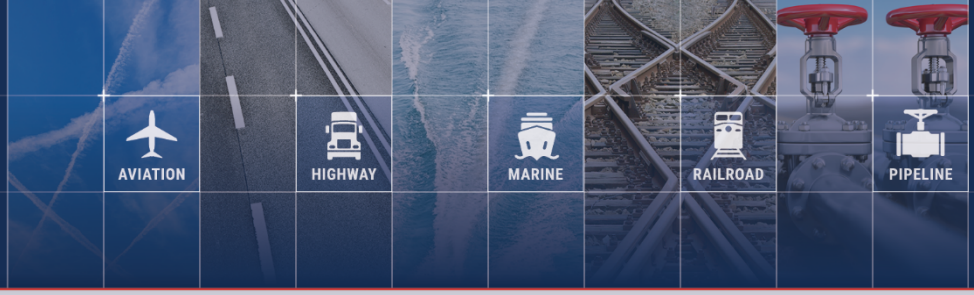

Aviation Investigation Final Report

Location:	Fremont, Ohio	**Accident Number:**	CHI08FA156
Date & Time:	June 8, 2008, 12:56 Local	**Registration:**	N29122
Aircraft:	Cessna U206C	**Aircraft Damage:**	Substantial
Defining Event:	Aerodynamic stall/spin	**Injuries:**	6 Fatal
Flight Conducted Under:	Part 91: General aviation - Other work use		

Analysis

On the day of the accident, the 86-year-old accident pilot was providing rides in his single-engine, six-seat airplane at the airport that he owned and managed. Passengers purchased tickets for the rides in the airport office. The rides were given concurrently with a Lions Club International charitable “fly-in breakfast” at the airport, which had been advertised in the local newspaper. According to a representative of the Lions Club, the air rides were a separate activity, and the money collected for the air ride tickets was not given to the charity (evidence indicates that the pilot retained the money). The accident flight was the fifth or sixth airplane ride the pilot gave that day. Videotapes of previous flights and of the beginning of the accident flight indicated that the pilot was performing nonstandard takeoffs. Rather than beginning a normal climb after lifting off from the ground, the pilot would maintain an altitude just above treetop level until reaching the departure end of the runway, at which point he would initiate a steep pitch-up maneuver followed by a pushover maneuver. Also, a witness, who was a pilot, reported that the accident pilot commonly performed a nonstandard maneuver called a “buttonhook turn” to align the airplane with final approach for landing. The maneuver involved flying the airplane at an altitude of about 300 feet above ground level perpendicular to the final approach course and then executing a 270-degree turn to the final approach. The witness stated that he observed the pilot perform this maneuver during one of the passenger-carrying flights preceding the accident flight.

About 30 minutes after the airplane departed on the accident flight, witnesses observed it returning to the airport. Witnesses near the accident site reported that the airplane was flying at a low altitude toward the runway when it banked, descended, and impacted the ground. One witness stated that the airplane “appeared to be flying very slow, almost on the edge of a stall.” This witness heard the engine “throttle up” and observed the airplane stall, with the left wing “dipping,” and then descend below the tree line.

The accident site was about 0.75 mile east of the approach end of runway 27. Ground scarring and wreckage distribution covered a relatively small area, consistent with an accident due to an aerodynamic stall. Examination of the airplane revealed no mechanical anomalies that would have precluded normal operation. During a test cell run, the airplane's engine performed within the manufacturer's specifications.

Review of the pilot's personal medical records indicated that he had been treated for age-related macular degeneration in both eyes for over 2 years. About 3 weeks before the accident, his distant visual acuity without correction was recorded as 20/200 for each eye. On at least two occasions, the pilot's retinal specialist advised him not to drive. However, the pilot continued to drive and was involved in a traffic accident, in which he turned in front of an oncoming vehicle, 10 days before the aircraft accident. The pilot's visual deficiency would have made it difficult for him to decipher the readings on cockpit instruments and to distinguish objects on the ground. This lack of visual acuity increased the likelihood that the pilot would fly at an inappropriate speed or altitude, thus increasing the chances of a stall.

About 1 year before the accident, the pilot applied for a Federal Aviation Administration (FAA) Airman Medical Certificate and provided false information about his eye condition (he did not report his visits to the retinal specialist). Even so, the pilot's visual deficiency, given its severity, should have been detectable during the vision examinations required before issuance of such an Airman Medical Certificate. However, the pilot's aviation medical examiner (AME) reported normal eye test results, including 20/20 uncorrected vision, and issued the pilot a second-class medical certificate. About 7 months after the accident, the FAA decertified the AME for improper issuance of medical certificates.

The pilot's autopsy noted severe coronary artery disease, which could have increased the likelihood of a heart attack or abnormal heart rhythm, resulting in impairment or incapacitation. There was no evidence of such an event, but no such evidence would necessarily be expected if death occurred within a few minutes to an hour of the impairment or incapacitation. The pilot's personal medical records did not indicate coronary artery disease.

Either the pilot's macular degeneration or his unrecognized coronary artery disease could have contributed to his failure to maintain control of the airplane. The NTSB could not conclusively determine whether either condition directly resulted in the accident. However, given the incompatibility of the pilot's vision deficiency with safe motor vehicle operation and the pilot's awareness of this, the pilot displayed extremely poor judgment in not only continuing to fly but

in deciding to perform passenger-carrying flights. Furthermore, the pilot did not provide all of the required information on his most recent application for an Aviation Medical Certificate, and his AME did not adequately evaluate the pilot's eyesight.

The passenger seated in the right front seat of the accident airplane was one of the accident pilot's former student pilots who purchased a ride in the airplane. He held a private pilot certificate, but did not hold a current Airman Medical Certificate. If the accident pilot had become incapacitated, it is possible this passenger could have taken control of the airplane. There was insufficient evidence to determine whether or not this passenger was manipulating the flight controls when the accident occurred.

The local FAA flight standards district office had no records of any concerns raised or complaints about the pilot. Also, the FAA had no record of the pilot applying for a Letter of Authorization to conduct passenger-carrying flights for compensation or hire, which is required by 14 Code of Federal Regulations (CFR) 91.147 for all passenger-carrying flights not conducted under 14 CFR 91.146 (flights for the benefit of a charitable, nonprofit, or community event). Therefore, the FAA was unaware of, and provided no oversight of, the pilot's passenger-carrying flights.

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 airplane control for an undetermined reason, which resulted in an inadvertent stall. Contributing to the accident was the pilot's poor judgment in continuing to fly with his severe visual deficiency. Also contributing to the accident was the aviation medical examiner's failure to accurately assess and report the pilot's visual deficiency.

Findings

Aircraft	(general) - Not attained/maintained
Personnel issues	Aircraft control - Pilot
Personnel issues	Decision making/judgment - Pilot
Personnel issues	Visual function - Pilot
Organizational issues	Personnel selection/training - Other institution/organization

Factual Information

History of Flight

Prior to flight	Miscellaneous/other
Approach	Loss of control in flight
Approach	Aerodynamic stall/spin (Defining event)
Uncontrolled descent	Collision with terr/obj (non-CFIT)

HISTORY OF FLIGHT

On June 8, 2008, about 1256 eastern daylight time, a Cessna U206C, N29122, piloted by a commercial pilot, impacted terrain about 0.75 miles east of the approach end of runway 27 at Fremont Airport (14G), Fremont, Ohio. The pilot was providing rides during a scheduled Lions Club “fly-in breakfast” at the airport at the time of the accident. The pilot and five passengers were fatally injured. Visual meteorological conditions prevailed at the time of the accident. Title 14 Code of Federal Regulations (CFR) Part 91 flight was not operating on a flight plan. The local flight originated from 14G about 1226.

The fly-in had been held for about the last 10 years at the airport, which was owned by the accident pilot, who was also a Lions Club member. According to the local Lions Club District 13B president, the air rides provided by the accident pilot were a separate activity, and money received from air rides was not given to the Lions Club.

An advertisement for the Fremont Lions Club was "ordered" and "approved" by the accident pilot. The advertisement ran in the June 5, 2008, edition of the Fremont News Messenger and stated, in part: "Ride in an Historic DC-3 airplane" and "Fly a REAL T-6 Texan."

The pilot of a North American T-6 stated that the accident pilot invited him to attend the fly-in. The T-6 pilot had attended 3 of the 5 fly-ins held during the last 5 years. The T-6 pilot stated that he provided flight lessons to pilots who attended the fly-in. On the day of the accident, he provided an instructional flight that consisted of "typical" introductory flight maneuvers.

The T-6 pilot said that the accident pilot had no involvement in the T-6 instructional flights. The T-6 pilot also stated that he is a flight instructor and provides T-6 training and tailwheel endorsements from his home base.

As he had done several years prior, the accident pilot also had requested an Emergency Medical Service (EMS) operator to attend the event. The EMS operator attended the fly-in for promotional purposes only and did not provide any rides during the event. It was against the EMS operator's policy to provide such rides.

A witness who had been helping passengers board the accident airplane stated that the accident pilot was short of help because the other pilots who were supposed to help him did not show up for the fly-in except for one pilot who used to be a flight instructor at 14G. The witness arrived at 14G about 0830 and the air rides began "shortly thereafter," at about 0930, which was the time the witness started helping. The witness reported that there were two women sitting at a table in a hangar next to a World War II display selling tickets, but the witness did not know their identities. The accident pilot first used an airplane other than the Cessna U206C for the first flight but then switched to the Cessna U206C because the radio in the first airplane was not working. That first airplane was put in a hangar. The witness did not know what time the accident pilot began using the Cessna U206C.

The accident pilot had a third airplane, which he did not use. The witness stated that "almost all the rides" that the accident pilot provided were in the Cessna U206C. The accident pilot flew about 8 to 10 flights in the Cessna U206C and would have had 2 to 3 flights remaining if the accident had not occurred. Passengers were charged $20 per person per ride or $10 per person per ride if that person weighed 50 pounds or less. The flights lasted 10 to 15 minutes. The air ride pilot placed all the air ride tickets that he collected from passengers in his pocket. The tickets were orange in color and similar to carnival ride tickets and the pilot had about 40 to 50 tickets. Nobody asked for passenger weights. The pilot ensured that the passengers were wearing their seat belts for the air rides. Each time that the accident pilot taxied the airplane onto the ramp, the airplane engine was shut down. The airplane engine started "good every time," according to the witness but prior to the accident flight, it took three attempts to start the engine. About 1030 or 1100, they checked the fuel and the airplane had "plenty of fuel," about 30 gallons in the left fuel tank and about 20 gallons in the right fuel tank. The other pilot, who was also providing air rides, began flying about 1200 in a Cessna 172M with registration markings of N73131.

According to the Federal Aviation Administration (FAA), the accident pilot did not apply for, nor receive, a Letter of Authorization (LOA) in order to conduct sightseeing or commercial air tours, as required by Federal Aviation Regulations (see “Tests and Research” section below for additional details).

A witness who had flown into 14G stated that he arrived about 0830. He stated that, by 0930, the winds increased. He stated that it took "every bit" of his piloting skills to land and he considered not landing due to the winds. During the witness's approach to 14G, he saw the accident pilot perform a "buttonhook turn," a term reportedly used by the accident pilot to describe a turn to final approach for landing. The witness stated that he was keeping an eye on the accident pilot because he knew that the accident pilot was going to perform that maneuver. The witness described the maneuver as flying the airplane downwind "a little bit lower" to base leg, continuing through the final approach, and then making a 270-degree turn onto final approach. The witnessing pilot estimated the altitude of this maneuver was 300 feet above ground level, near where the accident site was located. He said that he almost had a midair collision with the Cessna U206C during the approach to 14G.

The witness said that while he was at the airport office paying for his fuel, people came in to purchase tickets for air rides. The witness stated approximately 100 people were given rides that day. The witness stated that a Cessna 172 was initially used for the air rides but the accident pilot started using the Cessna U206C about 1100 because something had malfunctioned on the Cessna 172. It was the first time that the witness had seen the Cessna U206C. The witness left about 1200; at that time there were about 25 people in line waiting for an air ride. There were probably 5 to 6 air ride flights performed in the Cessna U206C before the accident..

Another witness, who had flown into 14G on the day of the accident, stated that there was heavy air traffic at the airport, and the accident pilot was not using his radio to provide position reports while flying. The witness heard ground personnel telling the air ride pilot to turn his radio on. After landing at the airport, the witness heard from another pilot that a near midair collision between the Cessna 206 and a homebuilt Van's RV airplane occurred when the Cessna U206C entered a low right base and the RV was on final from a left base approach.

Witnesses who observed the accident reported that the Cessna U206C was flying at a low altitude heading towards the west/southwest when it banked, descended, and impacted a field behind a house. One witness stated that the airplane was flying very slowly, almost on the edge of a stall. This witness further stated that he heard the engine "throttle up" and then the airplane appeared to stall with the left wing "dipping." The airplane then descended below the tree line.

PERSONNEL INFORMATION

The 86-year-old accident pilot was issued a commercial pilot certificate with airplane single-engine and multiengine land and sea ratings based upon military competency by the Civil Aeronautics Administration on March 6, 1945.

On October 10, 1987, he received his last issuance for an airman certificate and/or rating. The pilot was issued a Douglas DC-3 airplane rating at with a total flight time of 22,620 hours, which was listed on his airman certificate and/or rating application. The FAA inspector who issued the certificate checked the following statement indicating that he "personally reviewed this applicant's pilot logbook..."

On February 6, 1964, he was issued an initial flight instructor certificate, which was last renewed on January 14, 2007, with single- and multiengine airplane and instrument ratings based upon completion of a flight instructor renewal course.

On December 19, 1994, he was issued a mechanic certificate with airframe and powerplant ratings. On January 12, 2007, he received a renewal for inspection authorization based on having performed 9 annual inspections on aircraft.

The National Transportation Safety Board (NTSB) Investigator-In-Charge (IIC) did not receive

any of the accident pilot's logbooks following requests made to the pilot's son during the on-scene portion and subsequent portions of the investigation. The pilot's wife and son stated that they did not know where the pilot's logbooks were.

The accident pilot's airman medical certificate application, dated July 29, 1988, lists his total airplane flight time as 25,000 hours and 250 hours in the past 6 months. Subsequent medical applications had the following total and 6 month flight times, respectively.

August 3, 1989; 30,000 hours and 200 hours
August 30, 1990; 30,000 hours and 300 hours
September 3, 1991; 25,000 hours and 250 hours
October 8, 1992; 30,000 hours and 250 hours
November 4, 1993; 31,000 hours and 250 hours
November 7, 1994; 35,000 hours and 100 hours
August 17, 1995; 35,000 hours and 185 hours
August 28, 1996; 35,000 hours and 200 hours
August 14, 1997; 38,000 hours and 250 hours
September 4, 1998; 40,000 hours and 100 hours
October 1, 1999; 50,000 hours and 100 hours
November 1, 2000; 50,000 hours and 150 hours
November 26, 2001; 50,000 hours and 150 hours
December 21, 2002; 56,500 hours and 210 hours
January 2, 2004; 50,000 hours and 200 hours
January 7, 2005; 50,000 hours and 150 hours
March 2, 2006; 50,000 hours and 250 hours
May 4, 2007; 55,000 hours and 35 hours

FAA records show that the accident pilot was involved in an aviation incident on April 1, 2004, while piloting a Cessna 210L, N93948. The accident pilot was seated in the right pilot seat providing flight instruction to a private pilot in the left seat while they were en route to Bluffton Airport (5G7), Bluffton, Ohio, where the airplane was to undergo an adjustment to the landing gear warning horn. During the descent to 5G7, the landing gear warning sounded, and the private pilot asked the accident pilot if the landing gear should be lowered. The air accident pilot responded by saying that he would wait until they were on final approach to lower the landing gear. The landing warning horn continued to sound. The airplane impacted runway 5 during the landing. Following the incident, the accident pilot said that he became distracted and forgot to lower the landing gear because he was providing flight instruction while encountering strong crosswinds.

A company owned by the accident pilot was issued a Part 135 on-demand passenger operating certificate for a single-pilot operation on April 29, 1965. NTSB records show that the operator had an aviation accident on January 26, 1973, in a Cessna 207, N1582U, near Marion, Illinois. The airplane was piloted by a pilot other than the accident pilot. The pilot received

serious injuries and the passenger was fatally injured. The NTSB investigated this accident under accident number CHI73AC066. The accident pilot last received a Part 135 check ride by the FAA's Cleveland Flight Standards District Office (FSDO) on August 12, 2004, during which he passed the ground and flight portions of the check ride. The air ride pilot voluntarily surrendered the company's operating certificate on May 24, 2005.

According to the FAA's Cleveland FSDO, there had been no concerns or complaints regarding the accident pilot made to the FSDO office. before the accident.

According to Ohio State Highway Patrol and Fremont Police Department records, the air ride pilot was involved in four traffic accidents from 1998 to 2008, with the most recent occurring on May 30, 2008, near the intersection of State Route (SR)53 and the entrance to 14G when the air ride pilot's vehicle was hit by another vehicle. The air ride pilot reported to the Ohio State Highway Patrol that he was southbound on SR53. The sun was glaring into his vehicle, and he assumed that he had enough room to make a left turn into the airport entrance. He said that he saw the other vehicle when he was already into the turn. The driver of the other vehicle stated that the air ride pilot's vehicle turned 50-60 feet in front of her. A witness to the accident stated that the distance of the air ride pilot's vehicle was 20-30 feet from the other vehicle when the turn was made.

The right front seat passenger aboard the accident flight was a former student pilot of the air ride pilot. The right seat passenger held a private pilot certificate, and he was last issued a third class airman medical certificate on January 13, 1993. FAA airman medical records show that the right seat passenger accumulated a total flight time of 85 hours at the time of his medical certificate application.

AIRCRAFT INFORMATION

The airplane was a 1968 Cessna U206C airplane for which an application for registration was made by the air ride pilot's company on May 1, 1968. On September 20, 1995, application for registration was made by the pilot's trust, which the pilot was a trustee. A search of FAA aircraft registry information revealed eleven additional aircraft were registered to the pilot as trustee.

All maintenance entries in the aircraft and engine logbooks were made by the pilot beginning May 10, 1998, at 1,620 hours. The last airplane logbook entry was dated July 14, 2007, when an annual inspection was performed by the air ride pilot. The total airframe time was listed as 1,714 hours (1,710 hours was annotated with a line through this number).

The airplane was powered by a Continental IO-520-F fuel-injected, reciprocating engine, serial number 168387-8-F. According to the engine logbooks, the first entry dated June 23, 1968, lists the engine total time as 1.25 hours. The last entry in the engine logbook is dated July 14, 2007, for an annual inspection at 1,710 hours.

Teledyne Continental Motors (TCM) Service Information Letter SIL98-9A, provides time limits between major overhauls and lists the time between overhaul for TCM IO-520-F engines as 1,700 hours or 12 years.

AIRPORT INFORMATION

Fremont Airport (14G) incorporated two runways: runway 09/27 (4,137 feet by 60 feet, asphalt) and runway 18/36 (2,238 feet by 130 feet, turf). The airport was owned and managed by the air ride pilot, who purchased it about 1960.

A wood sign with "AIR RIDES - TRIPS" and "LEARN TO FLY" was located at the driveway entrance of 14G.

Air BP had sold fuel to 14G until July 15, 2006, at which time they debranded those sales due to recurring issues of:

- No documented training for personnel fueling aircraft or performing quality control/quality assurance checks

- No documented quality control/quality assurance records

- No misfueling and cross-drop prevention training in place

- Non-aviation grade hoses in use

- Nozzle screens missing from the over wing nozzle

The airport fuel facility was inspected during the on-scene portion of the investigation. There were no dates listed on the fuel pump fuel filters indicating when those filters were to be changed. Additionally, no records were presented upon request by the NTSB IIC listing inspection of the fuel facility and fuel filter change dates. Fuel dispensed from the fuel pump nozzles was blue in color with no visible water or contaminant. The filter sump on one tank contained brown colored liquid and the filter sump from an adjacent pump was blue in color with no visible water or contaminant.

Fueling records show that nine aircraft had obtained fuel at 14G on the day of the accident. No reports of fuel-related anomalies were received from any of those aircraft.

During a Transportation Security Administration (TSA) inspection of the airport about nine days prior to the accident, a TSA inspector met with the air ride pilot and his wife during which time the Inspector requested the air ride pilot's logbook. The air ride pilot told the inspector that he did not know where his pilot logbook was.

The airport office had at least five advertisements/flyers for fly-in events at Ohio airports that

offered breakfast/pancakes. Two of these noted events offered airplane rides for a per person fee. One of these flyers was for a "June 7th Fly-in/Drive-in Breakfast" with airplane rides for $20 per person. This flyer stated that the pancake breakfast was to be served by the Wooster Lions Club from 0700 to 1100.

WRECKAGE AND IMPACT INFORMATION

The accident site was located in a grass field in a residential neighborhood. The main wreckage was resting on a heading of about 170 degrees and was located about 0.75 miles east of the airport at an elevation of about 665 feet. No broken trees consistent with an in-flight impact near the accident site were noted. The accident site exhibited ground scarring limited to an area several feet around the planform of the airplane. The fuselage from the firewall to the forward portion of the empennage, between and including both wing roots, was consumed by fire.

The wing struts were attached to the wings and fuselage. The left wing displayed greater relative damage than the right wing from about the left wing's midspan to the wing tip. The forward portion of the left wing was deformed upwards about 40 degrees. Both wing fuel tank caps were in place and both fuel tanks contained a liquid consistent in color and odor with 100 low lead aviation fuel. The flap actuator extension equated to a 30 degree flap extension. The elevator tab was in the 5 degree nose up position.

The fuel selector was in the LEFT TANK position. The left and right fuel tanks were broken open and each contained about 5 and 15 gallons of fuel, respectively.

The propeller was separated from the engine and the propeller blades displayed S-shaped bending along with chordwise scratching.

Flight and engine control continuity was confirmed.

MEDICAL AND PATHOLOGICAL INFORMATION

On autopsy, the pilot was noted to have severe coronary artery disease with "only a pinpoint lumen remaining distally of the left anterior descending coronary artery," prostate cancer with evidence of radioactive seed implantation and no indications of spread beyond the prostate, and severe diverticulosis.

Review of the accident pilot's personal medical records indicated treatment for age-related macular degeneration in both eyes since at least April 2006. The accident pilot's left eye had been treated twice with laser photocoagulation, eleven times with bevacizumab injection, and once with combined photodynamic therapy and bevacizumab injection, with the last combined therapy on May 20, 2008. His records also note treatment of the right eye with laser photocoagulation on May 6, 2008. His distant visual acuity without correction was last noted on May 20, 2008, to be 20/200 for each eye. Distant visual acuity with correction was last

noted on April 8, 2008, to be just worse than 20/100 for each eye. Near visual acuity was last noted on May 13, 2007, for his better (left) eye, with best possible correction, to be 20/40. On that same date, his uncorrected distant visual acuities were noted to be 20/160 for his right eye and 20/100 for his left eye. He had been advised not to drive on at least two separate occasions (in October 2007 and January 2008) by his retinal specialist. The accident pilot's personal medical records also noted (in August 2006) a history of hyperglycemia (high blood sugar), with a hemoglobin A1c of 6.8 and blood glucose of 118, and of prostate cancer. There were no indications of heart disease in the personal medical records reviewed.

The accident pilot had not noted any conditions or treatments, and had specifically denied "Eye or vision trouble except glasses" and "Visits to Health Professional within Last 3 Years," on his most recent application for airman medical certificate, dated May 4, 2007, which has the following limitation: "must have available glasses for near vision." On the examination performed in conjunction with that application, his uncorrected distant vision was noted to be 20/20 in each eye separately and both eyes together, and his near vision was noted as corrected to 20/20 in each eye separately and both eyes together.

The records document the same aviation medical examiner (AME) on each application for Airman Medical Certificate and associated examinations since 1998. The FAA decertified the AME on January 28, 2009, for improper issuance of medical certificates.

TESTS AND RESEARCH

Engine Examination

The engine was shipped to Teledyne Continental Motors for an engine test run under the supervision of the NTSB. The engine was started on the first attempt, and the engine speed was advanced in steps. The engine throttle was advanced to 1,350 rpm, 1,600 rpm, and 2,100 rpm and held at each of these engine speeds for 5 minutes. The engine was then advanced to full throttle six times. The engine tested within the manufacturer's test specifications.

Video Documentation.

A family member of two of the passengers aboard the accident flight provided a video of flights that occurred during the Fly-In in addition to the accident flight takeoff. The video is included in the docket of this report.

ADDITIONAL INFORMATION

FAA Oversight

At the time of the accident, the Cleveland FSDO was responsible for the surveillance of 28 commercial aviation operators with Part 135 operating certificates in their territory. Their territory also contained five Part 141 flight schools, ten designated pilot examiners, and about

8,700 certified pilots. The FSDO employed four aviation safety inspectors dedicated for general aviation.

According to the FSDO's Operations Unit Supervisor, inspectors would, on occasion, provide surveillance and inspection during charity ride events. The decision to provide this function depended on several aspects such as the size of the event, location, risks associated with the event/operator, and the availability of inspectors. The supervisor indicated that it was not uncommon to have one to five events per weekend that involved operations known to the FSDO via a Letter of Agreement (LOA).

In regard to the accident flight, the FSDO was not contacted prior to the breakfast that charity rides were taking place, nor did the pilot/operator provide written contact with the FSDO at least 7 days prior to the event in accordance with FAA regulations.

The Cleveland FSDO had no record of the accident pilot submitting information required under Part 91.146 Passenger-carrying Flights for the Benefit of a Charitable, Nonprofit, or Community Event, or being issued, an application for a Letter of Authorization as indicated by Part 91.147 Passenger Carrying Flights for Compensation or Hire.

The information that must be provided to the local FSDO under Part 91.146 is:

(1) A signed letter detailing the name of the sponsor, the purpose of the event, the date and time of the event, the location of the event, all prior events under this section participated in by the sponsor in the current calendar year.
(2) A photocopy of each pilot in command's pilot certificate, medical certificate, and logbook entries that show the pilot is current in accordance with 61.56 and 61.57 of this chapter and that any pilot has as least 500 hours of flight time; and
(3) A signed statement from each pilot that lists all prior events under this section in which the pilot has participated during the current calendar year.

The following information is required for the issuance of an LOA under Part 91.147:

(1) Name of Operator, agent, and any d/b/a (doing-business-as) under which that Operator does business;
(2) Principal business address and mailing address;
(3) Principal place of business (if different from business address);
(4) Name of person responsible for management of the business;
(5) Name of person responsible for aircraft maintenance;
(6) Type of aircraft, registration number(s), and make/model/series; and
(7) An Antidrug and Alcohol Misuse Prevention Program registration.

Pilot Information

Certificate:	Commercial	**Age:**	86,Male
Airplane Rating(s):	Single-engine land; Multi-engine land	**Seat Occupied:**	Left
Other Aircraft Rating(s):		**Restraint Used:**	
Instrument Rating(s):	Airplane	**Second Pilot Present:**	
Instructor Rating(s):	Airplane multi-engine; Airplane single-engine; Instrument airplane	**Toxicology Performed:**	Yes
Medical Certification:	Class 2 Without waivers/limitations	**Last FAA Medical Exam:**	May 4, 2007
Occupational Pilot:	Yes	**Last Flight Review or Equivalent:**	
Flight Time:	55000 hours (Total, all aircraft)		

Aircraft and Owner/Operator Information

Aircraft Make:	Cessna	**Registration:**	N29122
Model/Series:	U206C	**Aircraft Category:**	Airplane
Year of Manufacture:		**Amateur Built:**	
Airworthiness Certificate:	Normal	**Serial Number:**	U206-1092
Landing Gear Type:	Tricycle	**Seats:**	6
Date/Type of Last Inspection:	July 14, 2007 Annual	**Certified Max Gross Wt.:**	3300 lbs
Time Since Last Inspection:		**Engines:**	1 Reciprocating
Airframe Total Time:	1714 Hrs as of last inspection	**Engine Manufacturer:**	Teledyne Continental
ELT:		**Engine Model/Series:**	IO-520-F
Registered Owner:	Damschroder Eugene E Trustee	**Rated Power:**	300 Horsepower
Operator:	Pilot	**Operating Certificate(s) Held:**	None

Meteorological Information and Flight Plan

Conditions at Accident Site:	Visual (VMC)	**Condition of Light:**	Day
Observation Facility, Elevation:	TDZ,622 ft msl	**Distance from Accident Site:**	20 Nautical Miles
Observation Time:	12:53 Local	**Direction from Accident Site:**	316°
Lowest Cloud Condition:	Scattered / 4500 ft AGL	**Visibility**	10 miles
Lowest Ceiling:	None	**Visibility (RVR):**	
Wind Speed/Gusts:	17 knots / 22 knots	**Turbulence Type Forecast/Actual:**	/
Wind Direction:	230°	**Turbulence Severity Forecast/Actual:**	/
Altimeter Setting:	29.93 inches Hg	**Temperature/Dew Point:**	33°C / 20°C
Precipitation and Obscuration:			
Departure Point:	Fremont, OH (14G)	**Type of Flight Plan Filed:**	None
Destination:	Fremont, OH (14G)	**Type of Clearance:**	None
Departure Time:	12:26 Local	**Type of Airspace:**	

Airport Information

Airport:	Fremont Airport 14G	**Runway Surface Type:**	Asphalt
Airport Elevation:	663 ft msl	**Runway Surface Condition:**	Dry
Runway Used:	27	**IFR Approach:**	None
Runway Length/Width:	4137 ft / 60 ft	**VFR Approach/Landing:**	Unknown

Wreckage and Impact Information

Crew Injuries:	1 Fatal	**Aircraft Damage:**	Substantial
Passenger Injuries:	5 Fatal	**Aircraft Fire:**	On-ground
Ground Injuries:		**Aircraft Explosion:**	None
Total Injuries:	6 Fatal	**Latitude, Longitude:**	41.333057,-83.161109

Administrative Information

Investigator In Charge (IIC):	Gallo, Mitchell
Additional Participating Persons:	Edward Skuza; Federal Aviation Administration; Cleveland, OH Steve Miller; Cessna Aircraft Company; Wichita, KS Greg Schmidt; Teledyne Continental Motors; Mobile, AL
Original Publish Date:	April 15, 2010
Last Revision Date:	June 6, 2024
Investigation Class:	Class
Note:	The NTSB traveled to the scene of this accident.
Investigation Docket:	https://data.ntsb.gov/Docket?ProjectID=68193