



# National Transportation Safety Board Aviation Accident Final Report

---

<b>Location:</b>	MONTAGUE ISLAND, AK	<b>Accident Number:</b>	ANC93FA012
<b>Date &amp; Time:</b>	11/06/1992, 1620 AST	<b>Registration:</b>	N1686U
<b>Aircraft:</b>	CESSNA 207	<b>Aircraft Damage:</b>	Destroyed
<b>Defining Event:</b>		<b>Injuries:</b>	2 Fatal
<b>Flight Conducted Under:</b>	Part 135: Air Taxi & Commuter - Non-scheduled		

---

## Analysis

THIS WAS 1 OF 2 COMPANY AIRPLANES THAT HAD LANDED ON A BEACH TO PICK UP HUNTERS FOR A RETURN TRIP TO SEWARD. THE OTHER AIRPLANE, A CESSNA 206, WAS FLOWN BY THE COMPANY CHIEF PILOT. THE WITNESSES IN THE CESSNA 206 SAID THAT THE ACCIDENT AIRPLANE TOOK OFF 5 MIN BEFORE THEIR CESSNA 206 AND 'DISAPPEARED INTO THE WEATHER AND WAS NEVER SEEN AGAIN.' THEY DESCRIBED THE WEATHER AT THE BAY & ALONG THE ROUTE TO SEWARD TO BE 400-600 FT CEILINGS & VISIBILITY APRX 1 MI IN FOG. THE WRECKAGE WAS LOCATED 6 MI WEST OF THE TAKEOFF POINT AT AN ELEVATION OF 1,000 FT IN MOUNTAINOUS TERRAIN.

## Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be: THE PILOT'S INTENTIONAL VFR DEPARTURE INTO INSTRUMENT METEOROLOGICAL CONDITIONS, AND THE COMPANY CHIEF PILOT'S FAILURE TO EXERCISE ADEQUATE SUPERVISION. THE WEATHER CONDITIONS WERE FACTORS IN THE ACCIDENT.

## Findings

---

Occurrence #1: IN FLIGHT COLLISION WITH TERRAIN/WATER  
Phase of Operation: CRUISE

### Findings

1. (F) WEATHER CONDITION - OBSCURATION
2. (F) WEATHER CONDITION - LOW CEILING
3. (F) WEATHER CONDITION - FOG
4. (C) VFR FLIGHT INTO IMC - INITIATED - PILOT IN COMMAND
5. (C) SUPERVISION - INADEQUATE - COMPANY/OPERATOR MANAGEMENT
6. TERRAIN CONDITION - MOUNTAINOUS/HILLY

## Factual Information

### HISTORY OF FLIGHT

On November 6, 1992, at approximately 1620 Alaska standard time, a wheel equipped Cessna 207 airplane, N1686U, operated by Trail Lake Flying Service, d.b.a. Harbor Air Service of Seward, Alaska, collided with terrain on Montague Island, located about 75 miles southwest of Seward. The airline transport pilot and one passenger were fatally injured, and the airplane was destroyed. The flight had originated at Seward to pick up hunters at Patton Bay, located on Montague Island and had arrived on the beach to coincide with low tide at approximately 1545. The accident airplane and another Harbor Air Service airplane, a Cessna 206 airplane, N999Z, flown by the company chief pilot, Captain Joe Holland, departed at approximately 1615, that airplane having arrived in Seward at 1700.

The accident airplane's emergency locator transmitter (ELT) alerted search and rescue authorities. Aircraft (SAR) from the Coast Guard located the wreckage at approximately 2300 that evening and confirmed that the occupants had received fatal injuries.

The unscheduled domestic passenger flight was operating under 14 CFR Part 135 when the accident occurred. Witnesses described the weather at the time of the flights to be instrument meteorological conditions. A company VFR flight plan was in effect at the time.

Passengers in the Cessna 206, N999Z, told the NTSB that there were four hunters in a party which had chartered Harbor Air to fly them to and from Montague Island. Two airplanes, a Harbor Air Cessna 206 and the accident Cessna 207, landed on the beach at North Patton Bay and the pilots decided to load the deer meat and supplies and one passenger in the 207 and three passengers and a rifle and a pack in the Cessna 206. These witnesses said that the accident airplane took off five minutes before their Cessna 206 and "disappeared into the weather and was never seen again."

Passengers in the Cessna 206 also provided statements to the NTSB that described the weather at Patten Bay and along the route from Montague Island to Seward to be ceilings 400 to 600 feet and visibility approximately 1 mile in fog, with wind 10 to 20 knots and higher gusts.

The wreckage of the Cessna 207 was located at approximately the 1000 foot elevation, 6 miles west of the north Patton Bay takeoff location.

The NTSB investigative team reached the site on Sunday, November 8, 1992 by Coast Guard helicopter. Investigative assistance to the NTSB was provided by members of the Coast Guard, Alaska State Troopers (AST) and the Federal Aviation Administration (FAA).

### INJURIES TO PERSONS

The pilot and the passenger, as sole persons on board received fatal injuries.

### DAMAGE TO AIRCRAFT

The Cessna 207 was destroyed by impact forces. There was no fire.

### PERSONNEL INFORMATION

John R. Katelnikoff, Pilot-in-Command

Captain John Russell Katelnikoff, a native of Kodiak, Alaska, had been employed, as reported by the operator, since approximately June of 1992, and, according to the operator, had been a

pilot previously for the operator during the summer flying season in 1989.

The investigation was unable to document any personal pilot flight time records. No pilot logs were produced for the investigation.

Records provided by the FAA indicated that at the time of the pilot's most recent medical examination, dated June 19, 1992, (First Class FAA Medical Certificate), the pilot stated that he was unemployed as of June 19, 1992.

A review of pilot medical records indicate that in August of 1977 he listed himself as a private pilot employed by "Kodiak Western" with 60 hours of pilot time in the position of "cargo".

In August (8/29/78) of 1978, he stated to a medical examiner that he had a commercial pilot's certificate and 330 flight hours and had been in the "present occupation" with Kodiak Western for "2 and 1/2 years."

Captain Fred Ball, director of Kodiak Area Peninsula Air operations, and former chief pilot for Kodiak Western told the NTSB in an interview on November 16, 1992, that he "had to let him (the accident pilot) go in 1980 after an accident down at Karluk (an airstrip near Karluk Lake on Kodiak Island). He described an accident in a Cessna 207 that was a result of an overloading and a takeoff crash. The former chief pilot told the NTSB that he had instructed Katelnikoff to carry only 2 passengers, however the pilot boarded 4 passengers and cargo, crashing on takeoff. He said that the pilot broke his nose in the accident.

FAA medical records indicate that the accident pilot had a scar on the bridge of his nose.

There are no records of application for medical certificates between 9/3/80 and 3/12/87. On the 3/12/87 application he gave his employer as "not applicable." No records were found by investigators to indicate the pilot had flown during the period of 1981 through 1986.

On February 11, 1988, the accident pilot applied for an annual medical certificate and listed his occupation as "commercial pilot" and his employer as the "Anchorage Times for 1 year." The NTSB interviewed former management officials with the Anchorage Times (Messrs Jenkins and Tobin) and they stated that they did not recall an employee named Katelnikoff and to their knowledge never employed a pilot.

On April 5, 1989, the accident pilot applied for an FAA annual medical certificate and listed his occupation as "commercial pilot" with Northern Air Cargo for "14 months." The NTSB was told by the Northern Air Cargo chief pilot's office on November 1, 1993, that they had no record of employing a pilot named Katelnikoff, and did not recall the name in any other capacity.

In an interview with (Mrs.) Linda K. Pflieger, the vice president of Trail Lake Flying Service, d.b.a. Harbor Air Service, on 11/7/92, the NTSB and FAA was told that "John (Katelnikoff) worked for us during the summer of 1989 and then left to fly in Kodiak."

Between 1987 and April 18, 1990, the pilot listed his total pilot time to have increased from 2300 to 3012 hours. In an application for medical certificate renewal on April 18, 1990, Mr. Katelnikoff listed his occupation as "pilot" for Peninsula Airways (Kodiak, Alaska) with a start date as May 5, 1990. Peninsula Airways confirmed that Mr. Katelnikoff was hired on May 16, 1990.

On December 14, 1990, in an application for a First Class Medical certificate, he listed his total pilot time as 3800 hours and indicated that he had flown 550 hours in the past 6 months for Penn Air (Peninsula Airways in Kodiak).

On November 20, 1991, in an application for a First Class Medical certificate, he listed his total pilot time as 5000 hours and his employer as "Penn Air."

The Kodiak Area Director of Operations of Peninsula Airways confirmed the employment dates of Mr. Katelnikoff and told the NTSB that Katelnikoff "was terminated" on November 17, 1991 and the reason given was that "he did not use good judgment, flew passengers in weather that was below what we considered as safe" (flying conditions). The chief pilot also said that "he could fly an airplane, he just couldn't think," adding that "I just couldn't sleep at night knowing that he (Katelnikoff) was flying our airplanes, I had to let him go."

In a statement to the NTSB (see attached statement), the director of operations stated, in part, "John, in my opinion did not have a healthy respect for weather related flying."

The Peninsula Airways director of operations was asked by the NTSB if he had been contacted by Harbor Air or anyone else for a reference, and he replied "no, if they had, I would have told them that I terminated him, and why."

Mr. Katelnikoff was rehired by the operator for the summer season in 1992. The company vice president, (Mrs. Linda Pfleger) told the NTSB "I hired him back, he worked for us before, he had lot's of experience." The NTSB asked the company vice president if she had done a background check of the pilot prior to hiring him in 1992, and she replied, "Yes, I called the people he worked for down at Kodiak Airways, and they gave him a good recommendation."

#### AIRCRAFT INFORMATION

N1686U was a 1975 single engine Cessna 207, and was configured with a pilot and three passenger seats. Its maximum gross weight was certificated at 3800 pounds. The gross weight of the accident airplane at the time of takeoff from north Patton Bay was calculated to be below 3800 pounds.

#### METEOROLOGICAL INFORMATION

Synoptic weather reports from the National Weather Service and Kenai FSS are attached to this report. No weather observations for Montague Island were available. The FAA Flight Service Station at Kenai received a pilot report from the area of the accident indicating "ceiling indefinite at 800 feet, sky obscured, visibility 1 (mile) in snow and fog, estimated temperature 28, wind 020 degrees and 28 knots, gusting to 38 knots." The nearest record observation were taken at Cordova, Alaska, 70 miles to the northeast. Observations for 1550 Alaska standard time and 1645 Alaska standard time were:

1550 AST, measured ceiling 3600 feet broken, 5,500 feet overcast, visibility 15 miles in light rain, temperature 45, dewpoint 38, wind 090 degrees at 9 knots, altimeter unknown.

1645 AST, measured ceiling 3,500 feet broken, 6,000 feet overcast, visibility 15 miles, temperature 44, dewpoint 37, wind 080 degrees at 9 knots, altimeter 29.09 inches of mercury ("Hg).

FAA records indicate that the pilot of the accident airplane called the Kenai FSS at 1004 Alaska daylight time on the day of the accident and was provided with the weather and advisories for the area. The controller stated (for the Cordova area) "we've got flight precautions for IFR conditions (instrument flight rules-ceiling and visibility below 1000 feet and 3 miles) and icing and turbulence over the entire area.

The records indicate that the pilot replied, "ok that [sic] all I need thanks a lot."

## COMMUNICATIONS

There were no known air traffic control or other communications known to or from the accident airplane. An FAA transcript of pilot communications to the Kenai FSS are attached to this report.

## WRECKAGE AND IMPACT INFORMATION

The terrain features of the accident area include steeply rising ground, at about 20 degree up slope, increasing to 45 degree angles within 1/4 mile and to a nearly vertical "box canyon like" bowl, approximately one mile across, with the highest point on the rim to be 2,986 feet. The bowl opens to the east southeast and the direction of the impact scar indicated this direction of flight.

The airplane's initial impact was found to be at the approximate coordinates of N59-58.00 and W147-29.00 as determined by LORAN (Long Range Aids to Navigation) aboard the Coast Guard rescue helicopter. Impact marks consisted of a 12 by 5 foot scar on the tundra on a heading of approximately 120 degrees magnetic.

The aircraft came to rest in a ravine, approximately 80 feet below and 40 feet, 120 degrees magnetic from the initial impact point.

Along with particles of paint and cockpit window plexiglass, investigators found the initial impact point to contain the right cabin door upper hinge strap, the left foot step (imbedded in the tundra), the left lower lift strut fairing, and the left fiberglass wing tip.

Investigators found only ground scars associated with fuselage marks. No wing strikes were found at the initial impact point. Investigators did not find marks or scars associated with any other impact points within a 1/4 mile radius of the fuselage impact.

All of the nine rivets on the cabin door hinge strap showed shear failure nearly flush with the hinge strap. Six of nine 1/8 inch rivets attaching the cabin door upper hinge showed distortion in the direction of approximately 60 degrees from a forward horizontal plane.

The left foot step was found to have penetrated the tundra nearly in a vertical plane and have failed at the upper attaching point at the fuselage without discernable forward movement. That foot step was removed by pulling it nearly straight up.

The fiberglass wing tips found at 90 degrees alignment to 120 degrees magnetic, approximately 35 feet apart, did not reveal impact damage, however the holes through which attaching rivets passed, were elongated at approximately 90 degree angles and torn through to the edges of the fiberglass material. The wing tips in the main wreckage contained the rivets and some of the ripped fiberglass behind the rivets.

The main wreckage was found bent, twisted, torn and compressed in the small creek. Continuity of flight controls was not possible to establish. The cabin was truncated and the engine was positioned under the main wreckage and under water. One blade of the propeller could be seen and it indicated torsional twisting and bending approximately 10 inches from normal propeller arc.

There was no indication of fire.

All flight and control surfaces were found.

All cockpit instrumentation and controls were destroyed and it was not possible to accurately

determine settings or readings.

The occupants were found to be wearing seat belts, but not found to be wearing shoulder harness restraints.

The individual identified by contents of his wallet to be the pilot was found to be occupying the left seat.

The wreckage was removed from the location on June 13, 1993. The engine was examined by NTSB, FAA and Teledyne Continental investigators at the Teledyne Continental Motors, Aviation Division, plant at Mobile, Alabama, on October 13, 1993. No anomalies were found to have preexisted the impact. The report of that examination is attached to this report.

#### MEDICAL AND PATHOLOGICAL INFORMATION

Autopsy results of the examination of the pilot indicated that fatal injuries were a result of massive trauma. Toxicological results were negative for the standard drug screening.

#### TESTS AND RESEARCH

See attached NTSB/FAA/Continental Motors engine examination of October 13, 1993.

#### ADDITIONAL DATA

The FAA Approved Operations Specifications and Operations Manual for Trail Lake Flying Service, Inc., lists its officers as:

President: Linda K. Pflieger    Director of Operations: Ludwig H. Pflieger    Director of Maintenance: Harold Maness    Chief Pilot: Joseph Paul Holland

The director of operations, listed in the FAA-Approved Operations Specifications and Operations Manual and qualified under 14 CFR Part 135.39, having the appropriate experience for the position, is required by the Operations Manual to "conduct personnel interviews, hire and discharge flight and maintenance personnel."

Interview with the Trail Lake Flying Service president:

In an interview conducted with the company president November 7, 1992 by the NTSB and the FAA, the Safety Board was advised that the Director of Operations was in Hawaii, with a prolonged illness and had not been able to fulfill the duties of the position.

In a statement (attached) the company president advised the Safety Board that the Director of Operations was present in Alaska for approximately 40 days between May 15, 1992 and November 17, 1992. The company president stated that she "hired the accident pilot" and said that her duties were "to see that the flights got out and came back."

The president was asked to describe the training that had been given to the accident pilot since his rehiring in 1992. She told investigators that it was "basically my husband's (the director of operations, Ludwig Pflieger) job, I didn't do training."

Investigators asked the president for a copy of the training manual. She provided a signed (by the FAA) copy from her office and said that it was the only copy. Investigators asked if the pilots used the training manual for reference in training, and the President replied, "yes, they can come in (to this office) and use it any time."

The FAA Approved training program, as provided to investigators indicated that the latest revision (Revision 2, dated July 1992) listed four (4) company instructors having the

authorization to provide training. These instructors were listed as:

Ludwig Pflieger    Joseph Holland    Dean Eichholz    Charles Ede

The investigation showed that Ludwig Pflieger was absent, reported as "recuperating from a heart attack in Hawaii" and was in Alaska approximately 44 days during the year.

Furthermore, Mr. Dean Eichholz and Mr. Charles Ede left the employment of Trail Lakes, d.b.a. Harbor Air "around the end of June," as reported by the company president. The FAA Approved July revision 2 to the training program did not reflect that Mr. Joe Holland was the only instructor left at the company at the time that Mr. Katelnikoff was hired (application date, June 24, 1992). Holland was also the only pilot flying all scheduled (Anchorage International and Seward), as well as the unscheduled air taxi operations.

Interview with the Trail Lake Flying Service chief pilot:

An interview with the company chief pilot, Captain Joseph Holland, was conducted by the NTSB on November 7, 1993, with the FAA Principal Operations Inspector for Trail Lake Flying Service present.

Records indicated that Captain Holland was appointed as company chief pilot on June 27, 1992. He said that he had received his private pilot's license in 1987 and had come to Alaska and flown for Skagway Air Service and Harbor Air "for the 1988 tourist season." He stated that he had flown for "Wings of Juneau in 1989 and 1990."

The NTSB investigation confirmed Captain Holland's employment with Wings of Alaska, Southeast, for that period with the management of that airline.

The Harbor Air chief pilot stated that he currently held Airline Transport and Commercial pilot certificates, with ratings in single and multiengine land and sea airplanes. He said that he had flown as a copilot on DHC-6-200 twin otters for Sound Adventures and on a Shorts Brothers SC-7 for "Northstar" of Anchorage.

The NTSB could not confirm Mr. Holland's employment with Sound Adventures or Northstar companies. The phone numbers of those companies listed in 1990 records had been disconnected and no listing was current for those organizations.

Captain Holland was asked to describe the training, if any, he had given to John Katelnikoff. He said that most of training was accomplished by Ludwig. The Safety Board asked, "if Ludwig was not here to do training, would John Katelnikoff have gone in to the president's office and taken the training manual to self-train? Captain Holland replied that he did not know if Ludwig (Pflieger) had been able to train John, but that he hadn't had occasion "to go over the books with John."

Captain Holland said that his main concern (in training John Katelnikoff) was "where to land on the beaches, which beaches were OK to land on." No training or instruction was documented for flight in marginal VFR conditions nor the procedures required when such conditions are encountered. He told investigators that he recalled "going over to Montague Island with John, empty." He was asked if that was a revenue flight, and he repeated that they had "gone over empty." The investigation did not reveal evidence of dedicated training flights of Katelnikoff, however flight records for the company indicated that he flew as pilot in command during July and August and averaged 110 hours monthly, logged as daytime, VFR flight.



Investigators did not find records of training flights conducted in July, August or later in 1992, and no flights by Eichholz, Ede or Pflieger.

Captain Holland said that he did not instruct John Katelnikoff in matters of navigation, to or from Montague Island or other locations. He said "I assumed he knew how to get back from Montague, he'd been there before."

Asked about the weather at the North Patten Bay beach on the accident day, Holland described it to be 1600 foot ceiling obscured, visibility 3 miles.

The FAA-Approved Operations Manual lists duties of the chief pilot to include all training activities of flight crew members. It also indicates that the chief pilot will "insure all flight crews conform to standard procedures as outlined in applicable FAA Regulations and Company policies, and to insure that all pilots maintain current route qualifications..."

#### Interview with FAA Principal Operations Inspector

The principal operations inspector (POI) responsible for the surveillance of the operator was interviewed on November 7 and 8, 1993 and this inspector assisted the NTSB in the accident investigation, as well. He told the NTSB that he had been assigned the responsibility for surveillance of that operator "earlier that year" but was unaware that the "director of operations was essentially gone most of the time" and that the company president was operating "like the director of operations" but without the qualifications as required in 14 CFR Part 135. He stated that he had "done work the management on the (Harbor Air Service) training manual," however had not specifically observed training of the accident pilot and had not been to Montague Island with the operator.

The POI was present during the interviews of the company president and the chief pilot. He said that the training manual complies with the Federal Aviation Regulations, but agreed that its application, availability and the intended training fell short of what he expected and "he was going to do something about it."

The POI also said that he was also unaware that the "problem of the supervision of the training program" had existed, (referring to the lack of training oversight by the director of operations and the single training manual) and "that he intended to do something about that."

The FAA reported that 122.5 hours of required National Program Guideline (NPG) activity and 85.2 hours of non-scheduled surveillance activity was conducted by various inspectors on the operator between October 1, 1991 and the accident date (November 6, 1992). The details of those activities are attached.

The POI told the NTSB that he was aware of the previous fatal accident (1990) in which the lack of training, geographic qualifications and a similar scenario of "VFR into IMC" played a part. (Visual Flight Rules flight into Instrument Meteorological Conditions)

That accident involved another Trail Lakes Flying Service (d.b.a. Harbor Air Service) Cessna 207 which crashed on June 25, 1990, on mountainous terrain at the 2,700 foot level near Aialak Bay, Alaska. Weather conditions were reported to be mountains obscured and the bases of the clouds to be 1,200 feet.

That pilot-in-command had been hired by Trail Lake Flying Service two months prior to the accident as a ground handler and an airplane refueler. He had been authorized to fly as pilot-in-command two days before the accident.

The accident pilot in the June 25, 1990 accident was a commercial pilot that did not possess a valid medical certificate. He and his four passengers received fatal injuries and the airplane was destroyed.

## Pilot Information

<b>Certificate:</b>	Airline Transport; Commercial	<b>Age:</b>	34, Male
<b>Airplane Rating(s):</b>	Multi-engine Land; Multi-engine Sea; Single-engine Land; Single-engine Sea	<b>Seat Occupied:</b>	Left
<b>Other Aircraft Rating(s):</b>	None	<b>Restraint Used:</b>	Seatbelt
<b>Instrument Rating(s):</b>	Airplane	<b>Second Pilot Present:</b>	No
<b>Instructor Rating(s):</b>	None	<b>Toxicology Performed:</b>	Yes
<b>Medical Certification:</b>	Class 1 Valid Medical--w/ waivers/lim.	<b>Last FAA Medical Exam:</b>	06/19/1992
<b>Occupational Pilot:</b>		<b>Last Flight Review or Equivalent:</b>	
<b>Flight Time:</b>	4734 hours (Total, all aircraft), 2000 hours (Total, this make and model), 4734 hours (Pilot In Command, all aircraft), 113 hours (Last 90 days, all aircraft), 42 hours (Last 30 days, all aircraft), 2 hours (Last 24 hours, all aircraft)		

## Aircraft and Owner/Operator Information

<b>Aircraft Make:</b>	CESSNA	<b>Registration:</b>	N1686U
<b>Model/Series:</b>	207 207	<b>Aircraft Category:</b>	Airplane
<b>Year of Manufacture:</b>		<b>Amateur Built:</b>	No
<b>Airworthiness Certificate:</b>	Normal	<b>Serial Number:</b>	20700286
<b>Landing Gear Type:</b>	Tricycle	<b>Seats:</b>	4
<b>Date/Type of Last Inspection:</b>	09/15/1993, 100 Hour	<b>Certified Max Gross Wt.:</b>	3800 lbs
<b>Time Since Last Inspection:</b>	180 Hours	<b>Engines:</b>	1 Reciprocating
<b>Airframe Total Time:</b>	11291 Hours	<b>Engine Manufacturer:</b>	CONTINENTAL
<b>ELT:</b>	Installed, activated, aided in locating accident	<b>Engine Model/Series:</b>	IO-520-F13B
<b>Registered Owner:</b>	LUDWIG AND LINDA PFLEGER	<b>Rated Power:</b>	300 hp
<b>Operator:</b>	HARBOR AIR SERVICE	<b>Operating Certificate(s) Held:</b>	On-demand Air Taxi (135)
<b>Operator Does Business As:</b>	TRAIL LAKE FLYING SERVICE, INC	<b>Operator Designator Code:</b>	TLFA

## Meteorological Information and Flight Plan

Conditions at Accident Site:	Instrument Conditions	Condition of Light:	Day
Observation Facility, Elevation:	, 0 ft msl	Distance from Accident Site:	0 Nautical Miles
Observation Time:	0000	Direction from Accident Site:	0°
Lowest Cloud Condition:	Partial Obscuration / 300 ft agl	Visibility	1 Miles
Lowest Ceiling:	Obscured / 800 ft agl	Visibility (RVR):	0 ft
Wind Speed/Gusts:	28 knots / 38 knots	Turbulence Type Forecast/Actual:	/
Wind Direction:	20°	Turbulence Severity Forecast/Actual:	/
Altimeter Setting:		Temperature/Dew Point:	4° C
Precipitation and Obscuration:			
Departure Point:		Type of Flight Plan Filed:	Company VFR
Destination:	SEWARD, AK (SWD)	Type of Clearance:	None
Departure Time:	1615 AST	Type of Airspace:	Class G

## Wreckage and Impact Information

Crew Injuries:	1 Fatal	Aircraft Damage:	Destroyed
Passenger Injuries:	1 Fatal	Aircraft Fire:	None
Ground Injuries:	N/A	Aircraft Explosion:	None
Total Injuries:	2 Fatal	Latitude, Longitude:	

## Administrative Information

Investigator In Charge (IIC):	DOUGLAS R HERLIHY	Report Date:	11/01/1994
Additional Participating Persons:	MICHAEL L DOLSEN; ANCHORAGE, AK JOHN V MOELLER; MOBILE, AL JOE SMITH; MOBILE, AL BRIAN F FINNEGAN; WICHITA, KS		
Publish Date:			
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 <a href="mailto:pubinq@ntsb.gov">pubinq@ntsb.gov</a> , or at 800-877-6799. Dockets released after this date are available at <a href="http://dms.nts.gov/pubdms/">http://dms.nts.gov/pubdms/</a> .		

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](#).