



National Transportation Safety Board Aviation Accident Final Report

Location:	Unalaska, AK	Accident Number:	ANCO1FA033
Date & Time:	01/23/2001, 2135 AST	Registration:	N19454
Aircraft:	Douglas DC-3	Aircraft Damage:	Destroyed
Defining Event:		Injuries:	2 Fatal
Flight Conducted Under:	Part 135: Air Taxi & Commuter - Non-scheduled		

Analysis

A Douglas DC-3 airplane departed an island runway during dark night, VFR conditions without filing a flight plan. The airplane collided with a volcanic mountain at 1,500 feet msl on the runway heading, 4.5 miles from the airport. Earlier in the day, the airplane arrived from Anchorage, Alaska, without a flight plan, having flown along the Alaska Peninsula when VFR flight was not recommended. The crew of the airplane initially planned to remain overnight on the peninsula, but the captain received a request to transport cargo to Anchorage. The airplane was loaded with cargo and fuel, and departed. The crew did not file a flight plan. The end of the departure runway is positioned at the edge of an ocean bay. Beyond the end of the runway, open water and rising volcanic island terrain are present. In the area of intended flight, no illumination of the terrain, or any ground based lighting was present. An obstacle departure procedure for the departure runway recommends a right turn at 2 DME from the runway heading, and then a climb to 7,000 feet. Forty-five minutes after departure, a fire was spotted on the side of a volcano cone, and an ELT signal was detected in the area. No company flight following procedures were found for the accident flight, and the airplane was not reported overdue until the following day. The day after the accident, the airplane wreckage was located on steep, snow-covered terrain. Due to high winds and blowing snow, a rescue team could not get to the accident site until three days after the crash. The captain was the president, the director of operations, and the sole corporate entity of the company. No current maintenance records, flight logs, or pilot logs were located for the company. In the past, the captain's pilot certificate was suspended for 45 days following an accident in a DC-3 airplane when he ran out of gas. Also, the captain's medical certificate had previously been considered for denial after serving 49 months in federal prison for cocaine distribution, but after review, the FAA issued the captain a first class medical. FAA medical records for the captain do not contain any record of monitoring for substance abuse. The first officer's medical had also been considered for denial after an episode of a loss of consciousness. After a lengthy review and an appeal to the NTSB, the FAA issued the first officer a second-class medical. The first officer was part of the flight crew when the captain ran out of gas, and she had two previous aviation accidents. A toxicological examination of the captain, conducted by the FAA, found cocaine and metabolites of cocaine. A toxicological examination of the first officer found two different prescription antidepressant drugs. The FAA prohibits narcotic and mood-altering drug use by pilots.

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Publications of the National Transportation Safety Board National Transportation Safety Board,1972 **Annual Report to Congress - National Transportation Safety Board** United States. National Transportation Safety Board,1968

Monthly Catalogue, United States Public Documents ,1977-07 Monthly Catalog of United States Government Publications ,1980-04 The Limits of Expertise R. Key Dismukes,Benjamin A. Berman,Loukia Loukopoulos,2017-03-02 Why would highly skilled well trained pilots make errors that lead to accidents when they had safely completed many thousands of previous flights The majority of all aviation accidents are attributed primarily to human error but this is often misinterpreted as evidence of lack of skill vigilance or conscientiousness of the pilots The Limits of Expertise is a fresh look at the causes of pilot error and aviation accidents arguing that accidents can be understood only in the context of how the overall aviation system operates The authors analyzed in great depth the 19 major U S airline accidents from 1991 2000 in which the National Transportation Safety Board NTSB found crew error to be a causal factor Each accident is reviewed in a separate chapter that examines events and crew actions and explores the cognitive processes in play at each step The approach is guided by extensive evidence from cognitive psychology that human skill and error are opposite sides of the same coin The book examines the ways in which competing task demands ambiguity and organizational pressures interact with cognitive processes to make all experts vulnerable to characteristic forms of error The final chapter identifies themes cutting across the accidents discusses the role of chance criticizes simplistic concepts of causality of accidents and suggests ways to reduce vulnerability to these catastrophes The authors complementary experience allowed a unique approach to the study accident investigation with the NTSB cognitive psychology research both in the lab and in the field enormous first hand experience of piloting and application of aviation psychology in both civil and military operations This combination allowed the authors to examine and explain the domain specific aspects of aviation operations and to extend advances in basic research in cognition to complex issues of human performance in the real world Although The Limits of Expertise is directed to aviation operations the implications are clear for understanding the decision processes skilled performance and errors of professionals in many domains including medicine Railroad Accident Report United States. National Transportation Safety Board,1974

Annual Report to Congress United States. National Transportation Safety Board,2000 **Moving Forward After the National Transportation Safety Board Report** United States. Congress. House. Committee on Oversight and Government Reform. Subcommittee on Federal Workforce, Postal Service, and the District of Columbia,2011 **National Transportation Safety Board Publications** ,1975 *National Transportation Safety Board Fiscal Year 2011 - 2010 Performance and Accountability Report* National Transportation Safety Board,2015-06-22 Since its creation in 1967 as an independent accident investigation agency within the newly created U S Department of Transportation DOT the NTSB s mission has been to determine the probable cause of transportation accidents and to formulate safety

recommendations to improve transportation safety **Safety Effectiveness Evaluation** United States. National
 Transportation Safety Board, **National Transportation Safety Board Public Forum on Driver Education and
 Training, October 28-29, 2003** ,2005 Eight Subway Train Fires on New York City Transit Authority with Evacuation of
 Passengers United States. National Transportation Safety Board,1981 **Monthly Catalog of United States Government
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Table of Contents National Transportation Safety Board Report

1. Understanding the eBook National Transportation Safety Board Report
 - The Rise of Digital Reading National Transportation Safety Board Report
 - Advantages of eBooks Over Traditional Books
2. Identifying National Transportation Safety Board Report
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an National Transportation Safety Board Report
 - User-Friendly Interface
4. Exploring eBook Recommendations from National Transportation Safety Board Report
 - Personalized Recommendations
 - National Transportation Safety Board Report User Reviews and Ratings
 - National Transportation Safety Board Report and Bestseller Lists

5. Accessing National Transportation Safety Board Report Free and Paid eBooks
 - National Transportation Safety Board Report Public Domain eBooks
 - National Transportation Safety Board Report eBook Subscription Services
 - National Transportation Safety Board Report Budget-Friendly Options
6. Navigating National Transportation Safety Board Report eBook Formats
 - ePub, PDF, MOBI, and More
 - National Transportation Safety Board Report Compatibility with Devices
 - National Transportation Safety Board Report Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of National Transportation Safety Board Report
 - Highlighting and Note-Taking National Transportation Safety Board Report
 - Interactive Elements National Transportation Safety Board Report
8. Staying Engaged with National Transportation Safety Board Report
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers National Transportation Safety Board Report
9. Balancing eBooks and Physical Books National Transportation Safety Board Report
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection National Transportation Safety Board Report
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine National Transportation Safety Board Report
 - Setting Reading Goals National Transportation Safety Board Report
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of National Transportation Safety Board Report
 - Fact-Checking eBook Content of National Transportation Safety Board Report
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning

- Utilizing eBooks for Skill Development
- Exploring Educational eBooks

14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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