National Transportation Safety Board
Aviation Accident Final Report

Location:	Gainesville, Florida	**Accident Number:**	ERA09FA039
Date & Time:	November 7, 2008, 02:46 Local	**Registration:**	N681KW
Aircraft:	PARTENAVIA SPA P.68C	**Aircraft Damage:**	Substantial
Defining Event:	Controlled flight into terr/obj (CFIT)	**Injuries:**	3 Fatal
Flight Conducted Under:	Part 135: Air taxi & commuter - Non-scheduled		

Analysis

The pilot of the multiengine airplane was flying two passengers at night on an instrument-flight-rules flight plan. One of the passengers had been on an organ recipient waiting list and his wife was accompanying him. A viable matched organ was available at a distant hospital and the passenger had to arrive on short notice for surgery the following morning. All radio communications during the flight between the pilot and air traffic control (ATC), a flight service station (FSS), and a fixed-based operator (FBO) were routine. The pilot was aware of the weather at the destination airport, and had commented to ATC about 75 miles from the destination that the weather was "going up and down...like a real thin fog layer." Additionally, better weather conditions prevailed at nearby suitable airports. The pilot mentioned one of those airports to ATC in the event he decided to divert.

According to an employee at an FBO located at the destination airport, the pilot contacted him via radio and asked about the current weather conditions. The employee replied that the visibility was low due to fog and that he could not see the terminal lights from the FBO. The pilot then asked which of the two alternate airports was closer and the employee stated that he did not know. The employee then heard the pilot "click" the runway lights and contact the local FSS. About 5 miles from runway 29, just prior to the initial approach fix, the pilot radioed on the common traffic advisory frequency and reported a 5-mile final leg for runway 29. The FSS reported that the current weather was automated showing an indefinite ceiling of 100 feet vertical visibility and 1/4 mile visibility in fog. The pilot acknowledged the weather information. The weather was below the minimum published requirements for the instrument-landing-system (ILS) approach at the destination airport.

Radar data showed that the flight intercepted and tracked the localizer, then intercepted the glideslope about 1 minute later. There were a few radar targets without altitude data due to

intermittent Mode C transponder returns. The last recorded radar target with altitude indicated the airplane was at 600 feet, on glideslope and heading for the approach; however, the three subsequent and final targets did not show altitude information. The last recorded radar target was about 1.4 miles from the runway threshold. The airplane flew below glideslope and impacted 100-foot-tall trees about 4,150 feet from the runway 29 threshold.

On-ground facility checks and a postaccident flight check of the ILS runway 29 approach conducted by the Federal Aviation Administration did not reveal malfunctions with the ILS. The cabin and cockpit area, including the NAV/COMM/APP, equipment were consumed by a postimpact fire which precluded viable component testing. Detailed examination of the wreckage that was not consumed by fire did not reveal preimpact mechanical malfunctions that may have contributed to the accident. Given that the pilot was aware of the weather conditions before and during the approach, it is possible that the pilot's goal of expeditiously transporting a patient to a hospital for an organ transplant may have affected his decision to initiate and continue an instrument approach while the weather conditions were below the published minimum requirements for the approach.

Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be: The pilot's failure to maintain the proper glidepath during an instrument-landing-system (ILS) approach. Contributing to the accident were the pilot's decision to initiate the ILS approach with weather below the published minimums, and the pilot's self-induced pressure to expeditiously transport an organ recipient to a hospital.

Findings

Aircraft	Descent/approach/glide path - Not attained/maintained
Environmental issues	Fog - Not specified
Personnel issues	Decision making/judgment - Pilot
Personnel issues	Motivation/respond to pressure - Pilot
Personnel issues	Aircraft control - Pilot

Factual Information

HISTORY OF FLIGHT

On November 7, 2008, at 0246 eastern standard time, a Partenavia SPA P68C, N681KW, operated by Florida Aero Charter Inc., doing business as Air Key West, crashed during approach to the Gainesville Regional Airport (GNV), Gainesville, Florida. The on-demand air taxi flight was conducted under the provisions of 14 Code of Federal Regulations Part 135. Night instrument meteorological conditions (IMC) prevailed, and an instrument flight rules (IFR) flight plan was filed. The certificated airline transport pilot and two passengers were killed and the airplane received substantial damage. The flight originated from Key West International Airport (EYW), Key West, Florida, at 0037.

The pilot worked for Air Key West and was based out of EYW. According to the pilot's girlfriend, the pilot previously flew on Monday, November 3. He was then off-duty on Tuesday and Wednesday, November 4 and 5. The pilot was on-duty Thursday, November 6; however, no flights were scheduled. The pilot went to bed early Thursday night, as he had a flight scheduled for 0600 on Friday, November 7. At 2223 on Thursday night, the pilot received a telephone call from an individual, who was on an organ recipient waiting list. The individual stated that an organ was available in Gainesville, and that he'd have to get there quickly for surgery the following morning. The pilot then called the airplane owner/operator, and the owner/operator decided to fly the 0600-trip so that the pilot could conduct the flight to GNV.

According to data from Lockheed Martin, the pilot telephoned about 2336 on November 6, 2008, and filed two IFR flight plans with the Miami Flight Service Station (FSS). The first IFR flight plan was for a direct flight from EYW to GNV, with three persons on board. The pilot advised the FSS specialist that he was transporting a kidney transplant patient and although he was not a Lifeguard or Angel Flight, he was requesting priority handling. The pilot indicated that he would be at GNV for only a short time and filed a second IFR flight plan for a return to EYW, with one person on board.

The accident flight checked in with Jacksonville terminal radar approach control (TRACON) at 0215, approximately 75 miles south of GNV. The controller provided the pilot with the Jacksonville altimeter and advised that no weather information was available at GNV. The pilot advised, "the weather looks like it's going up and down…like a real thin fog layer," and added, "we're kind of a priority trying to get a kidney transplant ah but if it's undoable at Gainesville we're probably be looking at Saint Augustine, just to give you a heads-up."

At 0216, the controller asked the pilot if he wanted an instrument landing system (ILS) approach to GNV. The pilot responded that he wanted an ILS approach to runway 29. At 0242, 6 miles from the WYNDS initial approach fix (IAF), the controller cleared the flight for the ILS runway 29 approach. At 0243, the controller terminated radar services and approved a radio frequency change to the common traffic advisory frequency (CTAF). The pilot acknowledged the CTAF frequency and advised "…we'll talk to ya on the way out…"

At 5 miles from runway 29, just prior to the WYNDS IAF, the pilot radioed on the CTAF and

reported a 5-mile final leg for runway 29. Gainesville FSS advised that automated GNV weather observation was indicating an indefinite ceiling of 100 feet vertical visibility, 1/4 mile visibility in fog, wind calm, temperature 11 degrees Celsius, dew point 10 degrees Celsius, altimeter 30.02 inches of mercury, and that no known airport traffic information was available. The pilot acknowledged the weather and traffic information. There was no further air traffic control or FSS communication with the flight.

According to an employee at a fixed based operator (FBO) located at GNV, the pilot contacted him via radio between 0200 and 0300, and asked about the weather and runway lighting conditions. The employee replied that the visibility was low due to fog, and he could not see the terminal lights from the FBO. The employee also stated that the runway lights were pilot-controlled-lighting, and they were not currently on the highest setting. The pilot then asked about which was a closer alternate airport, Leesburg Florida or St. Augustine Florida, and the employee stated that he did not know. The employee then heard the pilot "click" the runway lights and contact Gainesville Radio. He did not hear any further communications from the accident airplane.

According to radar data provided by the Federal Aviation Administration (FAA), the flight intercepted and tracked the localizer about 0243, and intercepted the glideslope about 0244. There were a few radar targets without altitude data, due to intermittent Mode C transponder returns. The last recorded radar target with altitude was at 0246:30, which indicated the airplane was at 600 feet and on glideslope; however, the three subsequent and final targets did not have altitude information. The last recorded radar target was at 0246:44, about 1.4 miles from the runway threshold.

PERSONNEL INFORMATION

The pilot, age 45, held an airline transport pilot certificate, with a rating for airplane multiengine land. He held a commercial pilot certificate, with ratings for airplane single-engine land, rotorcraft helicopter, and instrument helicopter. His most recent FAA second-class medical certificate was issued on November 21, 2007. At that time, the pilot reported a total flight experience of 8,300 hours.

The pilot's logbooks were not recovered; however, the operator was able to provide his flight experience. According to the operator, of the 8,300 total hours of flight experience, 7,400 hours were in multiengine airplanes, 1,500 hours were in the same make and model as the accident airplane, 1,100 hours were at night, and 1,800 hours were in actual IMC. The pilot flew 50 hours and 130 hours during the 30-day period and 90-day period preceding the accident, respectively.

AIRCRAFT INFORMATION

The seven-seat, high-wing, fixed-gear airplane, serial number 273, was manufactured in 1983. It was powered by two Lycoming IO-360, 200-horsepower engines, equipped with Hartzell propellers. The operator stated that the airplane was in "good shape," and he used the airplane the previous week for an FAA-checkride. The airplane's most recent 100-hour inspection was completed on September 19, 2008. The operator further stated that the airplane was equipped

with an IFR-certified Apollo GX50 global positioning system. The airplane was not equipped with a radar altimeter, ground proximity warning system, or a terrain awareness and warning system.

METEOROLOGICAL INFORMATION

During the telephone call with Miami FSS, the pilot received an abbreviated weather briefing, which included airmen's meteorological information (AIRMET) Sierra for IFR conditions north of Tampa Bay, up through Daytona and points north, developing through the evening. Specifically, the IFR conditions were forecast as ceilings below 1,000 feet and visibility below 3 miles due to mist and fog. At the time of the briefing, the FSS specialist noted he has seen some of the lower visibilities during the past hours; however, Gainesville was visual flight rules with clear skies, 10 miles visibility, and calm winds.

The reported weather at GNV, at 0153, was: wind calm; visibility 1/2 mile in fog; overcast ceiling at 100 feet; temperature 11 degrees Celsius; dew point 10 degrees Celsius; altimeter 30.03 inches of mercury.

The reported weather at GNV, at 0253, was: wind calm; visibility 1/4 mile in fog; vertical visibility 100 feet; temperature 11 degrees Celsius; dew point 10 degrees Celsius; altimeter 30.02 inches of mercury.

The reported weather at GNV, at 0353, was: wind calm; visibility 1/4 mile in fog; broken ceiling at 100 feet and overcast ceiling at 900 feet; temperature 10 degrees Celsius; dew point 9 degrees Celsius; altimeter 30.02 inches of mercury.

The reported weather at St. Augustine Airport (SJG), at 0155, was: wind calm; visibility 7 miles; scattered clouds at 100 feet; temperature 13 degrees Celsius; dew point 12 degrees Celsius; altimeter 30.04 inches of mercury.

The reported weather at SJG, at 0255, was: wind from 280 degrees at 3 knots; visibility 8 miles; broken ceiling at 100 feet; temperature 12 degrees Celsius; dew point 11 degrees Celsius; altimeter 30.02 inches of mercury.

The reported weather at SJG, at 0355, was: wind from 290 degrees at 3 knots; visibility 7 miles; few clouds at 200 feet; temperature 12 degrees Celsius; dew point 12 degrees Celsius; altimeter 30.02 inches of mercury.

AERODROME INFORMATION

A non-federal air traffic control tower was located at GNV. The tower was open from 0645 to 2230.

Runway 29 at GNV was 7,504 feet long, 150 feet wide, and constructed of grooved asphalt. Runway 29 was equipped with an ILS approach, a high intensity runway light system, and a four-light precision approach path indicator light system. It was also equipped with a medium intensity approach light system with runway alignment indicator lights.

Review of a terminal instrument procedure chart for the ILS runway 29 approach at GNV revealed that the decision height for the approach was 322 feet msl (200 feet agl). The minimum visibility requirement was 2,400 feet (1/2 mile).

WRECKAGE AND IMPACT INFORMATION

The wreckage was located in a wooded area about 0700, approximately 3,575 feet from the runway 29 threshold. The wreckage was examined on November 7 and 8, and all major components of the airplane were accounted for at the scene. An approximate 575-foot debris path was observed, that originated with tree strikes. The debris path extended on a course of approximately 290 degrees magnetic, and terminated at the main wreckage. Freshly cut tree branches were recovered along the debris path. They varied in diameter up to about 6 inches, and were cut at approximately 45-degree angles. The outboard one-third of both wings were located near the debris path origin. The stabilator was also located along the debris path, about 50 feet prior to the main wreckage, and was separated into two sections. The emergency locator transmitter (ELT) was not recovered and presumed destroyed.

The main wreckage was resting nose down, and oriented about a 090-degree heading. The cabin and cockpit area were consumed by fire. Flight control continuity was confirmed from the rudder and stabilator trim pulley, to the mid-cabin area. Continuity was also confirmed from the right aileron, to the inboard section of right wing, where the aileron cables were separated. The outboard section of left wing was entangled in an approximate 100-foot-tall tree. The aileron cables remained attached to the left wing. The stabilator was controlled by push-pull tubes, and an approximate 4-foot section of push-pull tube remained attached to the stabilator. The empennage, including vertical stabilizer and rudder, remained intact.

The airplane's flaps were observed in the retracted position. An airspeed indicator, altimeter, manifold pressure indicator, and rpm indicator were recovered from the cockpit, but sustained fire damage. One attitude indicator was recovered and observed to be tumbled. The attitude indicator was disassembled, and its gyro was found intact. The other attitude indicator was destroyed. Approximately two-thirds of both wings, the inboard sections including engines, remained intact. Both propellers remained attached to their respective engines, and were partially buried in the ground.

The engines were subsequently examined on November 9, at a recovery facility. Both engines were separated from the airframe for inspection, and their propellers exhibited s-bending and chordwise scratching. The throttle-butterfly valves for both engines were found near the full throttle positions. The valve covers and sparkplugs were removed from the engines. The top and bottom sparkplug electrodes were intact, and light to medium gray in color. The right engine spark plugs No. 1 top and bottom, No. 2 bottom, and No. 4 bottom were oil soaked. The vacuum pump from each engine was removed and disassembled, and their vanes were intact. Both oil filters, fuel screens, and oil screens were absent of debris, and oil was noted throughout each engine. The propellers were rotated by hand on both engines. Camshaft, crankshaft and valvetrain continuity was established to the rear accessory sections, and thumb compression was attained on all cylinders. All four magnetos sustained thermal damage and could not be tested.

MEDICAL AND PATHOLOGICAL INFORMATION

An autopsy was performed on the pilot by the State of Florida, District Eight Medical Examiner's Office, Gainesville, Florida, on November 8, 2008. The autopsy report noted the probable cause of death as an airplane accident.

Toxicological testing was performed on the pilot by the FAA Bioaeronautical Science Research Laboratory, Oklahoma City, Oklahoma. The results were negative for drugs and alcohol.

TESTS AND RESEARCH

A flight check of the ILS runway 29 approach at GNV was performed on November 7, 2008, by the FAA. The test did not reveal any malfunctions with the ILS.

ADDITIONAL INFORMATION

Operator

The owner/operator initially reported that the pilot had a friend who was on an organ recipient waiting list. The pilot had previously briefed the owner/operator about his friend's situation, and the owner/operator agreed to take the 0600-trip so that the pilot could conduct the flight to GNV. The owner/operator added that he did not charge any fee for the trip; it was a favor to the pilot, who was a good employee and friend, who had a friend in need of an organ transplant. The owner/operator further stated that he had never previously operated any Angel Flight or organ transport flight.

The owner/operator subsequently reported that he did not know the extent of the pilot's relationship with the passengers (organ recipient and his wife), and that the trip booking was handled by the pilot. To his knowledge, the owner/operator did not believe the pilot charged or intended to charge the passengers for the trip.

The pilot's girlfriend lived with him and was with him when he received the telephone call from the passenger at 2223. She reported that the pilot was in good health, well rested, and usually slept from approximately 2300 to 0700. She also stated that the pilot was not a friend of the passengers and she didn't believe they ever met. Through a mutual friend, the passengers learned that the accident pilot worked for Air Key West and could be contacted if a charter flight was needed.

The pilot's girlfriend further stated that from September 26, 2008 to October 21, 2008, the owner/operator was in French Guiana. During that time, a part-time employee of the owner/operator received an inquiry from the passengers regarding the possible need for a future charter flight, and the part-time employee referred the inquiry to the pilot as the owner/operator was out of the country. The pilot spoke with the passengers via telephone on a couple of occasions, to prepare for the day that the trip might be needed for an organ transplant.

The pilot's girlfriend added that when the pilot received the telephone call at 2223, he called the owner/operator. They discussed who would fly which trip. There was talk of a "credit card swipe," possibly for fuel. Additionally, there was talk of the pilot using the King Air 200 for the trip to GNV, as the owner/operator planned to use the accident airplane for the 0600-trip, but the pilot stated that the passenger's health insurance would not pay for the larger airplane. The pilot indicated that he would have the accident airplane back in time for the 0600-trip. The pilot then left for work in his uniform, which consisted of khaki pants and a polo shirt with an Air Key West logo.

According to the pilot and passengers' mutual friend, the pilot had not met the passengers in person before the accident flight. About 1 to 2 weeks prior to the accident, the mutual friend was speaking to one of the passengers about his need to get to GNV on short notice, as his "number was coming up for an organ transplant." The mutual friend mentioned that the pilot previously flew in the Navy and flew for Air Key West. During a subsequent conversation, the passenger stated to the mutual friend that he had the accident pilot booked for the trip, and that the cost of the trip would be $1,100 or $1,200.

According to the part-time employee at Air Key West, he never spoke to the passengers. The accident pilot mentioned that friends (or possibly friends of friends) needed a trip for an organ transplant. The accident pilot further suggested that the trip should be offered for free and he could generate good publicity/media for it. The part-time employee replied that he was not authorized to release the trip for free, and he subsequently emailed the owner/operator about the trip while he was out of the country; however, the email was not located. When the owner/operator returned, the part-time employee reminded him of the proposed free trip, and the owner/operator replied that he would have to speak to the accident pilot about it.
Federal Aviation Regulation (FAR)

Review of FAR 135.225 revealed:

"(a) No pilot may begin an instrument approach procedure to an airport unless...(2) The latest weather report issued by that weather reporting facility indicates that weather conditions are at or above the authorized IFR landing minimums for that airport..."

Search And Rescue

The Jacksonville TRACON controller (radar) was interviewed by a Safety Board investigator. The controller stated that on January 4, 2008, management reduced midnight staffing from three controllers to two, with one controller in the tower and one controller in the radar room. During the accident, the controller was also the supervisor, and as such he was required to perform duties related to the search and rescue that detracted from his control duties. He added that due to two-person midnight staffing, he was unable to perform all the required functions related to the search and rescue.

The controller stated that he kept the flight progress strip on his active board to indicate he had not received information on flight plan cancellation from N681KW. Keeping the flight progress strip in the active bay until the flight plan was cancelled was required by facility policy. At 0256, he called the Gainesville FSS as the FSS was calling him to inquire if N681KW had

cancelled his flight plan. The FSS had called to advise that they had requested a "ramp check" by crash, fire and rescue personnel at GNV, but they failed to locate the airplane.

The controller then retrieved the accident checklist from the supervisor's desk and called the manager at 0358, to advise him of the missing airplane and seek direction on how best to handle the developing situation. The manager directed the controller to call the police at GNV, which he did, and the manager advised that he was coming in to the facility to assist. The controller was of the opinion that the pilot had simply failed to cancel his flight plan and that he was safe on the ground at GNV. He then called GNV crash, fire and rescue, asked them to conduct another check of the airport, and provided the registration number of the missing airplane. Crash, fire and rescue called back shortly thereafter and advised that they did not locate the airplane.

The controller then called the Jacksonville air route traffic control center (ARTCC) and initiated standard notification procedures. Until the manager arrived, the controller answered telephone queries from FSS, the FAA regional communication center, the sheriffs department and Jacksonville ARTCC. The controller also asked two nearby aircraft if they heard an ELT signal. Both aircraft replied negative. The manager arrived shortly before 0500 and assumed the supervisor duties and the controller was relieved from control duties at that time. The continued search and rescue efforts included calling local hospitals to verify that a kidney had been delivered, as the manager incorrectly believed that the flight was delivering a kidney rather than a kidney recipient patient. After reviewing the radar playback of N681KW, the controller went home for the day still thinking that N681KW was safe on the ground and that the pilot simply forgot to close his flight plan. At approximately 0745, the manger called and advised the controller that N681KW had crashed on approach to GNV.

History of Flight

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

Pilot Information

Certificate:	Airline transport; Commercial	**Age:**	45,Male
Airplane Rating(s):	Single-engine land; Multi-engine land	**Seat Occupied:**	Left
Other Aircraft Rating(s):	Helicopter	**Restraint Used:**	
Instrument Rating(s):	Airplane; Helicopter	**Second Pilot Present:**	No
Instructor Rating(s):	None	**Toxicology Performed:**	Yes
Medical Certification:	Class 2 With waivers/limitations	**Last FAA Medical Exam:**	November 21, 2007
Occupational Pilot:	Yes	**Last Flight Review or Equivalent:**	May 8, 2008
Flight Time:	8300 hours (Total, all aircraft), 1500 hours (Total, this make and model), 7600 hours (Pilot In Command, all aircraft), 130 hours (Last 90 days, all aircraft), 50 hours (Last 30 days, all aircraft)		

Aircraft and Owner/Operator Information

Aircraft Make:	PARTENAVIA SPA	**Registration:**	N681KW
Model/Series:	P.68C	**Aircraft Category:**	Airplane
Year of Manufacture:		**Amateur Built:**	No
Airworthiness Certificate:	Normal	**Serial Number:**	273
Landing Gear Type:	Tricycle	**Seats:**	7
Date/Type of Last Inspection:	September 19, 2008 100 hour	**Certified Max Gross Wt.:**	4500 lbs
Time Since Last Inspection:		**Engines:**	2 Reciprocating
Airframe Total Time:	6971 Hrs as of last inspection	**Engine Manufacturer:**	LYCOMING
ELT:	Installed, not activated	**Engine Model/Series:**	IO-360
Registered Owner:		**Rated Power:**	200 Horsepower
Operator:		**Operating Certificate(s) Held:**	On-demand air taxi (135)
Operator Does Business As:	Air Key West	**Operator Designator Code:**	F33A

Meteorological Information and Flight Plan

Conditions at Accident Site:	Instrument (IMC)	**Condition of Light:**	Night
Observation Facility, Elevation:	GNV,152 ft msl	**Distance from Accident Site:**	1 Nautical Miles
Observation Time:	02:53 Local	**Direction from Accident Site:**	290°
Lowest Cloud Condition:		**Visibility**	0 miles
Lowest Ceiling:	Indefinite (V V) / 100 ft AGL	**Visibility (RVR):**	
Wind Speed/Gusts:	/	**Turbulence Type Forecast/Actual:**	/
Wind Direction:		**Turbulence Severity Forecast/Actual:**	/
Altimeter Setting:	30.02 inches Hg	**Temperature/Dew Point:**	11°C / 10°C
Precipitation and Obscuration:	N/A - None - Fog		
Departure Point:	Key West, FL (EYW)	**Type of Flight Plan Filed:**	IFR
Destination:	Gainesville, FL (GNV)	**Type of Clearance:**	IFR
Departure Time:	00:37 Local	**Type of Airspace:**	

Airport Information

Airport:	Gainesville Regional Airport GNV	**Runway Surface Type:**	Asphalt
Airport Elevation:	152 ft msl	**Runway Surface Condition:**	Unknown
Runway Used:	29	**IFR Approach:**	ILS
Runway Length/Width:	7504 ft / 150 ft	**VFR Approach/Landing:**	None

Wreckage and Impact Information

Crew Injuries:	1 Fatal	**Aircraft Damage:**	Substantial
Passenger Injuries:	2 Fatal	**Aircraft Fire:**	On-ground
Ground Injuries:	N/A	**Aircraft Explosion:**	None
Total Injuries:	3 Fatal	**Latitude, Longitude:**	29.683889,-82.249725

Administrative Information

Investigator In Charge (IIC):	Gretz, Robert
Additional Participating Persons:	LeRoy Stromenger; FAA/FSDO; Orlando, FL Edward Rogalski; Lycoming Engines; Williamsport, PA
Original Publish Date:	March 23, 2010
Note:	The NTSB traveled to the scene of this accident.
Investigation Docket:	https://data.ntsb.gov/Docket?ProjectID=69410

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.