



Brief of Accident (Continued)

ANC13FA030  
File No. 32935

03/08/2013

Aleknagik ,AK

Aircraft Reg No. N116AX

Time (Local): 08:15 AST

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Therefore, the flight crewmember's acceptance of what they believed to be a clearance to 2,000 feet, their descent to that altitude, and their initiation of a hold at that altitude indicates a lack of awareness of the information contained on the published procedure. Such a lack of awareness is inconsistent with pilot-in-command responsibilities and company procedures that require an instrument approach briefing during the descent and approach phases of flight. If the flight crewmembers had reviewed the published approach procedure and briefed it per the company's descent and approach checklist, they should have noticed that the minimum safe altitude in the TAA southeast of the IAF was 5,400 feet msl and that the minimum altitude for the hold was 4,300 feet msl. Examination of the wreckage and debris path evidence is consistent with the airplane having collided with rising terrain at 2,000 feet msl while flying in a wings-level attitude on the outbound leg of the holding pattern, which the flight crew should have flown at 4,300 feet msl.

However, the air traffic controller did not adhere to guidance contained in Federal Aviation Administration Order 7110.65, and his approach clearance to "maintain at or above 2,000 feet" msl until established on a published segment of the approach was ambiguous. The controller's approach clearance should have instructed the pilot to "proceed direct to ZEDAG, enter the TAA at or above 5,400 feet, cleared RNAV runway 19 approach." Instead, he instructed the pilot without specifying the segment of the approach that should be flown at 2,000 feet. Further, the controller did not notice the pilot's incorrect readback of the clearance in which he indicated that he intended to "maintain 2,000 feet" until established on the approach. Further, he did not appropriately monitor the flight's progress and intervene when the airplane descended to 2,000 feet msl. As a result, the airplane was permitted to descend below the minimum instrument altitudes applicable to the route of flight and enter the holding pattern well below the published minimum holding altitude.

Air traffic control (ATC) recorded automation data showed that the airplane's trajectory generated aural and visual minimum safe altitude warnings on the controller's radar display. However, the controller did not issue any terrain warnings or climb instructions to the flight crew. The controller said that he was not consciously aware of any such warnings from his display. These automated warnings should have been sufficient to prompt the controller to evaluate the airplane's position and altitude, provide a safety alert to the pilot in a timely manner, and instruct the pilot to climb to a safe altitude; it could not be determined why the controller was unaware of the warnings. The airplane was equipped with three pieces of navigation equipment that should have provided visual and aural terrain warnings to the flight crewmembers if they had not inhibited the function and if the units were operating properly. Damage precluded testing the equipment or determining the preaccident configuration of the units; however, the flight crew reported no equipment anomalies predeparture.

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OCCURRENCES

Enroute-holding (IFR) - Controlled flight into terr/obj (CFIT)

FINDINGS

Personnel issues-Action/decision-Info processing/decision-Decision making/judgment-Flight crew - C  
Personnel issues-Action/decision-Info processing/decision-Decision making/judgment-ATC personnel - F  
Environmental issues-Conditions/weather/phenomena-Ceiling/visibility/precip-Low ceiling-Contributed to outcome

Findings Legend: (C) = Cause, (F) = Factor

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

The flight crew's failure to maintain terrain clearance, which resulted in controlled flight into terrain in instrument meteorological conditions. Contributing to the accident were the flight crew's failure to correctly read back and interpret clearance altitudes issued by the air traffic controller, their failure to adhere to minimum altitudes depicted on the published instrument approach chart, and their failure to adhere to company checklists.

Also contributing to the accident were the air traffic controller's issuance of an ambiguous clearance to the flight crew, which resulted in the airplane's premature descent, his failure to address the pilot's incorrect read back of the assigned clearance altitudes, and his failure to monitor the flight and address the altitude violations and issue terrain-based safety alerts.