



# National Transportation Safety Board Aviation Accident Final Report

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<b>Location:</b>	Salt Lake City, Utah	<b>Accident Number:</b>	FTW03FA082
<b>Date &amp; Time:</b>	January 10, 2003, 20:50 Local	<b>Registration:</b>	N601RX
<b>Aircraft:</b>	Agusta A-109-K2	<b>Aircraft Damage:</b>	Destroyed
<b>Defining Event:</b>		<b>Injuries:</b>	2 Fatal, 1 Serious
<b>Flight Conducted Under:</b>	Part 91: General aviation - Positioning		

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## Analysis

While maneuvering low to the ground during night conditions, the air ambulance helicopter encountered fog and poor weather conditions, and impacted the terrain. Shortly after departing from its hospital base, the helicopter was cleared by air traffic control to proceed through a major airport's airspace to respond to a medical emergency. After crossing through the airspace, the pilot elected to abort the mission; however, he was instructed by air traffic control to hold and wait for clearance through the airspace due to landing traffic at the airport. After holding for approximately 10 minutes, the pilot stated, "I'm basically inadvertent IMC at this time and declaring emergency...I'm currently on a heading one five zero." Examination of the accident site revealed the helicopter impacted the terrain on a heading of 150 degrees, became airborne for approximately 1/4 mile, then impacted the terrain and came to rest upright in a grassy field. According to documents provided by the operator, the pilot had accumulated a total of 311 simulated instrument flight time, and 3 hours of actual instrument flight time. Examination of the helicopter revealed no evidence of an in-flight control or system malfunction prior to the initial impact. Prior to the accident helicopter's departure from the hospital base, another air ambulance company helicopter attempted the same mission; however, aborted the mission due to fog and deteriorating weather conditions.

## Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be: The pilot's delayed remedial action and continued flight into known adverse weather conditions which resulted in his failure to maintain clearance with the ground. Contributing factors were the prevailing fog, and the pressure to complete the mission induced by the pilot in command as a result of the air ambulance operation.

## Findings

Occurrence #1: IN FLIGHT ENCOUNTER WITH WEATHER

Phase of Operation: MANEUVERING

### Findings

1. (F) WEATHER CONDITION - FOG
2. (C) FLIGHT INTO KNOWN ADVERSE WEATHER - CONTINUED - PILOT IN COMMAND
3. (F) PRESSURE INDUCED BY CONDITIONS/EVENTS - PILOT IN COMMAND
4. (C) REMEDIAL ACTION - DELAYED - PILOT IN COMMAND

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Occurrence #2: IN FLIGHT COLLISION WITH TERRAIN/WATER

Phase of Operation: MANEUVERING

### Findings

5. (C) REMEDIAL ACTION - DELAYED - PILOT IN COMMAND
6. (C) CLEARANCE - NOT MAINTAINED - PILOT IN COMMAND
7. TERRAIN CONDITION - GROUND

## Factual Information

### HISTORY OF FLIGHT

On January 10, 2003, approximately 2050 mountain standard time, an Agusta A-109-K2 twin-engine helicopter, N601RX, operated as Life Flight 6, was destroyed when it impacted terrain while attempting to maneuver in dense fog near the Salt Lake City International Airport (SLC), near Salt Lake City, Utah. The instrument-rated commercial pilot and the flight paramedic were fatally injured, and the flight nurse was seriously injured. The helicopter was owned and operated by IHC (Intermountain Health Care) Health Services, Inc., of Salt Lake City, and doing business as (d.b.a.) IHC Life Flight. Night instrument meteorological conditions (IMC) prevailed for the 14 Code of Federal Regulations Part 91 flight, for which a company visual flight rules (VFR) flight plan was filed. The flight originated at the LDS Hospital, Salt Lake City, at 2032, and was destined for Wendover, Utah, to pick up a patient who had been injured in an auto accident.

According to Air Methods (another Salt Lake City air ambulance company), dispatch records, and a written statement provided by the Air Methods pilot, at 1949, a call was received from Tooele County, Utah, police dispatch requesting a helicopter to stand by for a possible medical response flight. Approximately 5 minutes later, an Air Methods flight was dispatched from the University of Utah Medical Center, Salt Lake City, for the medical emergency flight to Wendover. After departure, the Air Methods pilot contacted the SLC air traffic control tower (ATCT) and requested an "I-80 transition low-level west bound to Wendover." SLC ATCT instructed the Air Methods pilot to hold east of SLC due to landing traffic. The pilot held at 700-foot agl from approximately 2010 to 2019 while monitoring the ATCT and the automatic terminal information system (ATIS) frequencies. The pilot stated the weather "drastically changed from 2 miles visibility to 1/16th SM (statute miles) FG (fog)." Approximately 2019, ATCT cleared the pilot to transition over SLC; however, due to the deteriorating weather, the pilot elected to abort the flight and return to the University of Utah Medical Center.

Approximately 2030, the Air Methods flight terminated at the University helipad. After completing the shutdown and post flight procedures, the pilot returned to the Air Methods dispatch facility at the medical center. As the pilot walked into dispatch, he heard dispatch personnel and his crew discussing that Life Flight was attempting the flight. The pilot then contacted the Life Flight 6 pilot on the dispatch radio and reported that he just aborted the same mission because the visibility had reduced to 1/16 mile. The Life Flight 6 pilot stated he was going to try to get over the fog and get to Wendover.

Between 2017 and 2056, the following communications excerpts were recorded by Life Flight dispatch personnel (LFD), Tooele dispatch (TD), and the Life Flight 6 pilot (LF6). It should be noted that recorded times may vary between Air Methods dispatch and Life Flight dispatch due to time disparities between the facilities.

Approximately 2017, Tooele County dispatch and Life Flight Communication Center:

LFD: Life Flight [dispatcher]

TD: Hello this is [dispatcher] from Tooele County  
LFD: Hey  
TD: Are you guys able to fly  
LFD: Auh, I can check, we can sure give it a try  
TD: Well, Air Med can't, so I don't know if you could  
LFD: Oh, well  
TD: Is it the same  
LFD: Let me check with my pilot...

Approximately 2018, Life Flight 6 pilot and Life Flight Communication Center:

LF6: Life Flight [pilot]  
LFD: [Pilot] this is [dispatcher]  
LF6: Hi [dispatcher]  
LFD: This is [dispatcher], will you check weather for Wendover marker 22, mile marker 22  
LF6: You think there is a weather reporting service right at mile marker 22  
LFD: Well, yea, that's what I'm thinking (laughter), well, how about out west, can you fly out west  
LF6: I can see out west, all I got really is Wendover itself and it says 10 miles and I'll look back in Salt Lake again, got Salt Lake and they gotten really bad there right there in the valley 1/16th of a mile  
LFD: Ok, so this is a, um, you could probably look at mile marker 22 as closer to Wendover, so  
LF6: Is it  
LFD: Just yes or no  
LF6: Well, it's one of those things; I can give it a shot.  
LFD: Ok  
LF6: I can't make promises  
LFD: Alright, I can tell them we will give it a shot and there are no guarantees  
LF6: Is this a go  
LFD: Yes, let's plan on going, why don't you go get ready and I will call the dispatch back, and I will call dispatch back...

Approximately 2022, Tooele County and Life Flight Communication Center:

LFD: Hi, this is [dispatcher] at Life Flight  
TD: Dispatch [dispatcher]  
LFD: Yea, you know what, we are going to give it a try  
TD: Ok  
LFD: It looks like Wendover is clear enough to get into it; it's just going to be between here and there that could be iffy. They're going to lift to see how far they can get.  
TD: Ok  
LFD: But I can't really guarantee anything, so...  
TD: That's ok  
LFD: Tell me what you got

Approximately 2044, Life Flight Communications Center and Life Flight 6 pilot:

LF6: We are on the west side of the airport. Air Med got sent out for this same damn thing and then they called us to go out. Air Med turned around for low visibility so they go shopping for another helicopter and we're turning around at the west side airport. You know it what's their determination, you know

LFD: I understand, unfortunately that happens all day long a lot of the dispatch center do it, but so I understand that you are turning back twenty

LF6: I mean they need help, I mean when they need help, it's not you know like they call to just hi themselves anyway, there's a ton of air traffic out here so we'll wait to cross back over the airport.

LFD: Alright, were you able to get a hold of anyone the Wendover ambulance on the ground

LF6: We talked with them but we haven't make contact with them to tell them that we are turning around

LFD: Ok, no problem, I can tell Tooele Dispatch and let them know

LF6: Ok, that would be great

According to the communication transcript provided by the SLC ATCT, at 2031, the Life Flight pilot contacted SLC ATCT for a departure clearance from the LDS Hospital. Approximately 2033, the Life Flight pilot was cleared to proceed toward SLC via the signatory letter of agreement (LOA) and enter the Class B airspace. At 2033, the pilot advised ATCT that he was attempting to "climb out of it" and requested clearance to 7,000 or 8,000 feet. Life Flight 6 was cleared for the ascent and to remain to the east of SLC. At 2035, ATCT inquired how high did Life Flight 6 want to fly to obtain VFR. Life Flight 6 pilot reported that he attempted to climb; however, he would lose VFR and requested not to do that, but to transition through the SLC airspace "to see if it clears up any better for us." ATCT advised the pilot the visibility was 1/16th of a mile and to proceed inbound via the LOA and remain east of SLC. At 2037, ATCT asked the pilot, "based on [his] flight conditions" if could he continue westbound, and the pilot responded, "I'd like to give it a try if I could."

At 2039, Life Flight 6 was cleared westbound and to maintain VFR at or below 5,000 feet. At 2041, Life Flight 6 pilot stated he was on the west side of the airfield, and requested to head back to the east; however, he could hold over there. At 2044, the pilot asked ATCT whether he was cleared back to the east. ATCT informed the pilot that she could not let him go east until he could see other aircraft on final approach to runway 34R or have a "hole large enough to get [Life Flight 6] back to the east side."

At 2049:51, Life Flight 6 pilot reported to ATCT, "I'm basically inadvertent IMC at this time and declaring emergency." At 2051:03, ATCT asked the pilot whether he had runway 34L in sight, the pilot responded, "that's negative and I'm currently on a heading one five zero." ATCT instructed the pilot to turn right to a heading of 340 degrees to vector toward SLC. The accident aircraft did not acknowledge the instruction, the ATCT controller attempted to contact the Life Flight 6 pilot, and no further communications were received by ATCT from the accident aircraft. The SLC airport rescue and firefighting personnel were then notified of a possible crash.

A witness, who was located at a construction site approximately 1/4 mile south of the accident site, reported the accident helicopter was traveling over the job site trailer, and he noted the helicopter was "going north in the fog." The witness stated it was "very foggy, [and] could see

approximately 30 feet with headlights." The witness added he could see a glimpse of red from the helicopter light, could hear blades turning in a "woshing" sound for about 10 seconds, and then heard a crash. The witness called 911 and then assisted the law enforcement and rescue personnel in locating the aircraft.

Another witness, who was also located at the construction site, reported the helicopter came from the northwest and was low to the ground. The helicopter banked over the construction site with the engine making "high-low variable sounds." The helicopter then went to the north for approximately 10 seconds with no sound of the motor; however, he could hear the "rotor turning" for approximately 5 seconds before hearing an impact.

The SLC police department dispatch received the 911-phone call from a witness at 2056. The witness reported to the police dispatch "very thick fog...the helicopter barely missed their trailers...fog is very thick can only see 40 feet ahead." Approximately 2140, local law enforcement personnel and the witness located the helicopter.

According to a statement provided by Air Methods Chief Flight Coordinator, on the day of the accident, several flights were missed due to "extreme fog".

#### PERSONNEL INFORMATION

The pilot held a commercial helicopter certificate, issued on September 18, 1985, with an instrument helicopter rating. The pilot was issued a second-class medical certificate on March 15, 2002, with the limitation, "MUST HAVE AVAILABLE LENSES FOR NEAR VISION."

According to the operator, as of October 15, 2001, the pilot had accumulated 3,671 hours total flight time, 483 hours night flight time, 362 hours night cross-country time, 311 hours simulated instrument time, and 3 hours actual instrument time. The pilot completed his initial Agusta A-109-K2 training on October 27, 2001, which included 10.0 hours total flight time, and 40.0 hours ground training in the A-109-K2. The operator assigned the pilot to the A-109-K2 on October 29, 2001.

A review of the pilot's flight and duty time records, which were provided to the National Transportation Safety Board Investigator-In-Charge (NTSB IIC) by the operator, revealed that as of December 1, 2001, the pilot had accumulated approximately 114 flight hours as pilot-in-command in the Agusta A-109-K2, with 73.1 hours logged as day flight and 40.6 hours logged as night flight. The pilot had accumulated 34.9 flight hours, 22.6 flight hours, and 11.4 flight hours in the last 90, 60, and 30, days respectively.

On March 21, 2002, the pilot satisfactorily completed his Federal Aviation Regulations (FAR) Part 135 Airman Competency/Proficiency Check in the Bell 206 helicopter. According to the remarks, the pilot completed "inadvertent IMC with ILS (instrument landing system) recovery." On September 30, 2002, the pilot satisfactorily completed his FAR Part 135 Airman Competency/Proficiency Check in the Agusta A-109-K2 helicopter. According to the remarks, the pilot completed "inadvertent IMC with ILS (instrument landing system) recovery."

Prior to his employment with IHC, the pilot reported to the operator he had been a helicopter

pilot for 17 years and an Emergency Medical Services (EMS) pilot for over 5 years.

The two medical crewmembers, a flight nurse and a paramedic, were based at the LDS Hospital.

#### AIRCRAFT INFORMATION

The red and white accident helicopter (serial number 10017) was configured for the transport of medical patients with two seats in the cockpit, one rear-facing seat aft of the cockpit, one forward-facing seat, and one medical bed. The helicopter was powered by two 730-horsepower Turbomeca Arriel 1K1 turbo shaft engines (serial numbers 16016 and 16017) and equipped with a four bladed main rotor system, and a two bladed tail rotor. The helicopter was also equipped for IFR operations, and was equipped with a three-channel Stabilization Augmentation System (SAS), which provided the capability of automatically controlling the pitch, roll and yaw axes of the helicopter.

The helicopter was maintained in accordance with the Manufacturer's Recommended Extended Maintenance Program on a continuous basis. At the time of the accident, the airframe had accumulated 3,545.4 flight hours, the left engine had accumulated 2,801.9 hours and the right engine had accumulated 4,729.2 hours. The 1,200-hour inspection was completed on January 2, 2003, at a total time of 3,544.3 hours, and the 25-hour inspection was completed on January 9, 2003, at a total time of 3,544.3 hours.

#### METEOROLOGICAL INFORMATION

The Air Methods flight crew stated the visibility was clear from the University of Utah Medical Center to downtown Salt Lake City area. Shortly after departure, one crewmember noted, "there appeared to be almost a wall of clouds or fog to the west." A Life Flight crewmember, who assisted the accident crew prior to the flight, reported they could "see stars and moon" from the LDS Hospital helipad.

A National Oceanic and Atmospheric Administration (NOAA) representative received a phone call, between 2025 and 2035, from a Life Flight pilot who was located at the SLC airport. The pilot reported to the NOAA representative that he was concerned with the fog, which was "really thick, and the RVR (runway visual range) was zero..." The pilot inquired how long the fog would persist, and the representative stated 2 to 3 hours.

Local law enforcement officials who responded to the accident area stated "it was difficult locating the helicopter due to the fog...the night was very foggy and the crash site was very difficult to find...responding units experienced extreme dense fog."

At 2011, the SLC Airport reported winds from 340 degrees at 3 knots, 1/16 mile visibility with fog, and a vertical visibility (VV) of 200 feet. The temperature and dew point were both reported at 34 degrees Fahrenheit, and the altimeter setting was 30.10 inches of Mercury.

At 2056, the SLC Airport reported winds from 350 degrees at 6 knots, 1/8 mile visibility with fog, and a vertical visibility (VV) of 200 feet. The temperature, dew point, and altimeter setting

remained the same as the 2011 report.

## WRECKAGE AND IMPACT INFORMATION

The helicopter wreckage was located by rescue personnel one half mile southwest of the approach end of SLC runway 34L. A ground scar was oriented along a magnetic heading of 150 degrees. A 1/4 mile gap existed between the ground scar and the helicopter, which came to rest upright in a grassy field. The geographic coordinates of the helicopter wreckage were north latitude 40 degrees 46.3 minutes by west longitude 112 degrees 01.1 minutes at an elevation of approximately 4,000 feet msl.

The initial impact area contained three ground scars, which contained white paint transfer, that were consistent with the three landing gear assemblies. There were no additional ground scars noted in the initial impact area. The initial impact area measured approximately 330 feet in length, and contained the two main landing gear assemblies, the nose gear ski, several pieces of broken plexiglass, the outboard 4-inches of the left horizontal stabilizer, and shredded aluminum pieces from the left horizontal stabilizer.

The main wreckage came to rest approximately 90 degrees from the ground scars. Pieces of aluminum, consistent with the tail rotor blades, and pieces of plexiglass were located between the initial impact area and the main wreckage. The distribution path of the debris was consistent with a semi-circular flight path following the initial impact. The main wreckage consisted of the fuselage, the two engines, transmission, main rotor assembly, and the tail boom with the tail rotor gearbox and blade assembly separated. The tail rotor assembly came to rest adjacent to the tail boom. Separated honeycomb core sections of the main rotor blades were located within a 100-foot radius of the main wreckage.

On January 15, 2003, the wreckage was recovered by an aircraft retrieval/salvage firm to a hangar at SLC, and was examined by the NTSB IIC, operations and airworthiness inspectors from the Federal Aviation Administration (FAA), representatives from the airframe and engine manufacturers, and representatives from IHC Life Flight.

The cockpit and cabin fuselage from the avionics bay aft to behind the baggage compartment was crushed and distorted to the right when viewed from the tail. The cockpit and cabin floors were crushed upward. The cabin area roof, aft of the two forward cockpit seats, was crushed downward and to the right by the main rotor transmission and engines. The left side cockpit door and frame were cut and removed by rescue personnel. The damage sustained on the right side of the cockpit was consistent with impact from the main rotor blades. Several flight instruments were separated and displaced from their respective mounting structure. A majority of the cockpit windscreen was shattered and separated from the fuselage.

The tail boom was intact; however the tail boom was crushed upward and displaced to the right. The outboard 1-foot of the right horizontal stabilizer was bent upward and remained intact. The vertical stabilizer was intact and the leading edge displayed a puncture hole. The outboard 1-foot of the leading edge of the left horizontal stabilizer was crushed aft. The outboard 1-foot of the left horizontal stabilizer was bent aft and shredded. The tail boom skid was bent upward and to the left. The tail rotor gearbox separated from the tail boom mounting

structure. The tail rotor blades were bent and the outboard 4 to 6 inches of the blade tips were shredded. Continuity was established throughout the tail rotor gearbox to the blades. The tail rotor pitch links were intact. The forward tail rotor drive shaft was separated near the main transmission attach point. The separated drive shaft displayed signatures consistent with torsional overload. Continuity was established throughout the remaining tail rotor drive shafts, from the tail rotor gearbox to the separation near the main transmission attach point.

The engines remained attached to the airframe via the forward engine mounts; however, the aft engine mounts were separated. The left and right engine compressor sections were rotated by hand and continuity was noted to the accessories. Both engine to transmission drive shafts were separated from their respective attach flanges. The engines were removed and transported to the facilities of Turbomeca, near Grand Prairie, Texas, for further examination.

The main transmission was separated from the two forward and one aft attach mounts, and displaced to the right. Continuity was established from the drive shaft inputs to the rotor head. Blade up stops remained intact, and no evidence of blade coning was noted. All four main rotor blades remained attached to the rotor head. Three blades displayed leading edge gouging, scratching, and core separation.

#### PATHOLOGICAL INFORMATION

The Office of the Medical Examiner, State of Utah, Department of Health, Salt Lake City performed autopsies on the pilot and flight paramedic, on January 11, 2003. Specimens for toxicological tests were taken from the pilot by the medical examiner. According to the autopsy, the cause of death for both persons was blunt force injury of the chest.

The FAA's Civil Aeromedical Institute's (CAMI) Forensic and Accident Research Center examined the specimens taken by the medical examiner. The toxicological tests were negative for carbon monoxide, cyanide and alcohol. An unspecified amount of Verapamil (commonly known as Calan or Isoptin) was found in the blood and urine.

#### TEST AND RESEARCH

The engines were examined and disassembled on April 8, 2003, at the facilities of Turbomeca, under the supervision of the NTSB IIC and representatives from Turbomeca. Examination of the left engine (serial number 16016) revealed foreign object debris (FOD) in the module 03, gas generator combustion chamber. The FOD was consistent with red and white paint chips. Some metal spray deposits were noted on the first and second stage turbine wheels. The axial compressor rotor, free turbine rotor, and turbine reduction gearbox were free to rotate. The powershaft was intact and no evidence of twisting was noted. The fuel control unit was removed and tested according to an FAA approved test procedure. The unit operated according to the manufacturer's specifications.

Examination of the right engine (serial number 16017) revealed FOD in the module 02, axial compressor section, and the module 03 combustion chamber outer shell and inner chamber. The FOD was consistent with red and white paint chips and Kevlar debris. The axial compressor blades displayed evidence of FOD damage and the compressor rotor was free to

rotate. The free turbine rotor was free to rotate and did not display evidence of metal spray deposits. The fuel control unit was removed and tested according to an FAA approved test procedure. The unit operated according to manufacturer's specifications.

On July 29 and 30, 2003, at the facilities of Honeywell, near Glendale, Arizona, components of the autopilot system were tested under the supervision of the NTSB IIC and representatives of Honeywell. Examination of the gyro horizon revealed internal damage to the roll gimble, and witness marks on the sphere were consistent with a 55-60 degree nose up position. The DH (Decision Height) light bulb filament was stretched and broken, and the GA (Go-Around) light bulb filament was intact. The radio altimeter cockpit instrument DH bug was set at 500 feet agl. The radio altimeter unit was functionally tested and no anomalies were noted. The flight director mode selector was intact and no anomalies were noted. The two helipilot computers, and the flight director computer were not functionally tested due to lack of test equipment.

#### ADDITIONAL INFORMATION

The helicopter wreckage was release to the owner's representative on October 17, 2003.

#### Pilot Information

<b>Certificate:</b>	Commercial	<b>Age:</b>	47, Male
<b>Airplane Rating(s):</b>	None	<b>Seat Occupied:</b>	Right
<b>Other Aircraft Rating(s):</b>	Helicopter	<b>Restraint Used:</b>	
<b>Instrument Rating(s):</b>	Helicopter	<b>Second Pilot Present:</b>	No
<b>Instructor Rating(s):</b>	None	<b>Toxicology Performed:</b>	Yes
<b>Medical Certification:</b>	Class 2 Valid Medical--w/ waivers/lim	<b>Last FAA Medical Exam:</b>	March 15, 2002
<b>Occupational Pilot:</b>	Yes	<b>Last Flight Review or Equivalent:</b>	September 30, 2002
<b>Flight Time:</b>	3846 hours (Total, all aircraft), 124 hours (Total, this make and model)		

## Aircraft and Owner/Operator Information

<b>Aircraft Make:</b>	Agusta	<b>Registration:</b>	N601RX
<b>Model/Series:</b>	A-109-K2	<b>Aircraft Category:</b>	Helicopter
<b>Year of Manufacture:</b>		<b>Amateur Built:</b>	
<b>Airworthiness Certificate:</b>	Normal	<b>Serial Number:</b>	10017
<b>Landing Gear Type:</b>	Tricycle; Ski	<b>Seats:</b>	4
<b>Date/Type of Last Inspection:</b>	January 9, 2003 AAIP	<b>Certified Max Gross Wt.:</b>	5996 lbs
<b>Time Since Last Inspection:</b>	1.6 Hrs	<b>Engines:</b>	2 Turbo shaft
<b>Airframe Total Time:</b>	3545.4 Hrs at time of accident	<b>Engine Manufacturer:</b>	Turbomeca
<b>ELT:</b>	Installed, not activated	<b>Engine Model/Series:</b>	Arriel 1K1
<b>Registered Owner:</b>		<b>Rated Power:</b>	720 Horsepower
<b>Operator:</b>		<b>Operating Certificate(s) Held:</b>	On-demand air taxi (135)
<b>Operator Does Business As:</b>	IHC Life Flight	<b>Operator Designator Code:</b>	I2HA

## Meteorological Information and Flight Plan

<b>Conditions at Accident Site:</b>	Instrument (IMC)	<b>Condition of Light:</b>	Night/dark
<b>Observation Facility, Elevation:</b>	KSLC, 4227 ft msl	<b>Distance from Accident Site:</b>	1 Nautical Miles
<b>Observation Time:</b>	20:56 Local	<b>Direction from Accident Site:</b>	30°
<b>Lowest Cloud Condition:</b>	Unknown	<b>Visibility:</b>	0.13 miles
<b>Lowest Ceiling:</b>	Indefinite (V V) / 200 ft AGL	<b>Visibility (RVR):</b>	
<b>Wind Speed/Gusts:</b>	6 knots / 0 knots	<b>Turbulence Type Forecast/Actual:</b>	/
<b>Wind Direction:</b>	350°	<b>Turbulence Severity Forecast/Actual:</b>	/
<b>Altimeter Setting:</b>	30.1 inches Hg	<b>Temperature/Dew Point:</b>	1°C / 1°C
<b>Precipitation and Obscuration:</b>	N/A - None - Fog		
<b>Departure Point:</b>	Salt Lake City, UT	<b>Type of Flight Plan Filed:</b>	Company VFR
<b>Destination:</b>	Wendover, UT	<b>Type of Clearance:</b>	VFR
<b>Departure Time:</b>	20:32 Local	<b>Type of Airspace:</b>	Class B

## Airport Information

<b>Airport:</b>	SALT LAKE CITY INTL SLC	<b>Runway Surface Type:</b>	
<b>Airport Elevation:</b>	4227 ft msl	<b>Runway Surface Condition:</b>	Unknown
<b>Runway Used:</b>		<b>IFR Approach:</b>	Unknown
<b>Runway Length/Width:</b>		<b>VFR Approach/Landing:</b>	Unknown

## Wreckage and Impact Information

<b>Crew Injuries:</b>	2 Fatal, 1 Serious	<b>Aircraft Damage:</b>	Destroyed
<b>Passenger Injuries:</b>		<b>Aircraft Fire:</b>	None
<b>Ground Injuries:</b>	N/A	<b>Aircraft Explosion:</b>	None
<b>Total Injuries:</b>	2 Fatal, 1 Serious	<b>Latitude, Longitude:</b>	40.767776,-112.01139

## Administrative Information

<b>Investigator In Charge (IIC):</b>	Sauer, Aaron
<b>Additional Participating Persons:</b>	George D Cawthra; Federal Aviation Administration; Salt Lake City, UT Robert D Lesitsky; Federal Aviation Administration; Salt Lake City, UT Lynn S Higgins; Federal Aviation Administration; Salt Lake City, UT Paolo Ferreri; Agusta Aerospace Corporation; Philadelphia, PA Archie Whitten; Turbomeca Engine Corporation; Grand Prairie, TX William Butts; IHC Life Flight; Salt Lake City, UT
<b>Original Publish Date:</b>	March 30, 2004
<b>Note:</b>	The NTSB traveled to the scene of this accident.
<b>Investigation Docket:</b>	<a href="https://data.nts.gov/Docket?ProjectID=56318">https://data.nts.gov/Docket?ProjectID=56318</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](#).