National Transportation Safety Board
Aviation Accident Final Report

Location:	Chignik Lake, Alaska	**Accident Number:**	ANC17FA021
Date & Time:	May 1, 2017, 13:50 Local	**Registration:**	N803TH
Aircraft:	Cessna 208B	**Aircraft Damage:**	Substantial
Defining Event:	VFR encounter with IMC	**Injuries:**	1 Fatal
Flight Conducted Under:	Part 135: Air taxi & commuter - Non-scheduled		

Analysis

The airline transport pilot was conducting a commercial visual flight rules (VFR) flight. A passenger who was on the first segment stated that the pilot flew the airplane lower than usual for that route, and that the airplane flew through clouds during the flight. The passenger disembarked and the pilot departed on the second segment of the flight with a load of mail. The route included flight across a peninsula of mountainous terrain to a remote coastal airport that lacked official weather reporting or instrument approach procedures. About 28 minutes after departure, an emergency locator transmitter (ELT) signal from the airplane was received and a search and rescue operation was initiated.

The wreckage was located about 24 miles from the destination in deep snow on the side of a steep, featureless mountain at an elevation about 3,000 ft mean sea level. The accident site displayed signatures consistent with impact during a left turn. Examination of the airplane revealed no evidence of mechanical malfunctions or anomalies that would have precluded normal operation. The airplane was not equipped with any recording or flight tracking devices, nor was it required to be; therefore, the airplane's flight track before the accident could not be determined. The airplane was certified for instrument flight and flight in icing conditions and was equipped with a terrain avoidance warning system (TAWS) which was not inhibited during the accident. Although the TAWS should have provided the pilot with alerts as the airplane neared the terrain, it could not be determined if this occurred or if the pilot heeded the alerts.

A review of nearby weather camera images revealed complete mountain obscuration conditions with likely rain shower activity in the vicinity of the accident site. Visible and infrared satellite imagery indicated overcast cloud cover over the accident site at the time of the accident. The graphical forecast products that were available to the pilot before the flight indicated marginal VFR conditions for the entire route. There was no evidence that the pilot obtained an official weather briefing, and what weather information he may have accessed before the flight could not be determined. Additionally, the cloud conditions and snow-covered terrain present in the area likely resulted in flat light conditions, which would have hindered the pilot's ability to perceive terrain features and closure rates. Based on the weather camera, surface, and upper air observations, it is likely that the pilot encountered instrument

meteorological conditions inflight, after which he performed a left turn to return to visual meteorological conditions and did not recognize his proximity to the mountain due to the flat light conditions.

The pilot and the dispatch agent signed a company flight risk assessment form before the flight, which showed that the weather conditions for the flight were within the company's acceptable risk parameters. Although the village agents at the departure and destination airports stated that the weather at those coastal locations was good, the weather assessment for the accident flight was based on hours-old observations provided by a village agent who was not trained in weather observation and did not include en route weather information, the area forecast, or the AIRMET for mountain obscuration effective during the dispatch time and at the time of the accident. Since acquiring the accident route from another operator years earlier, the company had not performed a risk assessment of the route and its associated hazards. Multiple company pilots described the accident route of flight as hazardous and considered it an undesirable route due to the terrain, rapidly changing weather, and lack of weather reporting infrastructure; however, the company did not address or attempt to mitigate these known hazards through its risk assessment processes.

The company's controlled-flight-into-terrain (CFIT)-avoidance program stated that each pilot shall have one classroom training session and one CFIT-avoidance training session in an aviation training device (ATD) each year; however, the pilot's training records indicated that his most recent ATD session was 15 months prior. More recent CFIT avoidance training may have resulted in the pilot recognizing and responding to the reduced visibility and flat light conditions sooner.

Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be: The pilot's continued visual flight rules flight into an area of mountainous terrain and instrument meteorological conditions, which resulted in controlled flight into terrain (CFIT). Contributing to the accident was the company's failure to provide the pilot with CFIT-avoidance recurrent simulator training as required by their CFIT avoidance program and the company's inadequate flight risk assessment processes, which did not account for the known weather hazards relevant to the accident route of flight.

Findings

Personnel issues	Decision making/judgment - Pilot
Environmental issues	Low visibility - Decision related to condition
Environmental issues	Mountainous/hilly terrain - Decision related to condition
Personnel issues	Aircraft control - Pilot
Organizational issues	Recurrent training - Operator
Organizational issues	Adequacy of safety program - Operator
Organizational issues	Adequacy of policy/proc - Operator

Factual Information

History of Flight

Enroute	VFR encounter with IMC (Defining event)
Enroute	Loss of visual reference
Maneuvering	Controlled flight into terr/obj (CFIT)

On May 1, 2017, about 1350 Alaska daylight time, a Cessna 208B airplane, N803TH, sustained substantial damage after impacting steep, mountainous terrain near Chignik Lake, Alaska. The airline transport pilot was fatally injured. The airplane was operated by Grant Aviation, Inc., as a Title 14 *Code of Federal Regulations (CFR)* Part 135 non-scheduled mail contract flight. Instrument meteorological conditions (IMC) existed at the accident site and company flight following procedures were in effect for the visual flight rules flight, which departed Port Heiden Airport (PAPH), Port Heiden, Alaska, at 1325, destined for Perryville Airport (PAPE), Perryville, Alaska.

The pilot's flight and duty records indicated that he reported for duty about 0800 the morning of the accident. The pilot was scheduled for a six-segment route the day of the accident, originating from King Salmon Airport (PAKN), King Salmon, Alaska; the accident occurred on the second segment. The flight departed on the first segment at 1215 and proceeded to PAPH, arriving at 1313 with one passenger, who disembarked at PAPH. The passenger, who was a private pilot who often flew on Grant Aviation flights, reported that the pilot flew the segment lower than usual due to low clouds and that the pilot flew through clouds during the flight. The village agent who assisted the pilot on the ground stated that he appeared to be in good spirits. The airplane departed PAPH at 1325. The destination airport was about 80 miles south and located in a remote coastal area that did not have official weather reporting or instrument approaches available. The route required crossing the Aleutian Peninsula and mountainous terrain with elevations between 2,900 ft and 4,600 ft. The airplane's route of flight during this segment could not be determined as the area was not covered by radar service and the airplane was not equipped with tracking equipment.

At 1353, the Grant Aviation director of operations (DO) was notified that the US Coast Guard had received a 406-MHz emergency locator transmitter (ELT) signal from the accident airplane. The DO initiated the company's overdue aircraft procedures.

The wreckage was located at 1730 about 24 miles northeast of PAPE on a steep, snow-covered mountain. A rescue crewman was hoisted down to the site and determined that the pilot, who was inside the cockpit and strapped in his seat, had received fatal injuries. See figures 1 and 2.

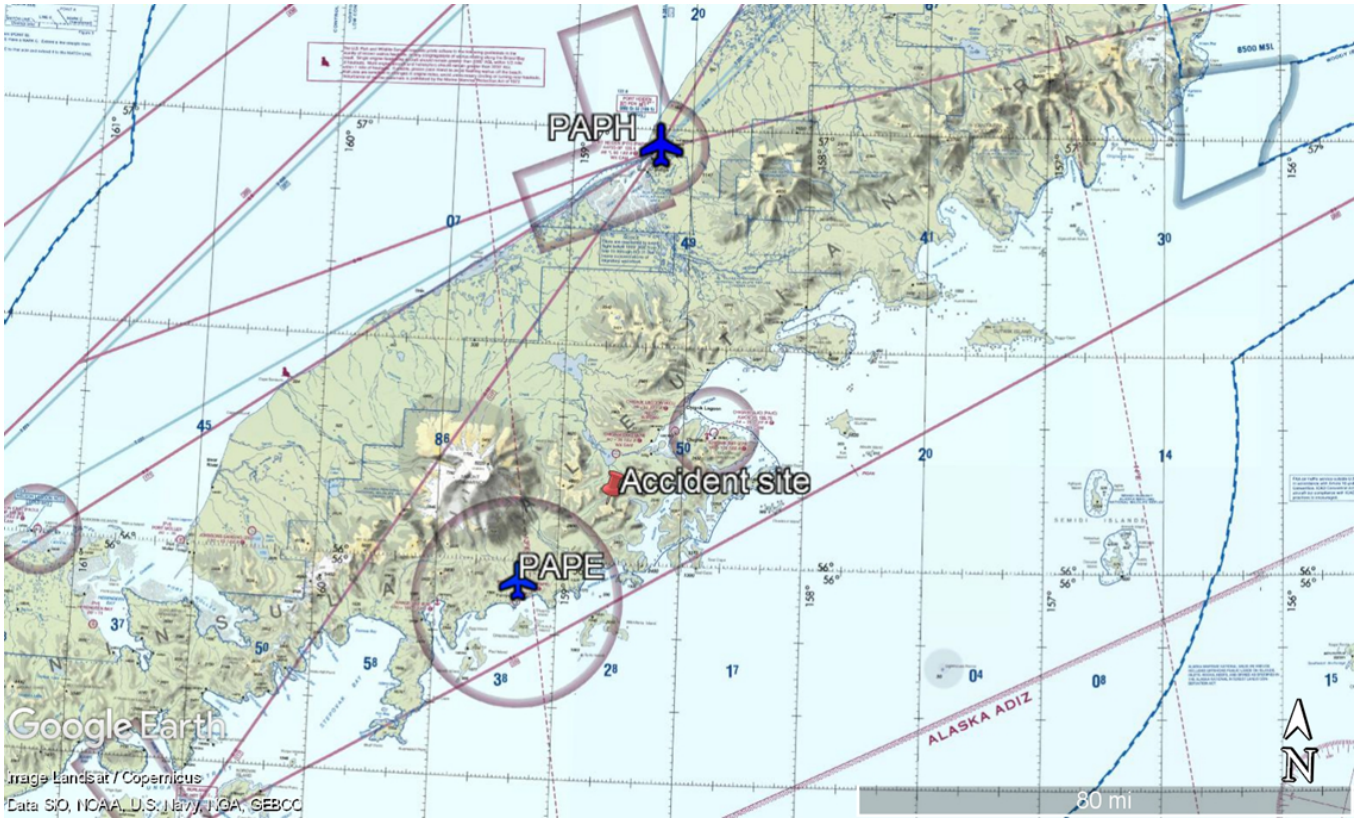

Figure 1. VFR Sectional chart with the accident site indicated.

Figure 2. Accident site.

Pilot Information

Certificate:	Airline transport; Flight instructor; Foreign	**Age:**	54,Male
Airplane Rating(s):	Single-engine land; Single-engine sea; Multi-engine land	**Seat Occupied:**	Left
Other Aircraft Rating(s):	Glider	**Restraint Used:**	5-point
Instrument Rating(s):	Airplane	**Second Pilot Present:**	No
Instructor Rating(s):	Airplane multi-engine; Airplane single-engine; Glider; Instrument airplane	**Toxicology Performed:**	Yes
Medical Certification:	Class 2 With waivers/limitations	**Last FAA Medical Exam:**	March 13, 2017
Occupational Pilot:	Yes	**Last Flight Review or Equivalent:**	
Flight Time:	4989 hours (Total, all aircraft), 904 hours (Total, this make and model), 4390 hours (Pilot In Command, all aircraft), 134 hours (Last 90 days, all aircraft), 87 hours (Last 30 days, all aircraft), 3 hours (Last 24 hours, all aircraft)		

The pilot, age 54, held an airline transport pilot certificate with an airplane multi-engine land rating and commercial privileges for airplane single-engine land and sea and glider. He held a flight instructor certificate for airplane single-engine and multi-engine, instrument airplane, and glider. Company

training records indicated that he had accumulated 4,989 hours of flight experience with over 904 hours in Cessna 208B airplanes. His most recent Federal Aviation Administration (FAA) second-class airman medical certificate was issued on March 13, 2017, with the limitation that he must wear corrective lenses. The pilot's personal logbooks were not located.

A review of company personnel records indicated that the pilot completed initial company training and was assigned as pilot-in-command (PIC) on the Cessna 207 on October 16, 2014. He was assigned PIC in the Gipps Aero GA-8 airplane on May 19, 2015. He completed initial Cessna 208B training and check rides on March 3, 2016 and was subsequently assigned as PIC in the Cessna 208B.

The pilot completed his most recent required proficiency check in the Cessna 208B on April 9, 2017. The flight included an instrument proficiency check and a line check. He completed recurrent ground training, which included controlled flight into terrain (CFIT) avoidance computer based training, on November 19, 2016. His most recent CFIT avoidance simulator training was completed on January 31, 2016.

A review of company flight and duty records revealed that the pilot had accumulated 87.6 flight hours in the previous month, of which 73.5 were accumulated during the previous 2 weeks while based at King Salmon. He had no flights scheduled the day before the accident. He flew the accident flight route on 9 of the previous 10 days.

Aircraft and Owner/Operator Information

Aircraft Make:	Cessna	**Registration:**	N803TH
Model/Series:	208B	**Aircraft Category:**	Airplane
Year of Manufacture:	1992	**Amateur Built:**	
Airworthiness Certificate:	Normal	**Serial Number:**	208B0321
Landing Gear Type:	Tricycle	**Seats:**	9
Date/Type of Last Inspection:	April 21, 2017 AAIP	**Certified Max Gross Wt.:**	9062 lbs
Time Since Last Inspection:	40 Hrs	**Engines:**	1 Turbo prop
Airframe Total Time:	17990.7 Hrs at time of accident	**Engine Manufacturer:**	Pratt & Whitney Canada
ELT:	C126 installed, activated, aided in locating accident	**Engine Model/Series:**	PT6A -114A
Registered Owner:		**Rated Power:**	675 Horsepower
Operator:		**Operating Certificate(s) Held:**	Commuter air carrier (135), On-demand air taxi (135)
Operator Does Business As:		**Operator Designator Code:**	ENHA

The accident airplane was manufactured in 1992. At the time of the accident, the airplane had accumulated 17,990.7 total flight hours and was maintained under an approved inspection program. The most recent inspection of the airframe and engine was completed on April 21, 2017.

The airplane was equipped with a Pratt & Whitney PT6A-114A turbine engine rated at 675 shaft horsepower. The engine had a total time in service of 13,120.1 hours; 2,882.3 hours had elapsed since the last overhaul. The propeller was a McCauley model 3GF34C703-B.

The airplane was equipped for instrument flight and flight into icing conditions and was certified for single-pilot operation. The airplane was equipped with a Garmin GNS 530 navigation system with integrated class B terrain awareness and warning system (TAWS) with visual and aural terrain alerts. A TAWS inhibit switch and TAWS inhibit light were included in the system. The Garmin GNS 530 does not retain memory.

The airplane was not equipped with automatic dependent surveillance-broadcast (ADS-B) equipment, flight tracking equipment, a flight data recorder, or a cockpit voice recorder. There was no regulatory requirement for this equipment to be installed.

A review of the aircraft logbook revealed that the company had been monitoring a reoccurring chip detector light. The chip detector light illuminated in flight on three occasions in February. Each time, small slivers of fuzz material were found on the accessories gearbox (AGB) magnetic chip detector. An oil sample analysis was conducted by an external laboratory, and a report dated March 31, 2017, stated that trace metallic elements were consistent with alloy steel flakes similar to AMS6260 or AMS6265, which is an alloy used for gears in the engine.

The pilot's flight log for the accident flight indicated a load of 1,322 lbs of mail, a takeoff weight of 8,100 lbs, and a center of gravity of 200.5 inches.

Meteorological Information and Flight Plan

Conditions at Accident Site:	Instrument (IMC)	**Condition of Light:**	Day
Observation Facility, Elevation:	PAJC,18 ft msl	**Distance from Accident Site:**	18 Nautical Miles
Observation Time:	20:39 Local	**Direction from Accident Site:**	54°
Lowest Cloud Condition:		**Visibility**	10 miles
Lowest Ceiling:	Overcast / 1700 ft AGL	**Visibility (RVR):**	
Wind Speed/Gusts:	/	**Turbulence Type Forecast/Actual:**	/
Wind Direction:		**Turbulence Severity Forecast/Actual:**	/
Altimeter Setting:	29.51 inches Hg	**Temperature/Dew Point:**	4°C / 2°C
Precipitation and Obscuration:			
Departure Point:	PORT HEIDEN, AK (PTH)	**Type of Flight Plan Filed:**	Company VFR
Destination:	PERRYVILLE, AK (PEV)	**Type of Clearance:**	None
Departure Time:		**Type of Airspace:**	Class G

At the time of the accident, an AIRMET valid for the accident site forecast mountain obscuration conditions due to clouds and precipitation. The area forecast issued at 1214 predicted scattered clouds at 2,000 ft above ground level (agl) and broken ceilings at 2,000 ft and 5,000 ft with tops to 10,000 ft. The

ceiling was forecast to be occasionally at 2,000 ft with isolated light rain showers and a freezing level at 1,500 ft. No turbulence or icing conditions were forecast. The Alaska Aviation Weather Unit flying weather graphic valid during the accident flight indicated marginal visual flight rules (VFR) conditions for the route of flight.

The nearest official weather reporting station was Chignik Airport (PAJC), located about 18 miles northeast of the accident site. At 1239, an aviation special weather report reported variable wind at 4 knots; 10 statute miles visibility; light rain; overcast clouds at 1,700 ft; temperature 39°F, dewpoint 36°F; and an altimeter setting of 29.51 inches of mercury.

The visible and infrared data from the Geostationary Operational Environmental Satellite number 15 (GOES-15) at 1300 indicated an overcast layer with mountain obscuration likely and cloud tops at 9,000 ft.

FAA weather camera images from Chignik Lake, about 7 miles north-northeast of the accident site at an elevation of 45 ft, revealed ceilings between 900 ft mean sea level (msl) and 2,700 ft msl, with forward visibilities between 1.5 and 5 miles in the vicinity of the accident site around the accident time (see figure 3). The images further suggest that mountain obscuration conditions prevailed with likely rain shower activity.

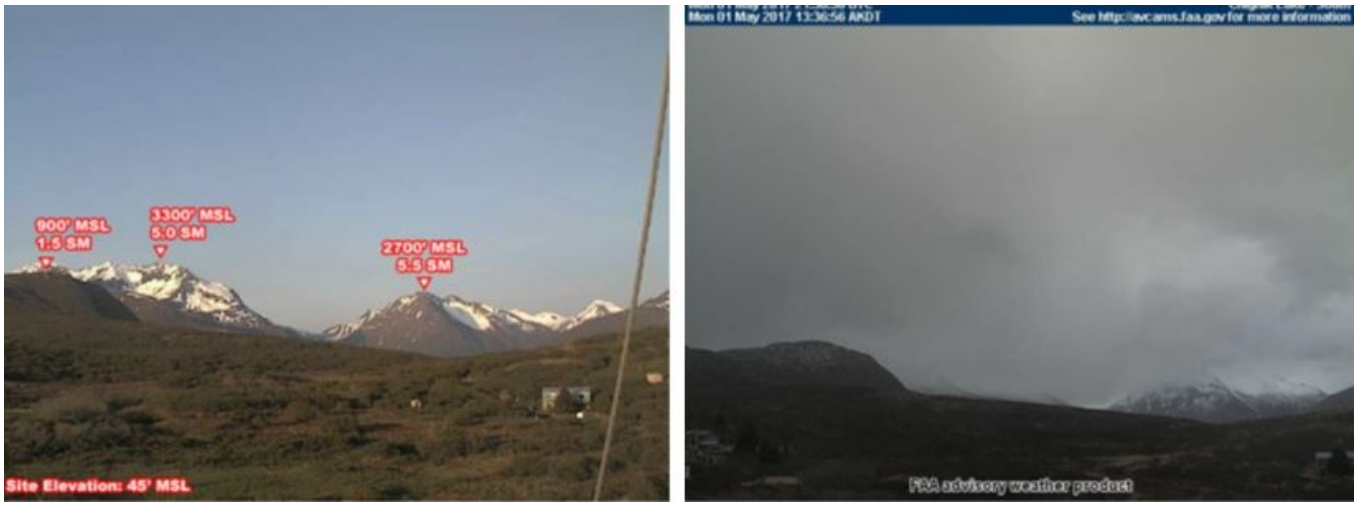

Figure 3. South-facing Chignik Lake FAA weather camera image on a clear day (left) and before the accident at 1347 (right).

The PAPE village agent stated that the weather at PAPE was generally good on the day of the accident. She was not a trained weather observer, but she had been observing weather in the area for over 10 years and knew how to estimate ceilings and visibility distances based on surrounding landmarks. She recalled that, while she was waiting on the airplane to arrive, the clouds were 3,000 ft scattered and visibility was

10 miles. She could see north over the pass to Chignik, which meant the ceiling was at least 2,500 ft in the mountain pass. She stated that the accident pilot did not call her for a weather observation update.

The dispatch agent on duty recorded airport weather information on a company form at intervals throughout the accident day. The PAPE weather entry, provided by the village agent at 1021, indicated winds from the east at 10 knots, 10 miles visibility, and an overcast ceiling of 3,500 ft. That was the sole entry for PAPE for the day, even though the flight was due to arrive at 1350. According to the dispatch agent's statement, she did not talk to the pilot or verbally provide any updates to him during the flight. The dispatch agent stated that she used the FAA Alaska weather camera website and village agent observations to document the weather for the flight.

The company's General Operating Manual, page 12-5, indicated that if official weather was not available, "personal observation or other persons competent to supply appropriate observations" were permitted.

A search of official weather briefing sources, such as Lockheed Martin Flight Service and Direct User Access Terminal Service, indicated that the accident pilot did not request an official weather briefing before the flight.

Wreckage and Impact Information

Crew Injuries:	1 Fatal	**Aircraft Damage:**	Substantial
Passenger Injuries:		**Aircraft Fire:**	None
Ground Injuries:	N/A	**Aircraft Explosion:**	None
Total Injuries:	1 Fatal	**Latitude, Longitude:**	56.140277,-158.804992(est)

On May 4, 2017, the Alaska State Troopers coordinated a recovery mission with members of the Alaska Mountain Rescue Group. The National Transportation Safety Board (NTSB) did not travel to the site due to the remote location and hazardous terrain.

According to information and photographs provided by the recovery crew, the wreckage came to rest in deep snow about 2,993 ft msl on the west face of a steep, featureless mountain in the Alaska Peninsula National Wildlife Refuge. It was located about 500 ft from the top of the mountain ridge and partially submerged in the snow on its left side with the nose section under the snowpack (see figure 4). The fragmented wreckage was contained in an area about 100 ft long by 35 ft wide, on a heading of about 031° true, with the right wing separated and located about 40 ft forward of the main wreckage and a trail of debris about 30 ft behind the empennage. The initial impact area was indicated by a narrow, 30-ft-long curved indentation in the snow about 65 ft behind the wreckage, indicative of a wing tip strike.

Figure 4. Aerial photograph of N803TH wreckage resting on left side of fuselage with nose under the snow pack (courtesy of the Alaska Mountain Rescue Group)

A postrecovery examination revealed structural damage to the area of the fuselage between the wing spar connections, a large hole and extensive buckling on the left side of the fuselage cabin and buckling on the left rear fuselage. The forward fuselage and cockpit were separated during recovery and exhibited fractures and inward compression deformations in the structure.

The right wing separated from the fuselage inboard of the wing attachment points with a section of the fuselage attached and spar deformation in a forward direction. The left wing exhibited separation at the forward attachment point with rearward overload tension signatures and compression buckling at the inboard trailing edge. The empennage was intact.

The flight controls were continuous from the cockpit to the flight control surfaces with the exception of the aileron cables, which were found separated and exhibited overload signatures.

The deice boots were intact with the exception of impact tears.

The propeller blades were each secure in the hub and exhibited trailing edge S-bending signatures consistent with engine power at the time of impact. The propeller shaft was fractured and separated from the engine and exhibited overload signatures.

The engine exhibited moderate impact damage to the exhaust duct, reduction gear box (RGB), the gas

generator case, and the accessory gearbox (AGB). The power and compressor rotors rotated without noise. The compressor turbine disk and power turbine vane and disk exhibited circumferential rubbing marks. Contact marks were found between RGB first and second stage carriers, which are indicators of engine power at impact. Both magnetic chip detectors showed fuzz material on the poles. The No. 3 and 4 bearings oil scavenge pump showed severe scoring marks into the housing and on the pump gears' tips. The RGB oil scavenge pump showed similar light scoring marks and metal debris. The oil sump contained a small crushed plastic cap that was deformed in a manner that corresponded to the size and shape of the oil pump gear tips. The cap likely passed through the oil scavenge system and came to rest in the sump. Oil was present throughout the system.

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

Additional Information

CFIT Manual

Grant's CFIT Avoidance Manual defined CFIT as, "when an airworthy aircraft under the control of the flight crew is flown unintentionally into terrain, obstacles or water, usually with no prior awareness by the crew."

Flat Light

Flat light was defined in Grant's CFIT Avoidance Manual as "an optical illusion that causes pilots to lose their depth-of-field and contrast vision. It is usually accompanied by overcast skies inhibiting any good visual clues. …occur primarily in snow covered areas. Flat light can completely obscure features of the terrain, creating an inability to distinguish distances and closure rates." Company policy stated that VFR flight in flat light conditions was allowed provided the pilot recognized the conditions and increased minimum flight altitude to 2,000 ft above the highest obstacle within a horizontal distance of 5 miles if operating over mountainous terrain. Pilots also had the option of obtaining IFR clearance and continuing the flight.

Deteriorating Flight Visibility

Deteriorating flight visibility was defined in Grant's CFIT Avoidance Manual as "the reduction of forward horizontal distance due to weather phenomena, such as rain, snow, fog, clouds, blowing snow, mist, virga, dust, or any other conditions that would reduce the pilot's ability to see from the cockpit."

The CFIT avoidance manual stated on page 2-4 that "it is Grant Aviation's policy that pilots operating in deteriorating visibility under VFR can continue to do so as long as the minimum ceiling and visibility requirements for VFR flight are observed. At any point during the flight if the minimum ceiling and visibility requirements for VFR flight are no longer observed pilots shall "refer solely to their instruments and ensure they have adequate ground clearance. Once stabilized they shall execute a stabilized altitude course reversal with a standard rate turn away from obstructions and rising terrain and divert to more favorable VFR conditions. Those pilots and aircraft that are capable of IFR flight have the

option of obtaining an IFR clearance…"

Medical and Pathological Information

The Alaska State Medical Examiner, Anchorage, Alaska, conducted an autopsy of the pilot. The cause of death was attributed to multiple blunt force injuries. Toxicology testing performed at the FAA Forensic Sciences Laboratory was negative for drugs and alcohol.

Tests and Research

The airplane's Garmin GNS 530W GPS receiver had two memory cards that were removed and read on a surrogate unit at the NTSB vehicle recorder laboratory. The aviation database on each was found to be valid from April 27, 2017 to May 25, 2017.

The TAWS inhibit switch was found in the neutral (off) position. The TAWS inhibit warning light and the reset switch were removed from the instrument panel and evaluated at the NTSB materials laboratory. Electrical continuity was established for the system and the reset switch functioned normally. Radiographic examination of the light bulb filament did not reveal evidence of stretching of the filament coil, suggesting that the light was not illuminated during impact.

Organizational and Management Information

Grant Aviation, Inc., is a 14 *CFR* Part 135 air carrier that holds on-demand and commuter operations specifications. The company headquarters are located at Ted Stevens Anchorage International Airport, Anchorage, Alaska. At the time of the accident, Grant operated 31 aircraft at 8 primary bases within the state of Alaska.

CFIT Avoidance Program

The company implemented a CFIT-avoidance training program in partnership with the Medallion Foundation. The program manual contained policies and procedures for flat-light conditions, white-out conditions, deteriorating visibility, estimating in-flight visibility, transitioning from deteriorating visual meteorological conditions to IMC, flying on unfamiliar routes and to unfamiliar airports or landing areas, and instrument approaches. The company DO had authority for the program, and the company chief pilot had responsibility of administering the program. The program was voluntary and administered outside of regulatory requirements; therefore, the FAA did not provide oversight of the training.

The CFIT-avoidance training program stated that each pilot shall have one classroom training session and one CFIT- avoidance session in an aviation training device (ATD) each year; however, the pilot's training records indicated that his most recent ATD session was 15 months before the accident.

Operational Control Program and Flight Risk Assessment

Grant Aviation implemented a Medallion Foundation Shield Operational Control program. (The Medallion Foundation was a non-profit organization with a core mission of reducing aviation accidents in Alaska. It operated between 2002 and 2019.) The Operational Control Manual stated, "this program has been incorporated into Grant Aviation's operations for the purpose of educating and instructing applicable personnel on the requirements of operational control, implementing a system that identifies risks and associated hazards of flight operations, requires shared decisions for dispatching of all flights, and monitoring of all flight to ensure safe and efficient flight operations."

The accident pilot and dispatch agent each shared the decision to dispatch the flight. The dispatch agent performed a risk assessment of the landing areas and provided that assessment to the pilot. The pilot's procedures were to consider his qualifications, physical and emotional state, ceiling and visibility, wind, equipment, and time of day. According to the flight dispatch documents, the weather information used for the risk assessment process was almost 2 hours old and only provided landing area assessments for some of the destinations on the planned route of flight. Both the pilot and the dispatch agent signed the Flight Risk Assessment for the flight that indicated a "2 yellow" value, which was acceptable.

The risk assessment process did not consider the en route portion of the flight, such as terrain hazards or area weather hazards such as AIRMETs. The VFR weather minimums used by the company were 500 ft ceiling and 2 statute miles visibility, regardless of the terrain or weather reporting infrastructure.

Multiple company pilots stated during interviews that it was well-known that flying down the Alaska peninsula was very hazardous and pilots considered it an undesirable route due to the terrain, rapidly changing weather, and lack of weather reporting infrastructure. The DO stated during an interview that the accident flight route was acquired from another company about 3 years before, but Grant never performed a broad risk assessment of the route.

Safety Program

The company had a Medallion Foundation safety program and manual. The safety officer was responsible for administering the program, which consisted primarily of a hazard reporting structure, risk assessment process, reports and routine safety committee meetings to address the reports. One of the goals of the program was to identify hazards that are unknown, unseen, or previously ignored in the workplace before an accident or incident occurs. The director of safety was responsible for ensuring that the tasks or functions of the safety program were successfully accomplished, including company safety meetings, audits, employee communication, hazard and risk analysis, and scheduling required training. The program was reactive and responded to inputs from employees, rather than a proactive safety risk management model that would be present in a robust safety management system (SMS). According to the DO, the safety officer position had been vacant since February. The DO assumed the safety officer duties after the accident.

Administrative Information

Investigator In Charge (IIC):	Price, Noreen
Additional Participating Persons:	Ryan Brinkman; Federal Aviation Administration; Anchorage, AK Austin Engebretson; Grant Aviation Inc.; Anchorage, AK Marc Gratton; Pratt and Whitney Canada Corp.; Montreal Henry Soderland; Textron Aviation; Witchita, KS Dan Knesek; Grant Aviation Inc.; Anchorage, AK
Original Publish Date:	April 13, 2020
Note:	The NTSB did not travel to the scene of this accident.
Investigation Docket:	https://data.ntsb.gov/Docket?ProjectID=95089