



# National Transportation Safety Board Aviation Accident Final Report

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<b>Location:</b>	Monroe, LA	<b>Accident Number:</b>	SEA05FA034
<b>Date &amp; Time:</b>	01/10/2005, 2010 CST	<b>Registration:</b>	N9474E
<b>Aircraft:</b>	Cessna 182R	<b>Aircraft Damage:</b>	Destroyed
<b>Defining Event:</b>		<b>Injuries:</b>	2 Fatal
<b>Flight Conducted Under:</b>	Part 91: General Aviation - Personal		

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## Analysis

The two Civil Air Patrol pilots took off on a dark night in order to shoot a number of practice instrument approaches in VFR conditions. The pilot who was believed to be sitting in the left seat and shooting the approaches was not instrument current at the time. After shooting the first approach, and just after being cleared for the second, the crew was advised that the ceiling had become 900 feet broken and that the field was then IFR. When queried by the controller, the crew said they wanted to continue their series of approaches via an IFR clearance. During the second approach they had trouble intercepting the localizer, and although they had by that time decided to make the next landing a full-stop, because they could not get established on the localizer, they eventually had to execute a missed approach. During the next approach they again had trouble getting established on the localizer, and when advised that they had a C130 following them on an approach for landing, the crew requested another missed approach. During that missed approach, while making a climbing turn in order to be repositioned for another approach, the flying pilot lost control of the aircraft, which descended into the waters of a shallow water collection pond/swamp.

## Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be: The failure of the pilot manipulating the controls to maintain aircraft control during a night missed approach in instrument meteorological conditions. Factors include a dark night and low ceilings.

## Findings

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Occurrence #1: LOSS OF CONTROL - IN FLIGHT  
Phase of Operation: MISSED APPROACH (IFR)

### Findings

1. (C) AIRCRAFT CONTROL - NOT MAINTAINED - PILOT IN COMMAND
2. (F) LIGHT CONDITION - DARK NIGHT
3. (F) WEATHER CONDITION - LOW CEILING

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Occurrence #2: IN FLIGHT COLLISION WITH TERRAIN/WATER  
Phase of Operation: DESCENT - UNCONTROLLED

### Findings

4. TERRAIN CONDITION - WATER
5. TERRAIN CONDITION - SWAMPY

## Factual Information

### HISTORY OF FLIGHT

On January 10, 2005, approximately 2010 central standard time, a Cessna 182R, N9474E, impacted the shallow waters of a swampy collection pond about eight miles northeast of Monroe Regional Airport, Monroe, Louisiana. Both occupants, each of whom held a commercial pilot certificate, received fatal injuries, and the aircraft, which was owned and operated by the Civil Air Patrol (CAP), was destroyed by the impact sequence. The local CFR Part 91 instrument proficiency flight, which departed Monroe Airport about 65 minutes prior to the accident, was being operated in instrument meteorological conditions (IMC) at the time of the accident. While in flight, the pilot had received a local instrument clearance to the Monroe Airport. There was no report of an ELT activation.

According to individuals at the airport, the two occupants executed a number of practice instrument approaches in visual meteorological conditions, and then landed, took a short break, and prepared to take off for another set of practice instrument approaches. Although it could not be positively confirmed, representatives of the operator believe that prior to the second flight, the two pilot's switched places, and the pilot who had been sitting in the right seat and operating the radios during the first flight was the one who did the flying from the left seat during the second flight. The operator based this assumption on the fact that an observer saw who was in which seat at the beginning of the first flight, and it was determined that the person in the right seat had been making the radio transmissions during that flight, while the pilot in the left seat during the first flight was the one making the radio transmissions during the second flight.

Prior to their departure, the flight crew of CAP flight 1630 contacted Monroe Ground, advised the controller that they had Information Victor, and then stated that they wanted to do two ILS's ( Instrument Landing System) and one VOR/DME (Very-High Frequency Omnidirectional Range/Distance Measuring Equipment) "under VFR (visual flight rules) conditions." The controller told them to maintain VFR at 2,000 feet, assigned them a discrete transponder code, and gave them the departure control frequency. The crew then asked for, and received, a clearance to take off on Runway 14 and maintain runway heading. After takeoff, the crew was directed to turn left to a heading of 060 degrees, for vectors to an ILS final approach for Runway 22, and then given climbout (missed approach) instructions of a left turn to 140 degrees, maintain 2,000 feet. The pilot handling the radios correctly read back the clearance, except for stating that the climbout was "runway heading to 2,000." The controller corrected him, and he correctly read back "140 to 2,000." The controller gave the crew two more turns, and then told them they were seven miles from Baiyu (the initial approach fix and outer marker), to turn left to 250 degrees, intercept the localizer, track it inbound, and to stand by for a clearance. The crew started the read-back, but after getting as far as the heading to turn to, paused and stated "...I didn't get those instructions." The controller then gave them a traffic advisory for the position of another aircraft in the radar pattern, and then gave them a clearance for the ILS, to which the crew correctly responded. Soon thereafter, the controller asked the crew what the bases were, and they asked him to repeat his transmission. The controller then transmitted, "Is it clear, or are there layers below you?" And the crew responded with "Don't see any clouds where we are right now." The crew was then directed to contact Monroe Tower, which they did after responding with "Ah, it looks like we spoke too soon. There is a little layer below us." Then, after contacting the tower and completing a stop-

and-go, they took off for the second approach.

After departure for the second approach, the crew contacted departure control and was given a heading of 070 degrees. After responding to that clearance, the crew transmitted "Going through a little cloud right now at 1,000 feet." After being given three more heading changes in order to position them northeast of the final approach course, they were cleared for a second ILS for Runway 22, and asked to maintain "max forward speed." Then about 15 seconds after clearing CAP 1630 for the approach, the tower announced "Attention all aircraft, information whiskey, altimeter 30.10, ceiling 900 broken, 4,700 broken." Then about five seconds later the tower transmitted "CAP Flight 1630, showing the field IFR now, ceiling 9,000 broken, say intentions." The crew responded with "Ah, that's affirmative, we're not in the clouds right now." The tower then responded with, "Correction, showing 900 broken, with 10 miles visibility," to which the crew responded "900 broken, 10 miles visibility." The tower controller then asked the crew if they would like "...an IFR clearance to the airport," and the crew responded with " Yeah, let's do IFR to the airport, and then can we do a VOR/DME after this under these conditions?" The tower controller then said "You're going to have to stay IFR to do the approach. Is that alright with you?" The crew of CAP 1630 responded to this transmission with "IFR approach, CAP 1630." They were then given an IFR clearance to the Monroe Airport via radar vectors, and given a new discrete transponder code. Soon thereafter they were switched to the tower and "cleared for the option," whereupon they advised the tower they were going to execute a stop-and-go, and then would like to shoot a VOR/DME. Then about 20 seconds after CAP 1630's last transmission, the tower controller transmitted "CAP Flight 1630, I'm showing you slightly east of the ILS final approach course. Are you picking it up?" CAP 1630 responded with "We're just now trying to make the adjustment. We see our problem." Then about five seconds later CAP 1630 transmitted "Are we still East of the localizer?" The controller told them that was affirmative, and CAP 1630 responded with "It's coming in now, thank you." Almost immediately, the tower controller asked "Are you going to need to be vectored for another approach," and the crew responded with "Yes, we want a VOR/DME." The controller's response to that transmission was "I mean, are you going to need a vector now to reattempt the ILS to 22?" To that the crew stated "We have intercepted the ILS." Then about five seconds later, the crew said that because of the low ceiling they had decided that the approach would end in a full-stop landing. Then about five seconds after that transmission, the controller asked CAP Flight 1630 to say what their heading was, and the crew responded with "Ah, can we do a missed approach on this and try it again?" At that point the tower controller told them to turn right to 320 degrees, and to maintain 2,100 feet for vectors for resequencing. The crew read back that clearance, and was soon switched back to approach control for another attempt at the ILS.

After switching back to approach, CAP 1630 was vectored to a position northwest of the ILS final approach course, and then given a heading of 120 degrees (within 12 degrees of being perpendicular to the inbound course), and subsequently advised that they could expect vectors across the final approach course for spacing behind traffic that was 6 miles southeast of their position. The crew of CAP 1630 responded to that transmission with "We'll be looking. You have a lot of static on your radio. It's hard to understand." The controller then asked CAP 1630 to confirm that they were on frequency 118.5, and not 126.9, which they confirmed. The controller then transmitted again, and asked 1630 if the transmission was any better, to which they responded "Ah, no, 1630." The controller then advised them "That's all I got for now," but within five seconds told them to change to frequency 126.9, because that might be better for

them. When the crew came up on that frequency, they advised the controller that it was "a little better," but that there was still a lot of static. The crew was given another heading change (to 220 degrees), and then soon thereafter, the controller advised them they were 10 miles from Baiyu, instructed them to turn right to 250 degrees, maintain 2,000 feet until established on the localizer, and then cleared them for the ILS for Runway 22. The crew of CAP 1630 read back the clearance, and were then directed to contact the tower

After contacting the tower, the crew was cleared to land and advised that the wind was 190 degrees at eight knots. Then about thirty seconds later, the tower controller advised the flight that the radar was showing them "...south of the ILS final approach course." The crew's response to that transmission was "Affirmative. We are trying to get over." Then about five seconds later, the controller transmitted "CAP Flight 1630, are you Northbound?" And about five seconds after that, the controller asked the crew of CAP 1630 to say their intentions. The crew responded with "We're trying to get lined up with the ILS," and the controller responded with "CAP 1630, you have a C130 following you, four miles." The crew responded to that information with "We can do a missed approach, and let him come on in" Then after a pause of about five seconds with no immediate response from the controller, the crew of CAP 1630 stated "Let's go ahead and do a missed approach and let him come on in." At that point, the controller instructed CAP 1630 to climb and maintain 2,100 feet, and to turn right to a heading of 270 degrees for resequencing. The crew responded to that instruction, and then was advised that they had traffic three miles east of their position, a C130 descending out of 1,800 feet. The crew of CAP 1630 said that they would be "looking for the traffic," and then they were directed to turn to a heading of 360 degrees. They responded with "360, 1630," and then were directed to contact departure. For the next 25 seconds there was no response from CAP 1630, so the controller again directed them to contact departure. There was no further response from the crew of CAP Flight 1630, and approximately one minute and twenty seconds after the flight had been instructed to contact the tower, and after several more attempts to contact them, the approach controller transmitted "CAP Flight 1630, radar contact lost."

#### METEOROLOGICAL INFORMATION

The Monroe Airport aviation surface observation (METAR) taken at 1853 local, which was approximately one hour and fifteen minutes prior to the accident, reported winds 180 degrees at eight knots, visibility 10 statute miles, few clouds at 3,200 feet, broken clouds at 9,000 feet, a temperature of 18 degrees Celsius, a dew point of 19 degrees Celsius, and an altimeter of 30.11 inches of mercury. By 1930, approximately 40 minutes prior to the accident, although the visibility was still 10 miles, the ceiling had dropped to 1,100 feet broken, with additional broken layers at 2,700 feet and 4,500 feet, and temperature/dew point differential of zero. By 1938 the ceiling had dropped further to 900 feet broken, with an overcast layer at 4,700 feet. By 1945 there was a 1,100 foot overcast ceiling at the airport, and by 1953 the overcast ceiling had dropped to 900 feet, and the visibility had dropped to eight miles. The first recorded observation taken after the accident was at 2053, approximately 40 minutes after the controller reported that radar contact had been lost. That observation indicated an overcast ceiling at 700 feet, a visibility of eight miles, winds of 170 degrees at 11 knots, and a temperature/dew point spread of zero.

#### IMPACT AND WRECKAGE INFORMATION

Although there were no known visual witnesses, around 2015 on the night of the accident, an individual who lives about a mile north of the accident site heard an aircraft fly over their home

heading in the direction of Monroe. This individual, who is used to aircraft flying over their house while on approach to land at Monroe Airport, said that this aircraft sounded closer and lower than they were used to. This individual further stated that the aircraft sounded like it was going very fast, and that the engine sounded loud and like it was at high speed. Approximately five to ten seconds after it passed over their house, they heard the sound of a "large crash." Immediately after the crash, this person went outside to see what they could see or hear. At that time, they could no longer hear any aircraft engine noise, nor were they able to see any aircraft flying toward Monroe. According to this person, who is used to hearing aircraft passing overhead, except for the loudness of the engine, and the fact that it sounded like it was at high rpm, there were no unusual engine noises.

After an all-night search, the aircraft was located at 0710 the next morning. It had impacted the shallow waters (three to four feet deep) of Wham Brake, a three mile-long by one and one-half mile wide collection pond/marsh. The center of the accident site was located at North 32 degree 36 minutes .095 seconds, West 091 degrees 55 minutes .819 seconds. The wreckage, which was in three main sections, was spread over a southwesterly track measuring about 100 feet long. The first two sections were made up primarily of wing structure, and the last section was made up mostly of fuselage and empennage parts. Because the water in the holding pond was contaminated with industrial waste, including Dioxin (a highly toxic man-made organic compound), and because the pond water was too shallow for a recovery barge, and too deep for most track vehicles, the recovery of the wreckage was delayed for approximately one week. Once the aircraft wreckage was recovered from the pond, it was taken to Air Salvage of Dallas, in Lancaster, Texas, where the engine, airframe structure, and systems underwent further limited inspections.

These inspections revealed that except for the aft part of the fuselage, and most of the empennage, the force of the impact had severely crushed, torn, and twisted the entire aircraft structure. Although the basic structure of the empennage remained readily identifiable, the leading edge of the horizontal stabilizer was crushed almost directly aft, and almost all of the empennage skin was wrinkled and or twisted. Do to the extent of the damage, control continuity could not be positively determined. All major aircraft structural components were recovered, and although the damage was extensive, the inspection of the structure did not reveal any evidence of pre-impact structural failure.

The engine was also inspected, and it was determined that the power train could be rotated manually, and that the valve train and accessory section functioned properly. The spark plugs showed no unusual contamination or abnormal electrode wear, and although the magnetos were too contaminated with water, mud and rust to produce a spark, their internal mechanisms functioned in a proper manner. The oil filter was removed and inspected, and no significant contaminates or metal filings were found. The carburetor was inspected, and the fuel bowl and finger screen were found to be contaminated with mud, water, and debris from the pond, due to the failure of their surrounding structure. The internal structure of the carburetor had a distinct aviation fuel smell, and the neoprene tipped float needle and its seat were unremarkable. The brass float was not crushed or deformed, and when shaken did not reveal any leakage of fluid into either of its lobes.

The propeller hub had torn from the crankshaft flange, and about one-third of the flange was missing. The four remaining holes through which the propeller attach bolts pass were oblonged in the plane of rotation. A portion of one of the remaining four holes had been torn away in a

direction opposite rotation. Both propeller blades were bent aft about 45 degrees, one about six inches from its root, and the other about one foot from its root. The most outboard 11 inches of the blade that was bent aft at a point six inches from its root, was folded forward 180 degrees into its own front. Neither blade had cord-wise scratching, but both had several deep gouges in their leading edge

The inspection of the engine and propeller did not reveal any evidence of an anomaly within those systems, nor any indication of a loss of engine power.

Due to the extent of damage to the area around the instrument panel, examination of the flight instruments and the vacuum system was limited to the attitude indicator and the vacuum pump itself. The entire attitude indicator was contaminated with mud, water, and debris from the collection pond. Its air intake port screen, which was open to the debris of the pond until the wreckage was recovered, contained mud and solid particles, to include a piece of red plastic-like material, measuring about one-eighth of an inch square. The attitude indicator was disassembled, and there was no clear indication of any pre-impact anomaly. The attitude indicator rotor mass was removed from its case, and there was no evidence of contamination or unusual staining of its scalloped steps. There was no circumferential scaring on the rotor, nor any indication that it had come in contact with its own case during the impact sequence.

The vacuum pump, which was also exposed to the waters of the pond, had very little particulate contamination, and it still rotated relatively freely. Its rotor had been fractured into two pieces. One piece contained two rotor sectors, and the other contained four sectors. Although the rotor had been fractured, it and its vanes remained in their normal position within the case. There was no evidence of vane damage or excess vane wear, no scalloping or scoring of the case walls, nor was there any blockage of the air ports due to accumulated contamination. No pre-impact anomalies were noted.

#### AIRCRAFT INFORMATION

The vacuum pump on this aircraft was last replaced in December of 2001. At the time of the accident, the pump had accumulated approximately 800 hours. A standby vacuum pump had been installed in November of 2001. In January of 2003, the directional gyro was replaced because it appeared to be precessing, and the turn coordinator was replaced in January of 2004 because it appeared not to be stable in a turn. The attitude indicator "failed" in April of 2004, and was replaced. During that replacement, it was discovered that the hoses leading to the attitude indicator had some residue in them, so those hoses were replaced.

In November of 2004, the pilot who was assumed to be flying in the right seat mentioned to others that it appeared that the vertical compass in this aircraft would stick at times, and during those times it would be temporarily off from the correct heading about 10 to 30 degrees. He also stated that the directional gyro was occasionally slow to move. He reportedly mentioned that he was going to take the aircraft to Monroe Air Center to have them look at the directional gyro and the vertical compass since he thought they still might be under warranty. But, according to Monroe Air Center, they were not asked to address either of these apparent discrepancies, and neither discrepancy was noted on the Aircraft Discrepancy Form for N9474E.

#### PERSONNEL INFORMATION

Both pilots held commercial pilot certificates, with single engine land and instrument ratings. Both had completed a Civil Air Patrol (CAP) Form 5 proficiency check on March 4, 2004. Both

held high performance and complex aircraft endorsements. Both had current second class medicals with waivers for corrective lenses. The pilot believed to be in the left seat had 18.2 hours of night time in the last two years, 9.3 of which were in the last six months. His flight log indicated 8.8 hours of actual instrument time in the last two years, 3.3 of which were in the last 6 months. The log also indicated he had accomplished 35 instrument approaches in the last two years, five of which were in the last six months (to include the three approaches on the night of the accident). The number of night hours, instrument hours, and approaches completed by the pilot assumed to be in the right seat could not be determined, as his personal log book was not located during the investigation, and CAP records did not record this data.

#### MEDICAL AND PATHOLOGICAL INFORMATION

The autopsies performed on both pilots indicated that the manner of death was accidental due to multiple traumatic injuries that occurred during the accident.

Forensic toxicology examinations were performed on specimens from both pilots, and both were negative for carbon monoxide, cyanide, and ethanol. The toxicology for the pilot assumed to be in the right seat was negative for all tested drugs, but the toxicology on the pilot assumed to be in the left seat was positive for Sertraline and Desmethylsertraline in both the liver and Kidneys. According to FAA's Southwest Regional Flight Surgeon, Sertraline (Zoloft) is an antidepressant medication, and Desmethylsertraline represents a metabolite of Sertraline. The flight surgeon further stated that use of this medication would have precluded medical certification of this pilot had it been reported to a medical examiner. He also said that any pilot who was already certified would have been warned not to fly while taking this medication, had an examiner become aware that the pilot was doing so.

As a follow-up on the toxicology, the Investigator-In-Charge (IIC) contacted the sister of this pilot, who stated that this individual had been taking about 50 mg of Zoloft per day for about the previous three months. According to her, her brother was involved in a child custody dispute that had caused him significant anxiety, and he had started taking this medication in order to help deal with that situation. She further stated that she was not sure where he had acquired the medication, but that she was unaware of any prescription being written by a doctor. She also said that the final determination of the child custody issue was scheduled to be decided the day of the accident, but that the judge involved had postponed the decision to a latter date.

#### ADDITIONAL DATA AND INFORMATION

The wreckage was released to Air Salvage of Dallas on October 24, 2005. At the time of the release the wreckage was located at their facility in Lancaster, Texas.



## History of Flight

### Pilot Information

<b>Certificate:</b>	Commercial	<b>Age:</b>	54, 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
<b>Instrument Rating(s):</b>	Airplane	<b>Second Pilot Present:</b>	Yes
<b>Instructor Rating(s):</b>	None	<b>Toxicology Performed:</b>	Yes
<b>Medical Certification:</b>	Class 2 With Waivers/Limitations	<b>Last FAA Medical Exam:</b>	10/01/2004
<b>Occupational Pilot:</b>		<b>Last Flight Review or Equivalent:</b>	03/01/2004
<b>Flight Time:</b>	1225 hours (Total, all aircraft), 37 hours (Last 90 days, all aircraft), 7 hours (Last 30 days, all aircraft), 1 hours (Last 24 hours, all aircraft)		

### Pilot Information

<b>Certificate:</b>	Commercial	<b>Age:</b>	80, Male
<b>Airplane Rating(s):</b>		<b>Seat Occupied:</b>	Right
<b>Other Aircraft Rating(s):</b>		<b>Restraint Used:</b>	Seatbelt
<b>Instrument Rating(s):</b>		<b>Second Pilot Present:</b>	Yes
<b>Instructor Rating(s):</b>		<b>Toxicology Performed:</b>	
<b>Medical Certification:</b>		<b>Last FAA Medical Exam:</b>	
<b>Occupational Pilot:</b>		<b>Last Flight Review or Equivalent:</b>	03/01/2004
<b>Flight Time:</b>	1350 hours (Total, all aircraft)		

## Aircraft and Owner/Operator Information

Aircraft Make:	Cessna	Registration:	N9474E
Model/Series:	182R	Aircraft Category:	Airplane
Year of Manufacture:		Amateur Built:	No
Airworthiness Certificate:	Normal	Serial Number:	18268418
Landing Gear Type:	Tricycle	Seats:	4
Date/Type of Last Inspection:	10/01/2004, Annual	Certified Max Gross Wt.:	3100 lbs
Time Since Last Inspection:	76.6 Hours	Engines:	1 Reciprocating
Airframe Total Time:	3843 Hours at time of accident	Engine Manufacturer:	Continental
ELT:	Installed, not activated	Engine Model/Series:	O-470-U
Registered Owner:	Civil Air Patrol Inc.	Rated Power:	2320 hp
Operator:	Civil Air Patrol Inc.	Operating Certificate(s) Held:	None

## Meteorological Information and Flight Plan

Conditions at Accident Site:	Instrument Conditions	Condition of Light:	Night/Dark
Observation Facility, Elevation:	KMLU, 80 ft msl	Distance from Accident Site:	8 Nautical Miles
Observation Time:	2053 CST	Direction from Accident Site:	40°
Lowest Cloud Condition:		Visibility	10 Miles
Lowest Ceiling:	Overcast / 900 ft agl	Visibility (RVR):	
Wind Speed/Gusts:	8 knots /	Turbulence Type Forecast/Actual:	/
Wind Direction:	190°	Turbulence Severity Forecast/Actual:	/
Altimeter Setting:	30.12 inches Hg	Temperature/Dew Point:	18°C / 17°C
Precipitation and Obscuration:	No Obscuration; No Precipitation		
Departure Point:	Monroe, LA (KMLU)	Type of Flight Plan Filed:	IFR
Destination:	(KMLU)	Type of Clearance:	
Departure Time:	1905 CST	Type of Airspace:	

## Airport Information

Airport:	Monroe Regional Airport (KMLU)	Runway Surface Type:	
Airport Elevation:	79 ft	Runway Surface Condition:	
Runway Used:	22	IFR Approach:	ILS
Runway Length/Width:	7500 ft / 150 ft	VFR Approach/Landing:	None

## Wreckage and Impact Information

<b>Crew Injuries:</b>	2 Fatal	<b>Aircraft Damage:</b>	Destroyed
<b>Passenger Injuries:</b>	N/A	<b>Aircraft Fire:</b>	None
<b>Ground Injuries:</b>	N/A	<b>Aircraft Explosion:</b>	None
<b>Total Injuries:</b>	2 Fatal	<b>Latitude, Longitude:</b>	32.601389, -91.930000

## Administrative Information

<b>Investigator In Charge (IIC):</b>	Orrin K Anderson	<b>Adopted Date:</b>	03/28/2006
<b>Additional Participating Persons:</b>	Brian Capone; Baton Rouge FSDO; Baton Rouge, LA Tom Moody; Cessna Aircraft Company; Wichita, KS John Kent; Teledyne Continental Motors; Mobile, AL		
<b>Publish Date:</b>			
<b>Investigation Docket:</b>	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.