January 2015 — POI Ty Bartausky is promoted to Operations Front Line Manager (FLM); Dee Rice is assigned as the new POI for SeaPort Airlines
Jan. 21, 2015 — FAA Meeting held with SeaPort Airlines Management and Principal Inspectors
Feb. 6, 2015 — Letter of Correction for Part 119.5 violation of Operations Specifications (Operations into non-approved airport)
Mar. 9, 2015 — Letter of Correction sent to address violation of pilot flight/duty times
Mar. 23, 2015 — Enforcement Investigation Report (EIR) closed - no action
Apr. 7, 2015 — EIR closed with civil penalty; One EIR closed with proposed civil penalty
Apr. 22, 2015 — Seaport's flight following and dispatch moved from Juneau to Portland FSDO
May 8, 2015 — Letter of surveillance findings and maintenance concerns sent to company
May 15, 2015 — Complaint filed by FAA: Company using ASAP program for discipline
June 10, 2015 — FAA Meeting held with Management and Principal Inspectors to discuss SeaPort
June 24, 2015 — 30 individual "R" item inspections conducted on SeaPort in Alaska by this date: Two findings noted concerning flight following and dispatch move to Portland
July 17, 2015 — Accident of Flight #202 in Juneau, Alaska – NTSB Investigation Initiated
July 20, 2015 — NTSB interview of David Williams of SeaPort Airlines
July 24, 2015 — FAA sends accident follow-up letter to SeaPort, asking for Risk Mitigation actions.
July 24, 2015 — FAA sends certified letter requesting meeting w/SeaPort President & Part 119 Mgmt.
July 29, 2015 — FAA Meeting held with SeaPort Airlines Management and Principal Inspectors to discuss risk mitigation strategy for improved control of VFR flight release, safety culture, experience gap of new pilots, increased surveillance plans.
July 29, 2015 — NTSB interview of President/CEO of SeaPort Airlines
July 30, 2015 — FAA sends letter to SeaPort regarding risk assessment and flight locating procedures
Aug. 6, 2015 — NTSB interview of SeaPort Dispatcher
Aug. 10, 2015 — FAA enroute flight inspection of Wings flight (Deke Abbott) -- no findings noted
Aug. 10, 2015 — Six individual "R" item inspections conducted on SeaPort in Alaska between July 20 and August 10. All closed satisfactory.
Aug.11, 2015 — NTSB interview of accident pilot's roommate and a SeaPort pilot
Aug.11, 2015 — FAA Letter of Surveillance to SeaPort regarding TAWS issues and cargo security
Aug.11, 2015 — FAA certified letter sent in response to August surveillance on SeaPort certificate.

[21] Detailed records to support each FAA entry are provided in Attachments 6 and 7 of this petition.

Aug.12, 2015 — NTSB interviews of accident pilot's sister, and a SeaPort Airlines dispatcher.
Aug.12, 2015 — Meeting with FAA Regional Flight Standards leadership and SeaPort Airlines' Director of Operations (DO) and Director of Maintenance (DM) regarding the training program and operational control
Aug.18, 2015 — Email from Alaska Flight Standards Deputy Division Manager to SeaPort Airlines POI discussing safety enhancements and feedback from the Juneau visit
Aug.21, 2015 — Results of Juneau FSDO Managers meeting with SeaPort Airline's DO and DM communicated to FAA Certificate Management Team (CMT)
Aug.24, 2015 — Contact with SeaPort Airlines to schedule meeting for plan to enhance safety.
Aug.24, 2015 — Completed complaint investigation re: allegations of "unsafe culture" and lack of operational control at SeaPort. Investigation could not confirm allegations
Sep. 16, 2015 — FAA POI and PAI conduct surveillance at SeaPort's operational control center in Portland; Issues found, i.e. loss of operational control of overwater operations at low altitude
Sep. 18, 2015 — FAA investigates a Pilot Deviation by a SeaPort Airlines pilot at Juneau Airport
Sep. 28, 2015 — Formal Risk Mitigation plan received from SeaPort Airlines (in response to accident)
Oct. 7, 2015 — NTSB interviews of FAA POI Dee Rice and FAA Manager Ty Bartausky
Oct. 8, 2015 — NTSB interviews of SeaPort Airline's DO, SOC Director, Dispatcher, and CP
Oct. 9, 2015 — FAA Letter of surveillance findings sent to SeaPort re: Operational Control issues, Flight Risk Assessment completion, and minimum safe operating altitudes
Oct. 12, 2015 — FAA notified via email of SeaPort Airline's intent to cease Alaska operations at the end of the business day on Oct. 16, 2015
Nov. 4, 2015 — NTSB interview of SeaPort Airlines Director of Safety/Security
Dec. 30, 2015 — FAA POI actions for Operational Control Onboard Operations closed with no findings.

9.0 NTSB Investigative Protocols Not Followed

As the Safety Board evaluates this petition, the FAA expects it to question why the FAA, as a party to the investigation, did not raise concerns regarding the NTSB's misperceptions of the FAA's oversight of SeaPort Airlines. The reasons can be found in the NTSB investigators' failure to facilitate adequate and appropriate communications with the parties to the investigation, and their failure to follow standard protocols for the draft report review process by the parties. These failures resulted in the FAA not having been provided a reasonable opportunity to contribute to the investigation. Specific examples of these process deficiencies include the following:

- The NTSB Operations Group Chairman trainee (Shaun Williams) did not provide timely draft interview summaries of the two FAA inspectors to the FAA member of the group for review and input, which does not comply with NTSB practices. This did not allow FAA a reasonable and timely opportunity to review the draft summary and provide corrections or clarifications.

- The draft factual section for the overall Accident Final Report was sent to FAA and the other parties to the investigation *prior* to the completion and review of the draft NTSB Operations Group Chairman's Report. The draft was conveyed via email by the NTSB IIC trainee (Shaun Williams) who urged the parties to review and comment within a short timeframe due to upcoming Promech Air Board Meeting.[22]

[22] See Attachment 8: Emails from NTSB regarding Report Production.

- The NTSB did not hold a "technical review" with the FAA and other parties to the investigation for this fatal scheduled air carrier accident, as per NTSB protocol, to discuss all factual evidence gathered in the investigation. Instead, the investigator trainee emailed draft documents and reports out piecemeal about 18 *months after the accident* to solicit inputs via email reply.[23]

- NTSB staff investigators and managers never conveyed to FAA's investigators and managers that FAA oversight was a concern or focus of the investigation. This is not consistent with the intent of the Safety Board's party process in which information sharing and discussion within the investigation is a time-honored hallmark to ensure the solicitation and review of all perspectives. News media inquiries prompted by the public release of the analysis and probable cause were the first indications to FAA that NTSB had concerns regarding any perceived FAA deficiencies.

The following timeline provides a summary of the NTSB actions cited above:

Mar. 21, 2017 — NTSB IIC trainee sends email to FAA and all party representatives asking if anyone had a chance to review the draft Accident Final Report, and if so, could the parties resend any comments.

Mar. 22, 2017 — FAA & other parties respond that the draft report had never been sent

Mar. 22, 2017 — NTSB IIC trainee transmits the draft NTSB Final Report to FAA and other parties, and requests any comments by March 30, 2017.

Mar. 27, 2017 — NTSB IIC trainee emails the draft Operations Group Chairman's Report, and interview summary attachments, to the FAA and other parties, requesting comments by April 4, 2017.

Apr. 5, 2017 — AVP-100 Director and FAA Ops Group member meet with NTSB IIC trainee, NTSB Alaska Chief, and NTSB Deputy Director at NTSB Headquarters regarding Medallion Foundation verbiage in draft Final Report; The FAA reps not told that FAA oversight is an issue of concern.

Apr. 19, 2017 — Probable Cause of SeaPort accident adopted; FAA not told that FAA oversight is cited as a contributing factor.

Apr. 24, 2017 — Probable Cause of the SeaPort accident released to public. The FAA is notified of it via media calls regarding the FAA contributing factor.

Apr. 25, 2017 — NTSB holds its public Board Meeting in Washington DC regarding the Promech Air accident that occurred in Ketchikan, Alaska. The SeaPort Airlines accident is referenced by NTSB in the Promech Air report.

The FAA recognizes that the NTSB staff was challenged by the resignation of the original IIC during the SeaPort Airlines investigation, the need to assign an investigator trainee to the investigation, and the urgency to quickly issue the report prior to the Promech Air Board Meeting so that the SeaPort Airlines accident could be cited. Nonetheless, these challenges cannot justify issuing an inaccurate and unsupported report unfairly misrepresenting the work of dedicated FAA aviation safety inspectors.

[23] See Attachment 8: FAA-NTSB Emails regarding NTSB Accident Report Production and Publication.

10.0 Conclusion

As explained in this petition, the NTSB has relied on inaccurate assumptions to reach the erroneous conclusion that the FAA was a contributing factor to the accident. Contrary to the report's findings, prior to the accident, the FAA had no indication that SeaPort Airlines was operating outside applicable regulatory requirements. While the FAA Certificate Management Team tasked with oversight of SeaPort Airlines conducted frequent and effective oversight, the results of the surveillance, prior to the accident, did not reveal issues warranting an investigation or extra surveillance.

The NTSB has relied too heavily on its inadequate interview summaries of two FAA inspectors. These summaries contain information that is unclear and presented in a confused time-context. Declarations by those inspectors, and other evidence submitted in support of this petition, indicate no knowledge by anyone at FAA — prior to the accident — that SeaPort Airlines pilots failed to comply with power-off glide distance requirements of 14 CFR § 135.183.

Therefore, the FAA requests that the final contributing factor citing FAA's "… failure to hold the company accountable for correcting known regulatory deficiencies and ensuring that it complied with its operational control procedures" be removed from the probable cause statement along with verbiage in the final two paragraphs in the report's analysis section associated with this factor.[24]

We value our working relationship with the NTSB and know we have a shared desire to improve aviation safety. It is in the spirit of that shared desire, and in the belief that investigatory conclusions must be based on accurate facts to be meaningful, that the FAA petitions the NTSB to correct the record and remove the FAA as a contributory factor in the SeaPort accident investigation report. This tragic case of a fatal air carrier accident demands, for the sake of accuracy, that the requested modifications be made.

Attachments:

1. NTSB Aviation Accident Final Report - Accident no. ANC15FA049
2. *Alaska Dispatch News* Article. "NTSB Alaska welcomes new investigators"
3. Excerpts from Attachment 1 to the NTSB Operations Factual Report – Interview Summaries
4. Declaration Statement of FAA Inspector Ty Bartausky *(new evidence)*
5. Declaration Statement of FAA Inspector Dee Rice *(new evidence)*
6. FAA Surveillance Records of SeaPort Airlines for 2015 *(new evidence)*
7. FAA Emails and Correspondence regarding Post-Accident FAA Actions *(new evidence)*
8. FAA-NTSB Emails regarding NTSB Accident Report Production and Publication

[24] During our review of this accident report, numerous errors were discovered that are not related to the subject of the FAA's petition. Recognizing that the Safety Board has the ability to correct other errors it may discover in the process of reviewing a report for a petition, the FAA has identified the following errors for the Board's consideration in its review: (1) The FAA inspector interview summaries have conflicting dates of when the interviews occurred; (2) The NTSB incorrectly conveyed in Inspector Rice's interview summary that a letter was "being held by Deek [sic] Abbott, FAA Alaska Regional Deputy Division Manager." The letter was drafted for her frontline manager, Inspector Bartausky; (3) The word "deficiencies" found in the probable cause statement denotes more than one deficiency, yet the NTSB cites only the gliding distance to shore issue; (4) The public docket of supporting materials for this case does not contain descriptive titles for each of the 29 attachments for the Operations Group Chairman's Factual Report, or the seven attachments to the Weather Study Report.