



National Transportation Safety Board Aviation Accident Final Report

Location:	Santa Fe, NM	Accident Number:	DEN08FA162
Date & Time:	09/29/2008, 2216 MDT	Registration:	N606SL
Aircraft:	Pilatus PC-12/47E	Aircraft Damage:	Destroyed
Defining Event:	Controlled flight into terr/obj (CFIT)	Injuries:	1 Fatal
Flight Conducted Under:	Part 91: General Aviation - Personal		

Analysis

The pilot was approaching his home airport under dark night conditions. He reported that he was five miles from the airport and adjusted the airport lighting several times. He made no further radio calls, though his normal practice was to report his position several times as he proceeded in the landing pattern. The airplane approached the airport from the southeast in a descent, continued past the airport, and adjusted its course slightly to the left. One witness reported observing the airplane enter a left turn, then pitch down, and descend at a steep angle. The airplane impacted terrain in a steep left bank and cart wheeled. An examination of the airframe, airplane systems, and engine revealed no pre-impact anomalies. Flight control continuity was confirmed.

The pilot had flown eight hours and 30 minutes on the day of the accident, crossing two time zones, and had been awake for no less than 17 hours when the accident occurred. The accident occurred at a time of day after midnight in the pilot's departure time zone. Post-accident toxicology testing revealed doxylamine and amphetamine in the pilot's tissues. The pilot had been diagnosed with attention deficit hyperactivity disorder (ADHD) almost five years prior to the accident and had taken prescription amphetamines for the disorder since that diagnosis. The FAA does not medically certify pilots who require medication for the control of ADHD. At the time of the accident, the pilot's blood level of amphetamines may have been falling, and he may have been increasingly fatigued and distracted. The use of doxylamine (an over-the-counter antihistamine, often used as a sleep aid) could suggest that the pilot was having difficulty sleeping.

Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be: The pilot's incapacitation due to fatigue resulting in an in-flight collision with terrain.

Findings

Personnel issues

Alertness/Fatigue - Pilot (Cause)

Impairment/incapacitation - Pilot (Cause)

Factual Information

HISTORY OF FLIGHT

On September 29, 2008, at 2216:27 mountain daylight time, a Pilatus PC-12/47E, N606SL, owned and operated by a private pilot, was destroyed when it impacted terrain three nautical miles north of the Santa Fe Municipal Airport (SAF), Santa Fe, New Mexico. A post impact fire ensued. Dark night visual meteorological conditions prevailed at the time of the accident. The personal flight was being conducted under the provisions of Title 14 Code of Federal Regulations Part 91 on an instrument flight rules (IFR) flight plan. The private pilot, the sole occupant on board, was fatally injured. The cross country flight departed Lubbock Preston Smith International Airport (LBB), Lubbock, Texas, approximately 2115 and was en route to SAF.

The pilot's family reported that several days prior to the accident, the pilot had flown the accident airplane to Akron, Ohio, from his home near Santa Fe, to spend the weekend in Akron with friends. On the morning of the accident, the pilot left his hotel at an unknown time and proceeded to the Akron-Canton Regional Airport. According to Federal Aviation Administration (FAA) records, the pilot departed Akron-Canton Regional Airport, Akron, Ohio, at 0717 (0917 Eastern Daylight Time (edt)) en route to Teterboro Airport (TEB), Teterboro, New Jersey. He arrived at TEB approximately 0850 (1050 edt). At Teterboro, the pilot contacted Lockheed Martin Flight Service Station (FSS) at 1353 (1553 edt) to file an IFR flight plan. The flight plan filed by the pilot identified TEB as the departure airport and SAF as the destination. The pilot planned six hours en route at flight level (FL) 280. The airplane departed TEB at 1424 (1624 edt). While en route, the pilot diverted to LBB to obtain fuel.

The pilot arrived at LBB at 2021 (2221 edt) and had the airplane refueled. He also spoke with his wife on the telephone, and did not report any problems regarding the airplane or himself. The pilot then departed LBB approximately 2115 (2315 edt).

Approaching Santa Fe, the pilot initiated a descent to 12,000 feet mean sea level (msl) as cleared by Albuquerque Center at 2158:56. The pilot was cleared for the visual approach into SAF at 2212:43 and canceled his flight plan ten seconds later. No further communications with the pilot were recorded.

Radar data, provided by Albuquerque Air Route Traffic Control Center (ZAB) in National Track Analysis Program (NTAP) format, depicted the accident flight approaching SAF. The airplane track progressed from the southeast towards the northwest on a measured magnetic bearing of 290 degrees in a descent. At an approximate altitude of 8,000 feet msl, approximately two nautical miles (nm) northeast of the airport, the track shifted to a magnetic bearing of 320 degrees and continued in a descent. The last radar target was recorded at 2216:27 at an encoded altitude of 7,200 feet msl, 3.2 nautical miles north of the airport on a measured magnetic bearing of 003 degrees from the airport. The airplane's ground speed remained above 200 knots until just prior to impact, when the ground speed slowed to 190 knots.

The National Transportation Safety Board (Safety Board) Investigator in Charge (IIC) interviewed one witness and received written statements from the same witness and one additional witness. The witnesses were located at SAF three miles south of the impact location. According to the witnesses, the airplane approached the airport from the "southeast" and "overflew" the area on a ground track consistent with a traffic pattern for one of the runways.

The airplane was visible due to the airplane position lights. The pilot reported over UNICOM that he was five miles from the airport. The runway lights were activated and the level of lighting was adjusted several times following the radio transmission. No other radio calls were made by the pilot. There were no other aircraft in the area at the time of the accident. According to one witness, the airplane initiated a left turn towards the airport at which time the airplane pitched down and descended at a "steep angle." The two witnesses resumed their normal duties, waiting for the airplane to land, unaware that the airplane had crashed. According to one witness, it was standard practice for the pilot to report five miles out in addition to his position on downwind, base, and final for the landing runways. The pilot did not make any of these traffic pattern reports.

PERSONNEL INFORMATION

The pilot, age 54, held a private pilot certificate with airplane single engine land, multi-engine land, and instrument ratings last issued on April 11, 2006. He was issued a third class airman medical certificate on July 27, 2007. The certificate contained the limitation "holder shall wear lenses that correct for distant vision and possess glasses that correct for near vision."

The pilot's family provided the Safety Board IIC a digital copy of the digital logbook that the pilot had maintained on his personal computer. A review of these records revealed the pilot had logged no less than 2,437 hours total flight time; 1,456 hours in turbine aircraft, 86.5 hours in the Pilatus PC-12/47E, 14 hours in a Pilatus simulator, and 85 hours of night flight experience, 2.4 hours of which were in the Pilatus. The last flight in this digital record was logged on September 26, 2008, and the flight totals did not include his flight activity between that time and the accident flight. The pilot satisfactorily completed the Pilatus PC-12 NG initial course at SIMCOM Training Center on July 24, 2008.

AIRCRAFT INFORMATION

The accident airplane, a Pilatus PC-12/47E (serial number 1020), was manufactured in 2008. It was registered with the FAA on a standard airworthiness certificate for normal operations. The airplane was powered by a Pratt & Whitney Canada PT6A-67P turbo propeller engine rated at 1,200 shaft horsepower. The engine was equipped with a four-blade, Hartzell propeller (model number HC-E4A-3D, serial number KX596).

The airplane was registered to Gardner Leasing LLC, operated by the pilot, and was maintained under an annual inspection program. The airplane was new and had been registered on August 26, 2008. According to Safety Board estimates the airplane had flown 100 hours, between the time it was sold to the pilot and the accident, and had an estimated total airframe time of 130 hours. A review of the maintenance records revealed no maintenance had been performed since the sale of the airplane. The last maintenance performed was the installation of a cabin entertainment system. This maintenance was performed by Pilatus Business Aircraft in Broomfield, Colorado. The installation was completed on July 24, 2008, at an airframe total time of 27.6 hours.

METEOROLOGICAL CONDITIONS

The closest official weather observation station was Santa Fe Municipal Airport (SAF), located three nm south of the accident site. The elevation of the weather observation station was 6,348 feet msl. The routine aviation weather report (METAR) for SAF, issued at 2153, reported, winds, 120 degrees at 8 knots, visibility, 10 miles; sky condition, clear below 12,000 feet; temperature 16 degrees Celsius (C); dew point, zero degrees C; altimeter, 30.43 inches.

According to the United States Naval Observatory, Astronomical Applications Department Sun and Moon Data, the moon rose at 0719 on the day of the accident and set at 1847 the same day. The moon phase was "new moon" as of 0212 the day of the accident.

AIRPORT INFORMATION

Santa Fe Municipal Airport is a public airport located in Class D airspace. The airport is located nine miles southwest of Santa Fe, New Mexico, at 35 degrees, 37 minutes, 01.59 seconds north latitude and 106 degrees, 5 minutes, 21.9 seconds west longitude, at a surveyed elevation of 6,348 feet. The airport had three open runways at the time of the accident; runway 2/20 (8,342 feet by 150 feet, asphalt), runway 15/33 (6,307 feet by 100 feet, asphalt), and runway 10/28 (6,300 feet by 75 feet, asphalt). The control tower is open between the hours of 0700 and 2100. When the control tower is closed, the airspace reverts to Class E airspace.

WRECKAGE AND IMPACT INFORMATION

The accident site was located in rolling, sparsely vegetated terrain at an elevation of 6,347 feet msl. The initial impact point, as identified by the investigator in charge, was 3.2 miles north of the center point of the airport on a magnetic bearing of 352 degrees from the airport; just east of the extended centerline for runway 15 or 3,000 feet west of the last known radar position. The point consisted of a long narrow scar, measuring 23 feet in length, which extended to the initiation of the burn area. The scar was two feet at its widest point and blue paint chips consistent with a wing tip were located within the scar. Several ground scars followed the initial ground scar. A larger ground scar extended through the center of the burn area and measured ten feet in width and 70 feet in length.

The debris field extended from the initial impact point, 540 feet to the main wreckage on a bearing of 200 degrees. A large burn area was contained within the debris field. Components located within the debris path included the left landing gear assembly, torn metal and composite material, the fuselage door, three propeller blades, fragmented portions of the left wing, and aileron control rods from the right and left ailerons. Additional debris extended from the burn area to the main wreckage. Cabin components, charts, manuals, engine components, and various personal effects were located within this portion of the debris path.

The winglet from the left wing separated and was located at the north end of the burn area. The winglet exhibited lateral forward to aft scratching and scrape marks. The orientation of these scratch marks was consistent with a 46 degree bank angle to the left at impact. A portion of the left wing, measuring 55 inches in length, was located in the debris field. The leading edge was crushed and torn.

The right flap separated from the wing assembly and was located in the debris field. The flap was bent and wrinkled and exhibited exposure to heat and fire. The outboard portion of the right wing, including a portion of the aileron, was located on the eastern edge of the burn area. The wing section was 86 inches in length and exhibited exposure to heat and fire. The aileron control tubes were located within the debris field. Damage was consistent with impact damage.

The left flap assembly separated from the left wing assembly and came to rest on the southwest side of the burn area and was bent and wrinkled. Approximately 40 inches of the inboard side of the flap separated partially from the outboard portion along the rib line.

The inboard portion of the right wing separated from the fuselage and was located at the southeast end of the burn area. The landing gear assembly remained attached and appeared to

be in an extended position. The wing section was charred, melted, and partially consumed by fire.

The main wreckage, which consisted of the fuselage (cockpit, cabin, and instrument panel), empennage, and engine assembly, came to rest inverted, oriented on an approximate heading of east. The forward and center section of the fuselage, to include the instrument panel, cockpit area, and cabin, were destroyed by fire.

The empennage consisted of the horizontal and vertical stabilizers, right and left elevator, and rudder. The skin of the empennage, aft of the pressure bulkhead, was melted and exhibited exposure to heat and fire. The empennage and aft fuselage, forward of the pressure bulkhead, was destroyed by fire. The rudder control was deflected to the right and the bottom of the control was torn and exhibited exposure to heat and fire. The vertical stabilizer was unremarkable.

The left side of the horizontal stabilizer and elevator was bent down 36 inches outboard from the control surface root. The elevator skin was torn. The leading edge of the stabilizer was crushed aft, wrinkled, and torn. The right side of the horizontal stabilizer and elevator was bent down approximately 45 degrees, 14 inches outboard from the control surface root. The elevator was buckled at several points. The outboard 15 inches of both surfaces was folded under and inboard 180 degrees.

The rudder control cables were continuous from the forward cockpit (rudder pedals), aft to the bell crank at the rudder assembly. The elevator control cables were continuous from the forward fuselage, aft, to the elevator. The was continuous to both sides of the elevator.

The engine assembly remained partially attached to the remains of the forward fuselage. The engine accessories, controls, cables, and tubing exhibited exposure to heat and fire. The cowling was crushed and torn. The propeller assembly separated from the engine and came to rest east of the main wreckage. The spinner on the propeller assembly was crushed and torn and exhibited rotational crushing. Three of the four propeller blades separated from the assembly and were located in the debris field. The engine was cut in half along the gas generator case, under the supervision of the Safety Board IIC, at the "C" flange and internal rotational scoring was noted, consistent with power at the time of impact.

The blades were labeled "A", "B", "C", and "D" for identification purposes only. Blade A remained attached to the propeller at the hub, and exhibited slight S bending. The face of the blade exhibited 45 degree and 90 degree chordwise scratching. The leading edge of the blade was polished and the trailing edge was bent slightly, eight inches inboard from the blade tip. Blade B was located within the burn area and exhibited exposure to heat and fire. The outboard 13 inches of the blade had separated. Both sections of blade exhibited leading edge polishing and chordwise scratching along the face of the blade. Blade C, also located within the burn area, was bent aft at midspan and exhibited exposure to heat and fire. The blade exhibited leading edge polishing and 45 degree and 90 degree chordwise scratching on the blade face. Blade D was located within a bush in the debris field and exhibited exposure to heat and fire. The blade exhibited S bending and was bowed aft at midspan. The leading edge exhibited polishing and several nicks.

The yaw damper (rudder trim) was found deflected to the right (full left rudder). According to Pilatus the yaw damper is normally engaged shortly after departure and is left on until short final for landing. This trim position is consistent with the flight profile at the time of the

accident and is considered normal. The aileron trim jack screw measurement was consistent with slight left aileron trim. The pitch trim jack screw measurement was consistent with slight nose up trim. The flap actuator measurements for both the left and right flap were symmetrical and consistent with an intermediate position of four degrees.

Electronic components from the fuselage were recovered and retained for further examination.

MEDICAL AND PATHOLOGICAL INFORMATION

The autopsy was performed by the University of New Mexico - Health Science Center - Office of the Medical Examiner on October 1, 2008, as authorized by the Rio Arriba County Coroner's office. The autopsy report noted the cause of death as "massive bodily trauma." Under "Cardiovascular System," the report noted, in part, "The remaining small portion of the heart ... weighs 120 grams. ... the fragment appears to be that of the left ventricular free wall that has a 2.0 cm thickness. One segment of coronary artery can be identified that has approximately 25% atherosclerosis. ..."

At autopsy, specimens were collected for toxicological testing to be performed by the FAA's Civil Aerospace Medical Institute, Oklahoma City, Oklahoma (CAMI Reference #200800237001). Doxylamine and 0.664 ug/ml amphetamine were detected in the liver. Doxylamine and 0.495 ug/ml amphetamine were detected in the kidney. Tests for carbon monoxide and cyanide were not conducted. Tests for ethanol were negative.

A review of the pilot's airman medical records, maintained by the FAA Aerospace Medical Certification Division, and the pilot's medical records maintained by his psychiatrist, was conducted by the Safety Board medical officer. The psychiatrist's records documented that the pilot had a history of Attention Deficit Hyperactivity Disorder (ADHD) diagnosed in January of 2004 and treated with daily prescription amphetamines since that time. Amphetamines were prescribed as daily treatment options starting in January of 2004. Since December 2007, the pilot had been prescribed 70 mg of lisdexamfetamine to be taken every morning.

The pilot's most recent application for third class medical certification, dated July 27, 2007, noted "yes" for the use of medication. Lipitor (atorvastatin) was the only medication listed. The response "No" was indicated for "Mental disorders of any sort." Visits to medical professionals for the last three years did not mention the pilot's psychiatrist.

TESTS AND RESEARCH

The modular avionics unit (MAU) was recovered from the wreckage and taken to a Honeywell facility in Phoenix, Arizona, for further examination. The unit was examined under the auspices of the Safety Board on November 3, 2008. Due to exposure to heat and fire, the data chips were melted, preventing a successful download of any non-volatile memory.

The enhanced ground proximity warning system (EGPWS) Mark VI was recovered from the wreckage and shipped to a Honeywell facility in Redmond, Washington, for further examination. The unit was examined under the auspices of the Safety Board on December 4, 2008. Due to exposure to heat and fire, the data chips and resistors were melted and separated from the circuit board, preventing a successful download of any non-volatile memory.

One KTR 2280 navigation/communications unit, KSA 2700 digital servos, KMC 2210 display controller, KMA 29 audio panel, and KSG 7200 Air Data and Altitude Heading Reference

System (ADAHRS) units were all recovered from the wreckage and shipped to Honeywell in Olathe, Kansas, for further examination. On December 16 and 17, 2008, the units were examined under the auspices of an inspector with the FAA Flight Standards District Office, Kansas City, Missouri. The following conditions and information were noted:

The KTR 2280 navigation/communication unit functions were normal and within specifications. The fault log reflected the last power cycle from 2058:34 to 2216:27 or 78 minutes. According to Honeywell the source for the time entry is from the flight management system. The flight management system obtains its time stamp from the LGS 200 GPS sensor.

Non-volatile memory was successfully recovered from the KSA 2700 yaw servo. A communications fault was recorded 4,577 seconds (76 minutes) after power application on the accident flight. Due to a lack of date/time stamp on this data, the exact time of occurrence could not be determined. According to Honeywell's report, the "communication fault occurs when the clutch is engaged; therefore, either yaw damp or the autopilot was active. When a communication fault occurs, the autopilot will automatically disengage." An examination of the internal gear train revealed no anomalies.

Non-volatile memory was successfully recovered from the KSA 2700 pitch servo after the memory chips were removed and installed in a host unit. According to Honeywell's report a "stuck clutch fault occurred approximately 86 seconds after power application." Due to a lack of date/time stamp on this data, the exact time of occurrence could not be determined but is consistent with the start of the accident flight. This fault was cleared and no other anomalies were recorded during the flight. An examination of the internal gear train revealed no anomalies.

Due to exposure to heat and fire non-volatile memory was not recovered from the KSA 2700 digital servo or the KSG 7200 ADAHRS.

ADDITIONAL INFORMATION

Pilatus Night Landing Operations

According to Pilatus, performance and operating requirements and practices are outlined in Section 4 of their manual. Pilot familiarity with the airport, environment, and personal technique may vary. The chief pilot for Pilatus Business Aircraft stated that approximately 5 miles from the airport he will slow the airplane to 150 knots indicated airspeed and will extend 15 degrees of flaps. It is noted that maximum flap extension speed is 165 knots. When the airplane is abeam the touchdown point, he will initiate his final approach check which includes extending the landing gear (below 180 knots), flaps, and will adjust other systems as required. Flap positions greater than 30 degrees are to be extended at 130 knots or less.

Pilot Squawk List

The family provided the Safety Board IIC a copy of a "Squawk" list that the pilot had maintained on his personal computer. The squawk list contained various issues that the pilot had encountered with the first entry date of "8/3/08" and the last entry date of "9/25." The pilot described the anomaly, described his actions, and then described the results. Occasionally, the pilot would just describe the issue or anomaly. The pilot described issues with the ADAHRS, primary flight display, CAS, transponder, and fuel quantity. The exact time frame of each occurrence with relation to the progression of the flight was not always noted.

According to the family, the pilot spoke with an employee from "Pilatus" about these anomalies

and issues. The pilot was assured that nothing was "catastrophic" or "flight critical" and the pilot would be fine to wait until the next scheduled maintenance to have the issues addressed. The pilot purchased the airplane from Aviation Sales in Englewood, Colorado, which is a Pilatus service and sales center. According to a representative with Aviation Sales, the pilot had not scheduled maintenance for the airplane, nor had the pilot discussed or provided a list of anomalies and issues with any employee of Aviation Sales. Pilatus Business Aircraft Limited in Broomfield, Colorado, did not have any interaction with the pilot regarding the anomalies and issues outlined in the squawk list.

A copy of the squawk list was provided to representatives of Pilatus and Honeywell for their review. With only the squawk list available, they reviewed and evaluated each issue. In a report issued by Pilatus and Honeywell it was expressed that these issues described by the pilot were either not catastrophic or did not have any link to the accident.

History of Flight

Approach	Controlled flight into terr/obj (CFIT) (Defining event)
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Pilot Information

Certificate:	Private	Age:	54, Male
Airplane Rating(s):	Multi-engine Land; Single-engine Land	Seat Occupied:	Left
Other Aircraft Rating(s):	None	Restraint Used:	Seatbelt, Shoulder harness
Instrument Rating(s):	Airplane	Second Pilot Present:	No
Instructor Rating(s):	None	Toxicology Performed:	Yes
Medical Certification:	Class 3 With Waivers/Limitations	Last FAA Medical Exam:	07/01/2007
Occupational Pilot:	No	Last Flight Review or Equivalent:	07/24/2008
Flight Time:	2437 hours (Total, all aircraft), 86 hours (Total, this make and model), 2240 hours (Pilot In Command, all aircraft), 125 hours (Last 90 days, all aircraft), 54 hours (Last 30 days, all aircraft), 8 hours (Last 24 hours, all aircraft)		

Aircraft and Owner/Operator Information

Aircraft Make:	Pilatus	Registration:	N606SL
Model/Series:	PC-12/47E	Aircraft Category:	Airplane
Year of Manufacture:		Amateur Built:	No
Airworthiness Certificate:	Normal	Serial Number:	1020
Landing Gear Type:	Retractable - Tricycle	Seats:	8
Date/Type of Last Inspection:	07/24/2008,	Certified Max Gross Wt.:	10450 lbs
Time Since Last Inspection:		Engines:	1 Turbo Prop
Airframe Total Time:	130 Hours at time of accident	Engine Manufacturer:	Pratt and Whitney Canada
ELT:	Installed, activated, did not aid in locating accident	Engine Model/Series:	PT6A-67P
Registered Owner:	On file	Rated Power:	1200 hp
Operator:	On file	Operating Certificate(s) Held:	None

Meteorological Information and Flight Plan

Conditions at Accident Site:	Visual Conditions	Condition of Light:	Night/Dark
Observation Facility, Elevation:	SAF, 6348 ft msl	Distance from Accident Site:	3 Nautical Miles
Observation Time:	2153 MDT	Direction from Accident Site:	180°
Lowest Cloud Condition:	Clear	Visibility	10 Miles
Lowest Ceiling:	None	Visibility (RVR):	
Wind Speed/Gusts:	8 knots /	Turbulence Type Forecast/Actual:	/
Wind Direction:	120°	Turbulence Severity Forecast/Actual:	/
Altimeter Setting:	30.43 inches Hg	Temperature/Dew Point:	16° C / 0° C
Precipitation and Obscuration:			
Departure Point:	Lubbock, TX (LBB)	Type of Flight Plan Filed:	IFR
Destination:	Santa Fe, NM (SAF)	Type of Clearance:	None
Departure Time:	2115 MDT	Type of Airspace:	

Airport Information

Airport:	Santa Fe Municipal Airport (SAF)	Runway Surface Type:	
Airport Elevation:	6348 ft	Runway Surface Condition:	
Runway Used:	N/A	IFR Approach:	Visual
Runway Length/Width:		VFR Approach/Landing:	Full Stop; Traffic Pattern

Wreckage and Impact Information

Crew Injuries:	1 Fatal	Aircraft Damage:	Destroyed
Passenger Injuries:	N/A	Aircraft Fire:	On-Ground
Ground Injuries:	N/A	Aircraft Explosion:	None
Total Injuries:	1 Fatal	Latitude, Longitude:	35.661389, -106.088056

Administrative Information

Investigator In Charge (IIC):	Jennifer Rodi	Report Date:	09/30/2009
Additional Participating Persons:	John R Dewitt; FAA Flight Standards District Office; Albuquerque, NM Bob Renshaw; Pilatus; Broomfield, CO Konrad Oetiker; Pilatus Aircraft; Stans Switzerland, Eugene Torrisi; Pratt and Whitney Canada; Albuquerque, NM Paul Gipson; Honeywell Aerospace Electronic Systems; Phoenix, AZ Denis Deroy; Transportation Safety Board of Canada		
Publish Date:	09/30/2009		
Investigation Docket:	NTSB accident and incident dockets serve as permanent archival information for the NTSB's investigations. Dockets released prior to June 1, 2009 are publicly available from the NTSB's Record Management Division at pubinq@ntsb.gov , or at 800-877-6799. Dockets released after this date are available at http://dms.ntsbt.gov/pubdms/ .		

The National Transportation Safety Board (NTSB), established in 1967, is an independent federal agency mandated by Congress through the Independent Safety Board Act of 1974 to investigate transportation accidents, determine the probable causes of the accidents, issue safety recommendations, study transportation safety issues, and evaluate the safety effectiveness of government agencies involved in transportation. The NTSB makes public its actions and decisions through accident reports, safety studies, special investigation reports, safety recommendations, and statistical reviews.

The Independent Safety Board Act, as codified at 49 U.S.C. Section 1154(b), precludes the admission into evidence or use of any part of an NTSB report related to an incident or accident in a civil action for damages resulting from a matter mentioned in the report. A factual report that may be admissible under 49 U.S.C. § 1154(b) is available [here](#).