



# National Transportation Safety Board Aviation Accident Final Report

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<b>Location:</b>	GREENWICH, CT	<b>Accident Number:</b>	IAD01FA070
<b>Date &amp; Time:</b>	06/22/2001, 0858 EDT	<b>Registration:</b>	N13VH
<b>Aircraft:</b>	Piper PA-32R-301	<b>Aircraft Damage:</b>	Destroyed
<b>Defining Event:</b>		<b>Injuries:</b>	1 Fatal
<b>Flight Conducted Under:</b>	Part 91: General Aviation - Business		

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## Analysis

The instrument rated pilot obtained weather briefings for his destination, which reported instrument meteorological conditions, including fog, mist, low visibilities and ceilings. The pilot then departed and flew to his destination, where he was cleared for an ILS approach. The airplane flew along the localizer course, and about a 1/2-mile from the approach end of the runway, the airplane initiated a climb and made a left turn toward the east. The airplane continued to turn left and flew north. It then began a series of left and right hand ascending and descending turns to various altitudes. During the last 3 minutes of flight, the airplane made 18 ascents and descents, with vertical speeds varying between positive 4,600 and negative 6,000 fpm, and its altitude varied between 600 and 1,800 feet msl. Two witnesses heard the airplane fly loudly overhead before it collided with terrain, and reported that the weather was very foggy. At the time of the accident, weather reported at the airport included zero visibility, fog, vertical visibility 100 feet. According to FAA Flight Training Handbook Advisory Circular (AC) 61-21A, "If neither horizon or surface references exist, the airplane's attitude must be determined by artificial means - an attitude indicator or other flight instruments. Sight, supported by other senses such as the inner ear and muscle sense, is used to maintain spatial orientation. However, during periods of low visibility, the supporting senses sometimes conflict with what is seen. When this happens, a pilot is particularly vulnerable to spatial disorientation." Two independent toxicology reports detected chlorpheniramine, a sedating antihistamine, in the pilot's blood and urine.

## 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 control of the airplane while maneuvering in instrument meteorological conditions, due to spatial disorientation. Factors in the accident were the fog, and the pilot's use of a sedating medication.

## Findings

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Occurrence #1: IN FLIGHT COLLISION WITH OBJECT  
Phase of Operation: MISSED APPROACH (IFR)

### Findings

1. OBJECT - TREE(S)
2. (C) AIRCRAFT CONTROL - NOT MAINTAINED - PILOT IN COMMAND
3. (C) SPATIAL DISORIENTATION - PILOT IN COMMAND
4. (F) WEATHER CONDITION - FOG
5. (F) USE OF INAPPROPRIATE MEDICATION/DRUG - PILOT IN COMMAND

## Factual Information

### HISTORY OF FLIGHT

On June 22, 2001, at 0858 eastern daylight time, a Piper PA-32R-301, N13VH, was destroyed when it collided with wooded terrain in Greenwich, Connecticut, while executing the missed approach for ILS RWY 16 at Westchester County Airport (HPN), White Plains, New York. The certificated private pilot was fatally injured. Instrument meteorological conditions prevailed for the flight that originated at Atlantic City Municipal/Bader Field (AIY), Atlantic City, New Jersey, at 0751. An instrument flight rules (IFR) flight plan was filed for the business flight conducted under 14 CFR Part 91.

Prior to departure, the pilot made two separate telephone calls to the Millville Automated Flight Service Station (AFSS), Millville, New Jersey, and obtained weather information.

The pilot made the first call at 0705, where he indicated that he was in a taxi cab on the way to the Atlantic City Airport. He told the weather briefer that he intended to fly from Atlantic City to White Plains, and would be leaving in about 15 minutes. The pilot then asked what the weather conditions were in White Plains, and the weather briefer responded, "zero zero."

The pilot asked, "Is it really?" The weather briefer replied, "Yes sir, I don't think you want to go right now."

The pilot then obtained the weather prognosis for White Plains. The prognosis, until 1000, included variable winds at 3 knots, 1/2-mile visibility, fog, mist, vertical visibility of 100 feet. It also included a temporary visibility of 1/4-mile visibility, fog, mist with a vertical visibility of 200 hundred feet.

The weather prognosis between 1100 and 1300 included wind from 110 degrees at 8 knots, visibility 3 miles, fog, mist, rain showers, a broken ceiling at 700 feet, and an overcast ceiling at 1,500 feet.

The pilot then stated his intentions to divert to Albany, New York, and obtained weather information for Albany. However, after receiving the weather information, the pilot said that he did not want to go to Albany. Instead, he wanted to go to an airport near Albany, but could not recall the name of the airport. After a brief search, the airport could not be located and no additional weather information was obtained.

The pilot then informed the weather briefer that he had just arrived at the airport and would have to terminate the briefing. However, he told the weather briefer that he would call back shortly.

The pilot made the second telephone call to the Millville AFSS at 0724, and was connected to a different weather briefer. The pilot asked what the weather was "going to look like" around 0900 and 1000 at White Plains. The briefer told the pilot, "Okay they're looking for up until ten a.m., two miles visibility, mist, ceiling five hundred overcast, then after ten a.m., seven hundred broken, one thousand five hundred overcast, three miles visibility."

The pilot then said, "okay, so we can get in there all right..", and filed an IFR flight plan from Atlantic City to White Plains. He selected Albany as the alternate airport.

Review of air traffic control (ATC) communications revealed that the pilot departed Atlantic

City at 0751. While en route, he communicated with several ATC facilities and learned that the ILS RWY 16 approach was in use at White Plains.

At 0838, an approach controller from New York Terminal Radar Approach Control (TRACON) provided the pilot with the current altimeter setting. He also asked the pilot if he was aware of the weather conditions at White Plains, and informed him that the runway visual range (RVR) there was 800 feet. The approach controller also asked the pilot if he had obtained current airport and weather information via the airport's automated terminal information system (ATIS). The pilot responded that he was in the process of obtaining that information.

About two minutes later, the pilot asked the approach controller if any airplanes had "gotten into" or had tried to get into White Plains that morning. The controller said that no one had tried or had landed there that morning. However, a business jet flew in a holding pattern for awhile, but decided to leave the area.

At 0842, the pilot requested the approach into White Plains and stated he would proceed to his alternate if he was unable to land. The approach controller then informed the pilot that the current RVR was 1,400 feet, and the pilot acknowledged.

The approach controller informed the White Plains tower controller that the pilot would attempt the ILS RWY 16 approach.

At 0846, the approach controller informed the pilot that the RVR at White Plains was 1,000 feet "touchdown and roll-out." The pilot acknowledged.

The approach controller cleared the pilot for the approach at 0847, and informed the White Plains tower controller that the airplane was established on the approach. Additionally, he provided the tower controller with missed approach instructions, which included a left turn to 090 degrees and climb to 2,000 feet.

The approach controller then instructed the pilot to contact the White Plains Control Tower, and the pilot acknowledged.

At 0849, the pilot contacted the White Plains Control Tower, and was cleared to land on runway 16.

At 0854, the tower controller asked the pilot twice if he was "going around." The pilot replied, "that's affirmative." The tower controller then directed the pilot to "turn left heading zero nine zero, climb and maintain two thousand." The pilot did not respond, and the tower controller again instructed the pilot to "turn left heading zero nine zero, climb and maintain two thousand." Again, the pilot did not respond, and the tower controller queried his intentions. The pilot responded, "I am going zero nine zero, but zero nine zero is to the right." The tower controller then instructed the pilot to, "fly heading zero nine zero, climb and maintain two thousand." The pilot did not respond.

The departure controller queried the tower controller about the airplane's position. The tower controller stated that she didn't "know what he was doing," and she thought that the pilot was "a little confused."

At 0855, the tower controller instructed the pilot to contact departure control on 126.4. The pilot responded, "out of control, we're gone."

Shortly after, the departure controller informed the tower controller that the pilot had not contacted departure control. The tower controller again instructed the pilot to contact

departure control. There was no response from the pilot.

The tower controller followed up with the departure controller to see if the pilot had contacted departure control. The departure controller had not established communications with the pilot, but received an "ident" signal from the airplane.

The tower controller then made several attempts to contact the pilot.

At 0857, the pilot broadcasted, "flight director is outta control." The tower controller immediately responded, but was unable to obtain a response from the pilot. She then informed him that his position was just northeast of the airport.

The departure controller then reported to the tower controller that the airplane had disappeared off his radar scope. The tower controller stated, "I think he is disorientated, we're rolling the trucks."

The tower controller made several more attempts to contact the pilot, but there was no further communications with him.

Shortly thereafter, a sound similar to an emergency locator transmitter (ELT) signal was heard in the control tower.

A witness, who lived directly across the street from the accident site, reported that he was in his home when he heard a low flying airplane. He went outside to his front steps to see if he could see the airplane, but it was "very foggy." The witness said that he heard the airplane circling overhead and that the engine was loud and operating smoothly. He then heard the airplane hit the ground.

A second witness, who lived diagonally across the street, about 150-200 yards from the accident site, was standing in his driveway. He said the weather was "very foggy with very little visibility." He heard the airplane's engine running loud and without interruption as it circled overhead for about 10 minutes. He then heard it coming down through the trees and explode.

A Safety Board engineer examined radar data from the airplane's flight and calculated performance parameters. According to her report:

"The accident aircraft was flying along the approach localizer for runway 16. About a half mile from the approach end of the runway 16, the airplane initiated a climb...and made a left turn. It flew northbound, and made several turns with ascending and descending altitude...The vertical speed of the accident aircraft was oscillating up and down in the last three minutes before the accident."

Interpolation of the performance parameters revealed that in the last 3 minutes of flight, the airplane made 18 ascents and descents. During that time, the airplane's vertical speed varied between positive 4,600 and negative 6,000 feet per minute (fpm), between an altitude of 600 and 1,800 feet mean sea level (msl), before the radar data ended.

The maneuvers were executed within a 1 by 1/2-mile wide area of airspace, about 1 mile north of the airport.

The accident occurred during the hours of daylight approximately 41 degrees, 5 minutes north latitude, and 73 degrees, 42 minutes west longitude.

#### PILOT INFORMATION

The pilot held a private pilot certificate with ratings for airplane single engine land, and instrument airplane.

The pilot's logbooks were not located. His most recent Federal Aviation Administration (FAA) third class medical certificate was issued on June 14, 2001. At that time, the pilot reported a total of 5,865 flight hours.

#### METEOROLOGICAL INFORMATION

The published weather minimums for the ILS 16 approach at White Plains included a 200 foot ceiling and 1/2-mile visibility.

At the time of the accident, the weather reported at White Plains was wind from 100 degrees at 6 knots. There was zero visibility, fog, and a vertical visibility (vv) of 100 feet. The temperature and dewpoint were both 64 degrees F, and the altimeter setting was 30.09 inches HG.

Weather at Albany, about 100 nautical miles (nm) north, at 0851, was reported as wind from 180 degrees at 9 knots, visibility 9 statute miles, sky conditions broken at 1,900 feet, temperature 64 degrees F, dewpoint 60 degrees F, and altimeter setting 30.05 inches HG.

#### AIDS TO NAVIGATION

On June 22, 2001, the Federal Aviation Administration (FAA) performed a flight test inspection of the ILS RWY 16 approach system. During the test, the audio morse-code identification transmitter was not broadcasting, but the navigational portion was operating satisfactorily.

The FAA also performed a flight test inspection of the missed approach procedure for runway 16, which involved the Carmel VOR/DME facility. According to the FAA flight test inspection report, the Carmel VOR/DME facility operation was found satisfactory.

The ILS RWY 16 approach included a medium intensity approach lighting system with runway alignment indicator lights.

Runway 16 was a 6,548-foot long by 150-foot wide asphalt runway, which was equipped with high intensity runway lights.

#### WRECKAGE INFORMATION

The wreckage was examined at the site on June 22-23, 2001. All major components of the airplane were accounted for at the scene. The airplane came to rest upright on an approximate heading of 060 degrees, at a ground elevation of about 485 feet msl.

Initial tree impact scars started approximately 80 feet from the main wreckage. Tree impact scars became progressively lower on the trees in the direction of the wreckage, which was in a general direction of 025 degrees.

Found along the wreckage path were the right wing tip, left aileron, outboard sections of the left wing, and several small pieces of debris.

Also found along the wreckage path, and around the area of the main wreckage, were several cut tree branches. Examination of the branches revealed they were cut approximately 45 degrees, and exhibited black paint transfer marks.

The cockpit, fuselage, and empennage were consumed by fire.

The left wing was separated at the wing root, and came to rest inverted to the right side of the fuselage. The outboard leading edge section of wing was found about 20 feet aft of the main wreckage. It was about 2-3 feet in length, and exhibited leading edge circular impact damage. A 3-foot section of the outboard wing was found about 40 feet aft of the main wreckage. The flap mechanism was separated from the flap. Both fuel tanks were consumed by fire.

The pitot/static lines sustained impact damage, but the pitot tube and static port were absent of debris.

The right wing remained attached to the wing root, and exhibited leading edge impact and fire damage along the entire length. Both fuel tanks were consumed by fire. The aileron was attached to both hinges and exhibited impact and fire damage. The flap was attached at the inboard hinge, and appeared to be in the retracted position.

The left horizontal stabilator exhibited leading edge impact damage. The outboard section of the stabilator was found about 75 feet aft of the main wreckage. The stabilator trim surface also exhibited impact damage.

The right horizontal stabilator exhibited leading edge impact damage.

The rudder and vertical stabilizer exhibited impact and fire damage.

Control cable continuity was established for all flight control surfaces to the forward cabin area.

The landing gear and flap handle appeared to be in the retracted position.

The fuel selector valve was found in the right tank position.

The engine was intact, and all three propeller blades remained attached to the propeller hub. The first blade exhibited a slight s-bend, chordwise scratching, and front face scoring at the tip of the blade. The second blade was curled aft at the tip, and exhibited s-bending, chordwise scoring, and leading and trailing edge nicks along the entire length of the blade. The third blade was twisted and bent aft. The tip was missing. The outboard section of the blade exhibited leading and trailing edge nicks.

Examination of the engine revealed that the dual magneto was destroyed from fire damage. The impulse coupling was intact, but could not be rotated.

The top and bottom spark plugs were removed and appeared light gray in color.

The fuel injector nozzles, except for the #5 nozzle, were removed and examined. Examination of the nozzles revealed that they were absent of debris.

Valve train continuity and compression were established for each cylinder by manual rotation of the propeller flange.

The oil filter and oil suction screen were examined and found absent of debris.

The fuel servo filter screen was removed and found absent of debris.

Examination of the airplane and engine revealed no mechanical deficiencies.

#### MEDICAL AND PATHOLOGICAL INFORMATION

An autopsy was performed on June 23, 2001, by the Office of the Chief Medical Examiner,

Farmington, Connecticut.

A toxicological examination was performed on July 13, 2001, by the Office of the Chief Medical Examiner, Farmington, Connecticut. The examination revealed that a trace amount of chlorpheniramine and caffeine were detected in the pilot's blood. Acetaminophen, caffeine and/or caffeine metabolites were also detected in the pilot's blood.

A toxicological examination was also performed by the FAA Toxicology Accident Research Laboratory, Oklahoma City, Oklahoma. Chlorpheniramine was detected in the pilot's blood and urine. Additionally, pseudoephedrine, ephedrine, and phenylpropanolamine were detected in the pilot's urine.

According to the Mosby Medical Encyclopedia:

"Chlorpheniramine is an antihistamine, used to treat a variety of allergic reactions...Drowsiness and dry mouth commonly occur.

"Ephedrine is a stimulant drug that opens the airway passages...It is used to treat asthma and bronchitis, and is also used as a nasal decongestant.

"Pseudoephedrine is a drug that affects the nervous system, used to reduce congestion in the nose and the Eustachian tube...Among the serious side effects are an increase in the activity of the central nervous system, headache, and rapid heart rate.

"Phenylpropanolamine is a blood vessel-narrowing drug given to relieve a stuffy nose and other cold symptoms... Among the more serious side effects are nervousness, an inability to sleep, loss of appetite, and high blood pressure."

#### TESTS AND RESEARCH

The vacuum pump, attitude indicator gyro housing and rotor were sent to the Safety Board's Materials Laboratory, Washington, DC. According to a Safety Board metallurgist, the vacuum pump had uniform wear on the vanes and no internal components were fractured or significantly damaged. There was evidence of high temperature exposure.

The gyro rotor and housing from the attitude indicator were also examined. The housing was slightly out of round and had suffered extensive high temperature exposure, but was not fractured. An examination of the exterior surface of the rotor and interior surface of the housing showed no sign of rotational contact.

#### ADDITIONAL INFORMATION

A handheld Garmin GPSMAP 195 was found at the accident site and sent to the manufacturer for examination. The unit was examined on August 2, 2001, under FAA supervision. Data was extracted from the unit and downloaded onto a map, using Garmin's MapSource program. The unit recorded the airplane's entire flight from Atlantic City to White Plains.

Examination of the flight track revealed that after departing Atlantic City, the airplane flew a northwesterly course until it was west of New York City, New York. The airplane then flew two northeasterly headings before it turned to the southeast, on a direct course to runway 16 at White Plains. The airplane flew this course for approximately 12 miles before it made a left hand turn less than a 1/2-mile from the end of the runway. The airplane continued to turn left to a northerly heading, then began a series of left and right hand turns before the data ended.

The last position calculated by the GPS receiver was 41 degrees, 05.282 minutes north latitude, and 073 degrees, 42.229 minutes west longitude.

According to the FAA Flight Training Handbook, Advisory Circular (AC) 61-21A, page 9, "The flight attitude of an airplane is generally determined by reference to the natural horizon. When the natural horizon is obscured, attitude can sometimes be maintained by reference to the surface below. If neither horizon or surface references exist, the airplane's attitude must be determined by artificial means - an attitude indicator or other flight instruments. Sight, supported by other senses such as the inner ear and muscle sense, is used to maintain spatial orientation.

However, during periods of low visibility, the supporting senses sometimes conflict with what is seen. When this happens, a pilot is particularly vulnerable to spatial disorientation. Spatial disorientation to a pilot means simply the inability to tell "which way is up."

According to an FAA Instrument Flying Handbook, AC 61-27C (Section II, "Instrument Flying: Coping with Illusions in Flight"), an illusion or false impression occurs when information provided by sensory organs is misinterpreted or inadequate and that many illusions in flight could be created by complex motions and certain visual scenes encountered under adverse weather conditions and at night. It also stated that some illusions may lead to spatial disorientation or the inability to determine accurately the attitude or motion of the aircraft in relation to the earth's surface.

The AC further stated that the most hazardous illusions that lead to spatial disorientation are created by information received from motion sensing systems, which are located in each inner ear. The AC also stated that the sensory organs in these systems detect angular acceleration in the pitch, yaw, and roll axes, and a sensory organ detects gravity and linear acceleration and that, in flight, the motion sensing system may be stimulated by motion of the aircraft alone or in combination with head and body movement. The AC listed some of the major illusions leading to spatial disorientation as follows:

"The leans - A banked attitude, to the left for example, may be entered too slowly to set in motion the fluid in the 'roll' semicircular tubes. An abrupt correction of this attitude can now set the fluid in motion and so create the illusion of a banked attitude to the right. The disoriented pilot may make the error of rolling the aircraft back into the original left-banked attitude or, if level flight is maintained, will feel compelled to lean to the left until this illusion subsides.

Coriolis illusion - An abrupt head movement made during a prolonged constant-rate turn may set the fluid in more than one semicircular tube in motion, creating the strong illusion of turning or accelerating, in an entirely different axis. The disoriented pilot may maneuver the aircraft into a dangerous attitude in an attempt to correct this illusory movement....

Inversion illusion - An abrupt change from climb to straight-and-level flight can excessively stimulate the sensory organs for gravity and linear acceleration, creating the illusion of tumbling backwards. The disoriented pilot may push the aircraft abruptly into a nose-low attitude, possibly intensifying this illusion.

Elevator illusion - An abrupt upward vertical acceleration, as can occur in a helicopter or an updraft, can shift vision downwards (visual scene moves upwards) through excessive stimulation of the sensory organs for gravity and linear acceleration, creating the illusion of being in a climb. The disoriented pilot may push the aircraft into a nose low attitude. An abrupt

downward vertical acceleration, usually in a downdraft, has the opposite effect, with the disoriented pilot pulling the aircraft into a nose-up attitude...."

The AC also stated that these undesirable sensations cannot be completely prevented but that they can be ignored or sufficiently suppressed by pilots' developing an "absolute" reliance upon what the flight instruments are reporting about the attitude of their aircraft.

The airplane wreckage was released on June 23, 2001, to a representative of the airplane owner's insurance company.

### Pilot Information

<b>Certificate:</b>	Private	<b>Age:</b>	63, Male
<b>Airplane Rating(s):</b>	Single-engine Land	<b>Seat Occupied:</b>	Left
<b>Other Aircraft Rating(s):</b>	None	<b>Restraint Used:</b>	Seatbelt, Shoulder harness
<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 3 Valid Medical--no waivers/lim.	<b>Last FAA Medical Exam:</b>	06/14/2001
<b>Occupational Pilot:</b>		<b>Last Flight Review or Equivalent:</b>	
<b>Flight Time:</b>	5865 hours (Total, all aircraft)		

### Aircraft and Owner/Operator Information

<b>Aircraft Make:</b>	Piper	<b>Registration:</b>	N13VH
<b>Model/Series:</b>	PA-32R-301	<b>Aircraft Category:</b>	Airplane
<b>Year of Manufacture:</b>		<b>Amateur Built:</b>	No
<b>Airworthiness Certificate:</b>	Normal	<b>Serial Number:</b>	32R-8113056
<b>Landing Gear Type:</b>	Retractable - Tricycle	<b>Seats:</b>	6
<b>Date/Type of Last Inspection:</b>	12/01/2000, Annual	<b>Certified Max Gross Wt.:</b>	3600 lbs
<b>Time Since Last Inspection:</b>		<b>Engines:</b>	1 Reciprocating
<b>Airframe Total Time:</b>	5448.5 Hours as of last inspection	<b>Engine Manufacturer:</b>	Lycoming
<b>ELT:</b>	Installed, activated, did not aid in locating accident	<b>Engine Model/Series:</b>	IO-540-K1G5D
<b>Registered Owner:</b>	HEBER, INC.	<b>Rated Power:</b>	294 hp
<b>Operator:</b>	HEBER, INC.	<b>Operating Certificate(s) Held:</b>	None

## Meteorological Information and Flight Plan

Conditions at Accident Site:	Instrument Conditions	Condition of Light:	Day
Observation Facility, Elevation:	HPN, 439 ft msl	Distance from Accident Site:	1 Nautical Miles
Observation Time:	0856 EDT	Direction from Accident Site:	360°
Lowest Cloud Condition:	Unknown	Visibility	0 Miles
Lowest Ceiling:	Indefinite (V V) / 100 ft agl	Visibility (RVR):	
Wind Speed/Gusts:	6 knots /	Turbulence Type Forecast/Actual:	/
Wind Direction:	100°	Turbulence Severity Forecast/Actual:	/
Altimeter Setting:	30.09 inches Hg	Temperature/Dew Point:	18° C / 18° C
Precipitation and Obscuration:			
Departure Point:	ATLANTIC CITY, NJ (AIY)	Type of Flight Plan Filed:	IFR
Destination:	WHITE PLAINS, NY (HPN)	Type of Clearance:	IFR
Departure Time:	0751 EDT	Type of Airspace:	Class D

## Airport Information

Airport:	WESTCHESTER COUNTY (HPN)	Runway Surface Type:	Asphalt
Airport Elevation:	439 ft	Runway Surface Condition:	Wet
Runway Used:	16	IFR Approach:	ILS
Runway Length/Width:	6548 ft / 150 ft	VFR Approach/Landing:	None

## 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:	41.092222, -73.700556

## Administrative Information

Investigator In Charge (IIC):	LEAH D YEAGER	Report Date:	04/18/2003
Additional Participating Persons:	DAVID C MOORE; TEXTRON/LYCOMING; ARSDLEY, PA ROBERT MARTELOTTI; THE NEW PIPER AIRCRAFT COMPANY; CENTERVILLE, VA JASON GEORGE; WINDSOR LOCKS, CT		
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](#).