



Aviation Investigation Final Report

Location:	Murrieta, California	Accident Number:	WPR23FA257
Date & Time:	July 8, 2023, 04:14 Local	Registration:	N819KR
Aircraft:	Cessna 550	Aircraft Damage:	Destroyed
Defining Event:	Altitude deviation	Injuries:	6 Fatal
Flight Conducted Under:	Part 91: General aviation - Personal		

Analysis

During an early morning night flight, the flight encountered deteriorating weather conditions with a low overcast ceiling and rapidly decreasing visibility at the destination due to fog.

A few minutes before the flight's arrival time at the destination airport, the weather had changed from being clear with 10 statute miles (sm) visibility to 300 ft overcast with 3/4 sm visibility. Additionally, in the next 20 minutes, the visibility further decreased to about 1/2 sm with fog.

The airplane was cleared for the RNAV (GPS) Runway 18 instrument approach to the airport. The lowest visibility requirement on the approach was 7/8 of a mile. During the final approach, the pilot executed a missed approach and asked to try another instrument approach. During the second instrument approach, while on final approach, the pilot failed to fly a stabilized approach as the airplane's descent rate and airspeed were excessive. Subsequently, the airplane descended below the decision altitude of the approach without appropriate visual references and impacted terrain about 810 ft short of the runway threshold.

The circumstances of the accident flight were consistent with controlled flight into terrain (CFIT).

The postaccident examination of the airplane and engines revealed no evidence of mechanical failures or malfunctions that would have precluded normal operation of the airplane.

The pilot had very low levels of ethanol detected in postmortem vitreous fluid and cavity blood. Some or all of this small amount of ethanol may have been from sources other than alcohol consumption. Although it is uncertain whether the pilot had consumed alcohol overnight, the

toxicology results indicate that it is unlikely that the pilot's performance would be significantly affected by ethanol.

The copilot's ethanol levels were high in all tested postmortem specimens. Based on the toxicology results and the circumstances of the event, it is likely that the copilot had consumed alcohol. However, based on the extent of his injuries, the presence of indicators of microbial decomposition, and the relative differences in ethanol levels across specimens, it also is likely that some of the detected ethanol was from sources other than alcohol consumption. The copilot's blood alcohol level at the time of the crash cannot be reliably determined from available evidence. Overall, alcohol-related impairment may have limited the copilot's ability to make a positive contribution to flight safety (such as by helping to monitor the approach); however, whether the effects of alcohol use by the copilot contributed to the accident outcome could not be determined.

Probable Cause and Findings

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

The flight crew's decision to descend below the decision altitude of an instrument approach without having the appropriate runway visual reference(s) distinctively identified and with the visibility below the minimum that was prescribed for the approach, which resulted in controlled flight into terrain.

Findings

Personnel issues	Incorrect action performance - Pilot
Personnel issues	Use of available resources - Flight crew
Personnel issues	Situational awareness - Flight crew
Environmental issues	Low visibility - Decision related to condition
Environmental issues	Fog - Effect on personnel
Personnel issues	Circadian rhythms or jetlag - Flight crew

Factual Information

History of Flight

Approach-IFR final approach	Altitude deviation (Defining event)
Approach-IFR final approach	Controlled flight into terr/obj (CFIT)

On July 8, 2023, about 0414 Pacific daylight time, a Cessna 550, jet airplane, N819KR, was destroyed when it was involved in an accident near Murrieta, California. The 2 pilots and 4 passengers were fatally injured. The airplane was operated as a Title 14 *Code of Federal Regulations (CFR)* Part 91 personal flight.

According to ADS-B and air traffic control data provided by the Federal Aviation Administration, the airplane departed French Valley Airport (F70), Murrieta/Temecula, California, on a cross-country flight to Harry Reid International Airport (LAS), Las Vegas, Nevada, about 2118 the night before. The airplane departed on the return flight back to F70 about 6 hours later. After climb-out, the airplane leveled off at an altitude of about 19,000 ft mean sea level (msl). About 27 minutes into the flight, the airplane started a descent to its destination. About 0344, the pilot established contact with the Pomona radar controller and requested to cancel their IFR clearance. The controller acknowledged the cancellation and provided the altimeter setting and advised that VFR altitude and routing was at their discretion and that he had no weather or landing information for F70. The pilot responded and advised that he had the weather and landing information for F70. About 0351, and about 25 miles north of F70, the pilot reported that he had received updated weather and requested an IFR pickup for the RNAV (GPS) Runway 18 approach at F70.

A few minutes before their arrival time at the destination airport, the weather had changed from being clear with 10 sm visibility to 300 ft overcast with 3/4 sm visibility. Additionally, in the next 20 minutes, the visibility further decreased to about 1/2 sm with fog.

The airplane was cleared to the F70 airport via direct to the TIQMU waypoint (Initial Approach Fix) for the RNAV (GPS) Runway 18 instrument approach at F70, and to maintain 6,000 ft msl. The controller confirmed that the pilot was in receipt of weather and NOTAMs and then instructed the pilot to maintain at or above 4,600 ft msl until TIQMU, cleared for the approach, and to report inbound at TIQMU. At 0353, the pilot reported established on the approach and was approved a frequency change to the common traffic advisory frequency (CTAF).

During the final approach, the airplane's airspeed was fast and it leveled off near the decision altitude for several seconds. (According to the FAA Instrument Flying Handbook, when

decision altitude is reached, a missed approach must be initiated if the required visual reference to continue the approach has not been established.) Subsequently, after a few seconds of delay, the pilot executed a missed approach, and about 0400 requested another instrument approach. During the second instrument approach, the airplane flew a right traffic pattern, was cleared to 5,000 ft msl, and was re-cleared for the approach. About 0407, the pilot requested to change to advisory frequency. The controller approved the pilot's request to change to advisory frequency and requested that he report IFR cancellation airborne or on the ground. The pilot acknowledged and there were no further transmissions with the pilot. The airplane crossed TIQMU at 4,600 ft msl and then turned southbound. While on final approach, the airplane descended below the decision altitude of the approach.

Subsequently, the airplane impacted terrain about 800 ft short of the runway 18 threshold. A postimpact fire ensued that consumed most of the fuselage. The last ADS-B data point indicated that the airplane was on a heading about 180°, the ground speed was about 128 knots, and the altitude was 1,450 ft msl (100 ft above ground level[agl]).

The airplane was equipped with a Garmin GTN 750 unit that could simultaneously provide weather, approach, and vertical guidance information. The flight data during the last 30 seconds of data showed the airplane's indicated airspeed was about 130 knots and the heading was about 180°. During the last 20 seconds of data, the airplane's descent rate was about -762 fpm until it started to level off and begin a slight climb. About 5 seconds later, the airplane's descent rate increased to about -2,320 fpm during the last 3 seconds of data.

Pilot Information

Certificate:	Commercial	Age:	25, Male
Airplane Rating(s):	Single-engine land; Single-engine sea	Seat Occupied:	Left
Other Aircraft Rating(s):	None	Restraint Used:	Unknown
Instrument Rating(s):	Airplane	Second Pilot Present:	Yes
Instructor Rating(s):	None	Toxicology Performed:	Yes
Medical Certification:	Class 1 Without waivers/limitations	Last FAA Medical Exam:	March 9, 2023
Occupational Pilot:		Last Flight Review or Equivalent:	
Flight Time:	(Estimated) 950 hours (Total, all aircraft)		

Co-pilot Information

Certificate:	Commercial	Age:	32, Male
Airplane Rating(s):	Single-engine land; Multi-engine land	Seat Occupied:	Right
Other Aircraft Rating(s):	Helicopter	Restraint Used:	Unknown
Instrument Rating(s):	Airplane	Second Pilot Present:	Yes
Instructor Rating(s):	Airplane single-engine	Toxicology Performed:	Yes
Medical Certification:	Class 1 Without waivers/limitations	Last FAA Medical Exam:	January 25, 2023
Occupational Pilot:		Last Flight Review or Equivalent:	
Flight Time:	(Estimated) 1600 hours (Total, all aircraft)		

Passenger Information

Certificate:		Age:	Female
Airplane Rating(s):		Seat Occupied:	Unknown
Other Aircraft Rating(s):		Restraint Used:	
Instrument Rating(s):		Second Pilot Present:	Yes
Instructor Rating(s):		Toxicology Performed:	
Medical Certification:		Last FAA Medical Exam:	
Occupational Pilot:		Last Flight Review or Equivalent:	
Flight Time:			

Passenger Information

Certificate:		Age:	Female
Airplane Rating(s):		Seat Occupied:	Unknown
Other Aircraft Rating(s):		Restraint Used:	
Instrument Rating(s):		Second Pilot Present:	Yes
Instructor Rating(s):		Toxicology Performed:	
Medical Certification:		Last FAA Medical Exam:	
Occupational Pilot:		Last Flight Review or Equivalent:	
Flight Time:			

Passenger Information

Certificate:	Age:	Female
Airplane Rating(s):	Seat Occupied:	Unknown
Other Aircraft Rating(s):	Restraint Used:	
Instrument Rating(s):	Second Pilot Present:	Yes
Instructor Rating(s):	Toxicology Performed:	
Medical Certification:	Last FAA Medical Exam:	
Occupational Pilot:	Last Flight Review or Equivalent:	
Flight Time:		

Passenger Information

Certificate:	Age:	Male
Airplane Rating(s):	Seat Occupied:	Unknown
Other Aircraft Rating(s):	Restraint Used:	
Instrument Rating(s):	Second Pilot Present:	Yes
Instructor Rating(s):	Toxicology Performed:	
Medical Certification:	Last FAA Medical Exam:	
Occupational Pilot:	Last Flight Review or Equivalent:	
Flight Time:		

Both pilots had a type rating for the CE-550 aircraft with the limitation of a second pilot-in-command required.

Aircraft and Owner/Operator Information

Aircraft Make:	Cessna	Registration:	N819KR
Model/Series:	550	Aircraft Category:	Airplane
Year of Manufacture:	1979	Amateur Built:	
Airworthiness Certificate:	Normal	Serial Number:	550-0114
Landing Gear Type:	Retractable - Tricycle	Seats:	9
Date/Type of Last Inspection:	June 30, 2023 Annual	Certified Max Gross Wt.:	13300 lbs
Time Since Last Inspection:		Engines:	2 Turbo fan
Airframe Total Time:	14569.5 Hrs as of last inspection	Engine Manufacturer:	P&W CANADA
ELT:	Installed	Engine Model/Series:	JT15D-4
Registered Owner:	PRESTIGE WORLDWIDE FLIGHTS LLC	Rated Power:	2500 Lbs thrust
Operator:	On file	Operating Certificate(s) Held:	None

According to the airplane's operating manual, the reference speed with flaps positioned to land, pressure altitude 2,000 ft, anti-ice systems off, 10°C, and at a gross weight of 9,500 pounds was 95 knots indicated airspeed (KIAS); at a gross weight of 10,000 pounds, the reference speed was 99 KIAS.

Meteorological Information and Flight Plan

Conditions at Accident Site:	Instrument (IMC)	Condition of Light:	Night
Observation Facility, Elevation:	KRNM,1385 ft msl	Distance from Accident Site:	35 Nautical Miles
Observation Time:	04:11 Local	Direction from Accident Site:	162°
Lowest Cloud Condition:	Clear	Visibility	0.75 miles
Lowest Ceiling:	Overcast / 200 ft AGL	Visibility (RVR):	
Wind Speed/Gusts:	/	Turbulence Type Forecast/Actual:	None / None
Wind Direction:		Turbulence Severity Forecast/Actual:	N/A / N/A
Altimeter Setting:	29.85 inches Hg	Temperature/Dew Point:	13°C / 12°C
Precipitation and Obscuration:	Moderate - None - Mist		
Departure Point:	Las Vegas, NV (LAS)	Type of Flight Plan Filed:	IFR
Destination:	Murrieta, CA	Type of Clearance:	IFR
Departure Time:	03:16 Local	Type of Airspace:	Class G

A review of the NWS Surface Analysis Chart revealed that a low-pressure system was located at the intersection of the California, Nevada, and Arizona borders.

A sounding analysis model indicated a cloud layer between 1,650 ft and 2,650 ft msl. No icing was indicated below 10,000 ft msl. No possibility of low-level wind shear (LLWS) was depicted. Light clear air turbulence was indicated in several layers between 1,000 ft and 10,000 ft.

The F70 automated weather forecast at 03:15 Pacific daylight time called for clear ceilings and 10 sm of visibility. At 03:55, the ceiling and visibility rapidly decreased to overcast at 300 ft agl and 3/4 visibility with mist. At 0415, near the accident time, the ceiling remained overcast at 300 ft agl and the visibility decreased to 1/2 mile with fog.

There were no disseminated pilot reports (PIREPS) distributed into the national airspace system during the two hours before and after the accident time within 100 miles and below an altitude of 18,000 ft.

There were no convective or non-convective Significant Meteorological Information (SIGMET) advisories valid for the accident site during the accident time.

The NWS Aviation Weather Center had Airmen's Meteorological information (AIRMET) advisory Sierra valid for the accident site and time for below 8,000 ft. The AIRMET Sierra was issued at 0145 and updated at 0401 with forecast mountain obscuration conditions due to clouds and fog.

The NWS weather forecast office in San Diego, California, issued the following area forecast for the region of the accident site: Areas of low clouds will gradually spread to 20 miles inland by 1200Z Sat with bases 1000-1600 ft msl, with local terrain obscurations.

A search of archived information indicated that the accident pilot did not request weather information from Leidos Flight Service. The pilot did have an account through Foreflight and filed a flight plan, but no weather imagery was viewed in Foreflight.

Astronomical data for the accident location and time indicated that sunrise was 0545 and moonrise was 0454.

Airport Information

Airport:	FRENCH VALLEY F70	Runway Surface Type:	Asphalt
Airport Elevation:	1349 ft msl	Runway Surface Condition:	Dry
Runway Used:	18	IFR Approach:	RNAV
Runway Length/Width:	6000 ft / 75 ft	VFR Approach/Landing:	None

The publicly owned airport did not have a control tower.

The FAA flight-tested the Precision Approach Path Indicator lights (PAPIs) to Runway 18 on July 10, 2023. The PAPIs were determined to be satisfactory. Additionally, the flight test found the Runway 18 Runway End Identifier Lights (REILs) and the pilot control lighting (PCL) were satisfactory.

The Automated Weather Observing System was inspected by a technician on July 10, 2023. All documentation and equipment parameters were operational and within tolerances.

The RNAV (GPS) 18 was the instrument approach flown (see figure 1).

Localizer performance with vertical guidance (LPV) approach takes advantage of the refined accuracy of Wide Area Augmentation System (WAAS) lateral and vertical guidance to provide an approach similar to a category 1 ILS. Like an ILS, a LPV has vertical guidance and is flown to a Decision Altitude (DA). The design of an LPV approach incorporates angular guidance with increasing sensitivity as an aircraft gets close to the runway. Sensitivity is nearly identical to that of an ILS at similar distances. This is intentional to aid pilots in transferring their ILS flying skills to LPV approaches.

MURRIETA/TEMECULA, CALIFORNIA

AL-6941 (FAA)

19171

WAAS CH 78135 W18A	APP CRS 179°	Rwy ldg 6000 TDZE 1350 Apt Elev 1350
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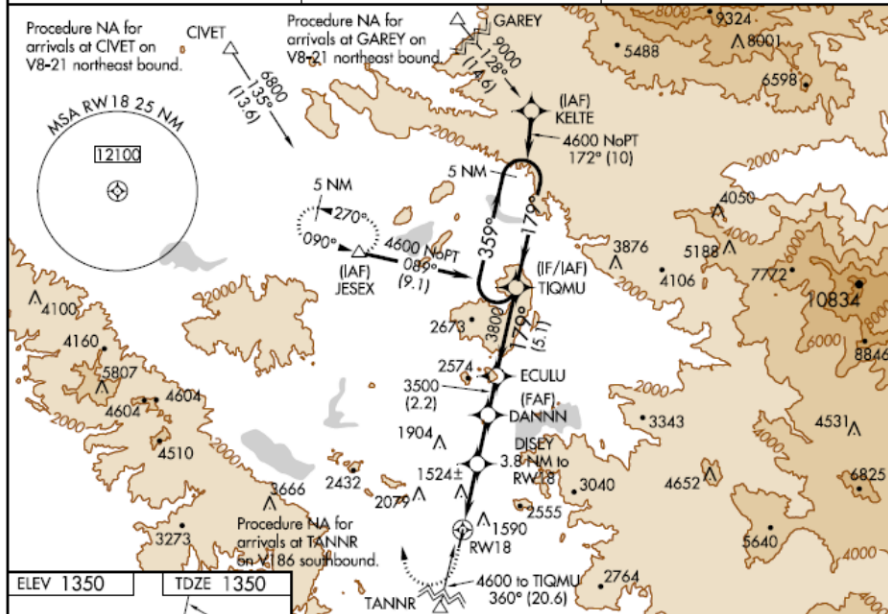
RNAV (GPS) RWY 18

FRENCH VALLEY (F70)

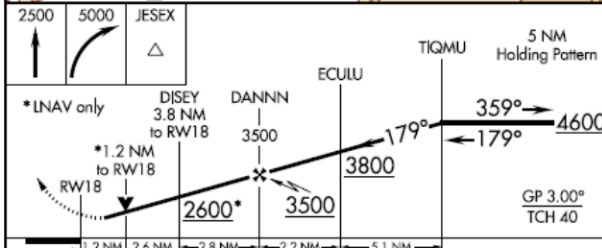
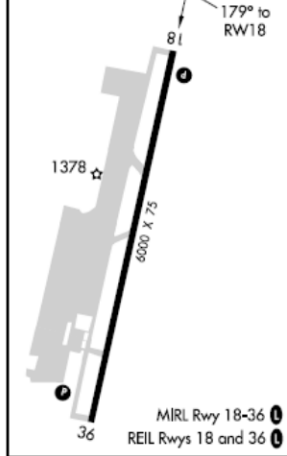
NA DME/DME RNP-0.3 NA. Baro-VNAV and VDP NA with Ramona altimeter setting. Circling NA west of Rwy 18-36. For uncompensated Baro-VNAV systems, LNAV/VNAV NA below -17°C (2°F) or above 54°C (130°F). When local altimeter setting not received use Ramona altimeter setting: increase LPV DA to 1685 feet and all visibilities ¼ mile, LNAV/VNAV DA to 1955 feet and all visibilities ¾ mile, all MDA 80 feet and LNAV visibility Cat B ¼ mile, Cat C ½ mile, and Circling visibility Cat C ¼ mile. Helicopter visibility reduction below ¾ SM NA.

MISSED APPROACH: Climb to 2500 then climbing right turn to 5000 direct JESEX and hold.

AWOS-3 119,025	MARCH APP CON* 133.5 306,975	UNICOM 122.8 (CTAF) 0
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ELEV 1350	TDZE 1350
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CATEGORY	A	B	C	D
LPV DA	1600-7/8	250 (300-7/8)		NA
LNAV/VNAV DA	1871-13/4	521 (600-13/4)		NA
LNAV MDA	1780-1	430 (500-1)	1780-1 1/4 430 (500-1 1/4)	NA
CIRCLING	2020-1	670 (700-1)	2060-2 710 (800-2)	NA

MURRIETA/TEMECULA, CALIFORNIA
Amdt 2 08JAN15

33°34'N-117°08'W

RNAV (GPS) RWY 18

Figure 1. Runway 18 RNAV (GPS) instrument approach plate.

Wreckage and Impact Information

Crew Injuries:	2 Fatal	Aircraft Damage:	Destroyed
Passenger Injuries:	4 Fatal	Aircraft Fire:	On-ground
Ground Injuries:		Aircraft Explosion:	None
Total Injuries:	6 Fatal	Latitude, Longitude:	33.584444,-117.12583(est)

Examination of the accident site revealed that the airplane impacted terrain on the extended runway centerline about 810 ft short of the runway 18 threshold at F70. The terrain was covered with sagebrush at an elevation of about 1,340 ft msl. All major components of the airplane necessary for flight were found at the accident site. The airplane's configuration was determined to be gear down and flaps fully extended. Flight control continuity was established.

A review of the enhanced ground proximity warning system (EGPWS) unit revealed that the accident flight data was present. A single Mode 4 too-low gear alert was the only alert recorded and was consistent with an alert after the airplane accomplished a missed approach on the first approach and retracted the landing gear at a low altitude.

The postaccident examination of the airplane and engines revealed no evidence of mechanical failures or malfunctions that would have precluded normal operation of the airplane.

Flight recorders

The airplane was equipped with a cockpit voice recorder (CVR) that was removed and examined by the NTSB Vehicle Recorders Laboratory for potential download. The CVR did not contain data from the accident flight and none of the recovered audio was pertinent to the investigation.

Medical and Pathological Information

The Riverside County Sheriff's Coroner Division performed an autopsy on the pilot's remains. The autopsy report listed the cause of death as "blunt force trauma."

The FAA Forensic Sciences Laboratory performed toxicological testing on specimens from the pilot. The pilot's results for the testing of drugs of abuse, alcohol, and carboxyhemoglobin were negative. Ethanol was not detected at a reporting threshold of 0.01 g/dL.

The Riverside County Sheriff's Coroner Division performed an autopsy on the copilot's remains. The autopsy report listed the cause of death as "blunt force trauma."

The FAA Forensic Sciences Laboratory performed toxicological testing of postmortem specimens from the copilot. Ethanol was detected at 0.196 g/dL in chest cavity blood, at 0.109 g/hg in brain tissue, and at 0.365 g/hg in liver tissue. N-propanol, n-butanol, and methanol were also detected at low levels in blood but were not detected in brain or liver tissue. The toxicology report noted subjective evidence of organic decomposition.

N-propanol and n-butanol are alcohols that can be produced by microbes in a person's body tissues and fluids after death. Methanol is wood alcohol; it is present at low levels in some foods and drinks and has a variety of industrial uses. There is some evidence that methanol detected in a postmortem specimen may be more likely to be due to dietary sources (such as alcoholic beverage consumption) or contamination rather than postmortem microbial production, although postmortem methanol production has been reported.

Ethanol is the intoxicating alcohol in beer, wine, and liquor, and, if consumed, can impair judgment, psychomotor performance, cognition, and vigilance, with detrimental effects on piloting tasks that worsen as ethanol levels increase. FAA regulation imposes strict limits on flying after consuming ethanol, including a prohibition on piloting a civil aircraft while having a blood ethanol level of 0.04 g/dL or greater. When absorbed into circulation after alcohol consumption, ethanol distributes relatively evenly throughout the body along with water. In living people, ethanol is eliminated from blood at a rate of approximately 0.008 to 0.035 g/dL per hour (0.01-0.025 g/dL per hour for most people).

Alcohol consumption is not the only possible source of ethanol in postmortem specimens. Ethanol sometimes may be produced by microbes in a person's body tissues and fluids after death, potentially elevating ethanol levels in affected postmortem specimens. Postmortem ethanol production is made more likely by extensive trauma, which can spread microbes. Vitreous fluid typically is better protected against the spread of microbes and therefore is less susceptible to postmortem ethanol production than are other specimen types. However, postmortem ethanol production can occur in vitreous fluid.

Additional Information

Title 14 *CFR* 91.175, Takeoff and landing under IFR, states in part:

Operation below DA/DH or MDA. Except as provided in 91.176 of this chapter, where a DA/DH or MDA is applicable, no pilot may operate an aircraft, except a military aircraft of the United States, below the authorized MDA or continue an approach below the authorized DA/DH unless—

(1) The aircraft is continuously in a position from which a descent to a landing on the intended runway can be made at a normal rate of descent using normal maneuvers, ...

(2) The flight visibility is not less than the visibility prescribed in the standard instrument approach being used; and

(3) Except for a Category II or Category III approach where any necessary visual reference requirements are specified by the Administrator, at least one of the following visual references for the intended runway is distinctly visible and identifiable to the pilot:

(i) The approach light system, except that the pilot may not descend below 100 feet above the touchdown zone elevation using the approach lights as a reference unless the red terminating bars or the red side row bars are also distinctly visible and identifiable.

(ii) The threshold.

(iii) The threshold markings.

(iv) The threshold lights.

(v) The runway end identifier lights.

(vi) The visual glideslope indicator.

(vii) The touchdown zone or touchdown zone markings.

(viii) The touchdown zone lights.

(ix) The runway or runway markings.

(x) The runway lights.

According to the FAA Instrument Flying Handbook, "Decision altitude (DA). A specified altitude in the precision approach, charted in feet MSL, at which a missed approach must be initiated if the required visual reference to continue the approach has not been established."

According to the FAA Airplane Flying Handbook:

Pilots may consider the following elements when attempting to set up and fly a stabilized approach to landing. The pilot should focus on the elements that lead to a stabilized approach rather than the order of the elements or the insistence on meeting all of the approach criteria.

Airspeed. The aircraft speed is within +10 /-5 KIAS of the recommended landing speed specified in the AFM.

Decent rate: A descent rate (generally 500-1,000 fpm...makes for a safe approach). Minimal adjustments to the descent rate as the airplane approaches the runway provide indication of a stabilized and safe approach.

It further describes, under the heading, "Night Illusions. Darkness or low visibility increases pilot susceptibility to error"

A black-hole approach occurs when the landing is made from overwater or non-lighted terrain where the runway lights are the only source of light. Without peripheral visual cues to help, orientation is difficult. The runway can seem out of position (down-sloping or up-sloping) and in the worst case, results in landing short of the runway. If an electronic glide slope or visual approach slope indicator (VASI) is available, it should be used. If navigation aids (NAVAIDs) are unavailable, the flight instruments assist in maintaining orientation and a normal approach. Anytime position in relation to the runway or altitude is in doubt, the pilot should execute a go around. Also, flying over terrain with only a few lights makes the runway recede or appear farther away. With this situation, the tendency is to fly a lower-than normal approach. A review of the airfield layout and boundaries before initiating any approach helps maintain a safe approach angle.

The investigation team traveled to the accident site the night after the accident and observed the field located about 1,800 ft before the approach to end of runway 18; it was dark with no lights present.

The FAA pilot's Handbook of Aeronautical Knowledge identified operational pitfalls that pilots need to be aware of. The first is the Duck-under syndrome. "A pilot may be tempted to make it into an airport by descending below minimums during an approach. There may be a belief that there is a built-in margin of error in every approach procedure, or the pilot may not want to admit that the landing cannot be made completed and a miss approach must be initiated." Another potential pitfall was "Get-there-itis." This disposition impairs pilot judgement through fixation on the original goal or destination, combined with a disregard for any alternative course of action.

According to the FAA Advisory Circular on Basics of Aviation Fatigue, "individuals living on a regular 24-hour routine with sleep at night have two periods of maximum sleepiness, also known as Window of Circadian Low. One occurs at night, roughly from 3 a.m. to 5 a.m., a time when physiological sleepiness is greatest and performance capabilities are lowest."

Administrative Information

Investigator In Charge (IIC):	Nixon, Albert
Additional Participating Persons:	Edwin Miller; Federal Aviation Administration AVP-100; Washington, DC Matthew Rigsby; Federal Aviation Administration AVP-100; Washington, DC Jeff Newcomer; Federal Aviation Administration; Riverside, CA Robert Michaelson; Federal Aviation Administration; Riverside, CA Ernest Hall; Textron Aviation; Wichita, KS Kurt Gibson; Textron Aviation; Wichita, KS Eugene Torrisi; Pratt and Whitney Canada; Quebec, OF
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Last Revision Date:	
Investigation Class:	Class 3
Note:	
Investigation Docket:	https://data.nts.gov/Docket?ProjectID=192559

The National Transportation Safety Board (NTSB) is an independent federal agency charged by Congress with investigating every civil aviation accident in the United States and significant events in other modes of transportation—railroad, transit, highway, marine, pipeline, and commercial space. We determine the probable causes of the accidents and events we investigate, and issue safety recommendations aimed at preventing future occurrences. In addition, we conduct transportation safety research studies and offer information and other assistance to family members and survivors for each accident or event we investigate. We also serve as the appellate authority for enforcement actions involving aviation and mariner certificates issued by the Federal Aviation Administration (FAA) and US Coast Guard, and we adjudicate appeals of civil penalty actions taken by the FAA.

The NTSB does not assign fault or blame for an accident or incident; rather, as specified by NTSB regulation, “accident/incident investigations are fact-finding proceedings with no formal issues and no adverse parties ... and are not conducted for the purpose of determining the rights or liabilities of any person” (Title 49 *Code of Federal Regulations* section 831.4). Assignment of fault or legal liability is not relevant to the NTSB’s statutory mission to improve transportation safety by investigating accidents and incidents and issuing safety recommendations. In addition, statutory language prohibits the admission into evidence or use of any part of an NTSB report related to an accident in a civil action for damages resulting from a matter mentioned in the report (Title 49 *United States Code* section 1154(b)). A factual report that may be admissible under 49 *United States Code* section 1154(b) is available [here](#).