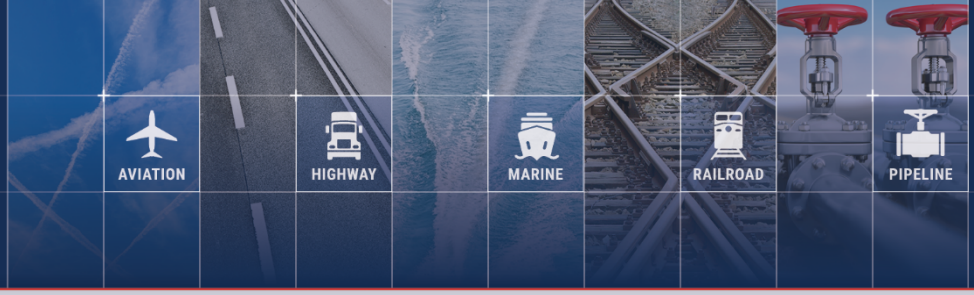

Aviation Investigation Final Report

Location:	Selmer, Tennessee	**Accident Number:**	ERA09FA027
Date & Time:	October 23, 2008, 21:34 Local	**Registration:**	N7510Y
Aircraft:	Piper PA-30	**Aircraft Damage:**	Substantial
Defining Event:	Collision with terr/obj (non-CFIT)	**Injuries:**	1 Fatal
Flight Conducted Under:	Part 91: General aviation - Personal		

Analysis

The non-instrument-rated pilot took off under visual flight rules toward an area where, before the flight, he admitted the weather “was not too good.” Approaching the destination at night, during rain, and with the cloud ceiling about 500 feet above the ground, a witness saw the airplane fly over her house at what she estimated was about 100 feet. The airplane subsequently impacted a plowed cornfield 1.4 miles south of the witness’s house, and 12 miles north of, and headed toward, the destination airport. There were no known witnesses to the accident, and an examination of the wreckage revealed no mechanical anomalies that would have resulted in the accident. The landing gear and flaps were retracted. Wreckage path examination revealed that the airplane likely impacted the ground nose-low, and bounced once, before impacting again with the right wing down before sliding to a stop. The pilot’s required Federal Aviation Administration medical certificate had expired over 2 years prior to the accident, since which time the pilot had two strokes and coronary artery bypass surgery. Multiple medications were found in the pilot’s luggage, including a prescription antidepressant, an impairing prescription anti-anxiety medication, a sedating over-the-counter antihistamine, and over-the-counter nasal decongestants. On autopsy, a complete blockage of one coronary artery graft was noted and toxicology results indicated recent use of the antidepressant. The anti-anxiety medication and antihistamine were not reported on toxicology testing, but toxicology reporting thresholds for those substances were above the levels at which impairment could be seen. The circumstances of the accident were consistent with spatial disorientation, but given the pilot’s medical history and likely recent use of impairing medications, the possibility of impairment or incapacitation cannot be eliminated. The pilot failed to maintain a current medical certificate, used an impairing prescription medication, and knew that inclement weather existed that exceeded his qualifications. He was asked to stay overnight at a previous stop, but stated that he wanted to go home.

Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be: The pilot's failure to avoid terrain during night instrument meteorological conditions.

Findings

Aircraft	Altitude - Not attained/maintained
Environmental issues	Dark - Not specified
Environmental issues	Low ceiling - Not specified
Personnel issues	Decision making/judgment - Pilot
Personnel issues	Use of medication/drugs - Pilot

Factual Information

History of Flight

Enroute	Low altitude operation/event
Maneuvering	Collision with terr/obj (non-CFIT) (Defining event)

HISTORY OF FLIGHT

On October 23, 2008, about 2134 central daylight time, a Piper PA-30, N7510Y, registered to and operated by a private individual, crashed in a corn field near Selmer, Tennessee. Night instrument meteorological conditions (IMC) prevailed and no flight plan was filed for the 14 Code of Federal (CFR) Part 91 personal flight from Searcy Municipal Airport (SRC), Searcy, Arkansas, to Roscoe Turner Airport (CRX), Corinth, Mississippi. The airplane was substantially damaged by impact and the certificated private pilot was killed. The time of departure from SRC was estimated to be between 1835 and 1845.

There was no record of any weather briefing with Lockheed Martin Automated Flight Service Station (LM AFSS) or either Direct User Access Terminal (DUAT) vendor for the intended flight. Additionally, there was no record of contact with any Federal Aviation Administration (FAA) air traffic control (ATC) facility during the flight.

According to a fuel receipt, the pilot purchased fuel at Durango-La Plata County Airport (DRO), Durango, Colorado, at 1208 local time. The airplane later arrived at Hutchinson County Airport (BGD), Borger, Texas, and while there, all four fuel tanks were filled. According to the refueler, he recognized the airplane from a week earlier, when the airplane arrived with a landing gear problem. He asked the pilot if the landing gear was working properly and the pilot responded, "yes." He then asked the pilot about the en route weather, and the pilot stated that, "…it was not too good, but that he had radar. He then departed at about 4:00 p.m."

The airplane subsequently proceeded to Searcy Municipal Airport, where the pilot purchased about 18 gallons of fuel. Payment for the fuel by credit card occurred about 1828. A friend of the pilot reported going to the airport between approximately 1830 and 1845 to see him, but when the friend arrived, the airplane had already departed. There were no known witnesses who saw the airplane depart.

A witness, located approximately 1.4 nautical miles north-northeast of the crash site, reported that about 2130, an airplane flew low over her house at 100 feet above ground level (agl) in a south or southwesterly direction. It was raining at the time, but not lightning, and she could not see stars or the moon. Additionally, a pilot-rated witness reported that IMC conditions prevailed in the area due to clouds and fog.

There were no known witnesses to the accident; the airplane crashed in a plowed corn field and the wreckage was spotted the next morning.

PERSONNEL INFORMATION

The pilot, age 71, held a private pilot certificate with ratings for airplane single engine land and multi-engine land, issued December 21, 1982. His latest FAA third class medical certificate was issued October 8, 2004. For a person over the age of 40, a third class medical certificate expires the 24th month after the month of the date of examination. The pilot listed 3,650 hours of total flight time on the application for his latest medical certificate.

The pilot was not instrument rated. The pilot's son reported that his father flew instrument flight rules (IFR) “a lot’ and he (his father), felt comfortable flying in instrument meteorological conditions, but would not fly an approach to minimums.

AIRCRAFT INFORMATION

The airplane was manufactured in 1964, by Piper Aircraft, Inc., as model PA-30, and was designated serial number 30-574. It was powered by two Lycoming IO-320-B1A 160-horsepower engines equipped with Hartzell constant speed propellers. It was also equipped with a two-axis Century III autopilot flight system.

Review of the maintenance records revealed the airplane was last inspected in accordance with an annual inspection on January 18, 2007. Federal regulations (14 CFR Part 91.409) indicate no person may operate an aircraft unless within the preceding 12 calendar months, it has had an annual inspection in accordance with (IAW) 14 CFR Part 43 and been returned to service. At the time of the accident, the airplane had operated for approximately 47 hours since the inspection.

METEOROLOGICAL INFORMATION

A friend of the pilot reported that the pilot knew about the weather conditions in the area of the destination airport before his initial departure. The pilot advised him that he may have to approach the destination airport from the north. The friend asked the pilot to spend the night but the pilot stated that he wanted to get home.

A special surface observation weather report (SPECI METAR) recorded at Robert Sibley Airport (SZY), Selmer, Tennessee, at 1956, indicated the wind was from 290 degrees at 7 knots, the visibility was 9 statute miles, a few clouds existed at 500 feet, and broken clouds existed at 4,100 feet. The temperature and dew point were 12 and 11 degrees Celsius respectively, and the altimeter setting was 30.18 inches of mercury (inHg). The accident site was located approximately 7 nautical miles southwest of SZY.

A SPECI METAR recorded at SZY at 2044, indicated the wind was variable at 5 knots, the

visibility was 3 statute miles, and broken clouds existed at 400 feet. The temperature and dew point were 11 and 10 degrees Celsius respectively, and the altimeter setting was 30.20 inHg.

A SPECI METAR recorded at SZY at 2129, indicated the wind was calm, and the visibility was 4 statute miles. Broken clouds existed at 500 feet and overcast clouds existed at 1,400 feet. The temperature and dew point were each 9 degrees Celsius, and the altimeter setting was 30.20 inHg.

AIRPORT INFORMATION

Roscoe Turner Airport had one asphalt runway designated 18/36. It had an instrument landing system (ILS) or localizer approach to runway 18, and area navigation (RNAV) or global positioning system (GPS) approaches to runways 18 and 36. The airport also had an automated weather observing system (AWOS)-3.

WRECKAGE AND IMPACT INFORMATION

The airplane crashed in the southwest corner of a rectangular, north/south-oriented, plowed corn field; the crash site was located approximately 12 nautical miles north of the destination airport.

The airplane came to rest upright on a magnetic heading of 278 degrees, approximately 247 feet from the first observed ground contact location. The energy path was oriented on a magnetic heading of 184 degrees. Debris along the energy path between the first ground contact location and the resting point of the wreckage consisted of the nose landing gear door and shimmy damper, outside air temperature (OAT) gauge, right aileron, DME antenna, left propeller with fractured crankshaft flange, 3M Weather Stormscope avionic equipment, and numerous IFR charts and some VFR charts.

Ground scars were not continuous from the first point of ground contact to the resting point of the airplane. The first ground scar measured approximately 72 feet in length; the pitot mast was noted near the end of this ground scar. The second ground scar began approximately 40 feet from the end of the first ground scar and the OAT gauge and nose landing gear door and shimmy damper were noted in this location. The left propeller was found on the right side of the energy path approximately 192 feet from the first ground contact location and the right aileron was noted on the left side of the energy path approximately 201 feet from the first ground contact location.

The airplane’s nose section and the cockpit to the pilot's seat were destroyed. The right side of the fuselage in the cockpit and cabin area was structurally opened along the length and was displaced (rolled) to the left approximately 25 degrees. The right engine with attached propeller remained partially attached to the wing. The right horizontal stabilator was bent up approximately 10 degrees beginning about midspan, while no appreciable damage was noted to the left side of the horizontal stabilator, vertical stabilizer, or rudder.

Stabilator and rudder flight control cable continuity was confirmed from each attach point near the control surface to the cockpit attach point. The stabilator trim tab was found positioned 4.5 degrees tab trailing edge up, which is 50 percent of nose down trim setting; however, the trim could have been moved during the crash sequence. The rudder trim was neutral.

The left wing, vertical stabilizer, horizontal stabilator, rudder, stabilator trim tab, and left engine remained attached. The lower surface of the left wing was not visually inspected; however, the upper surface of the left wing exhibited chordwise compression wrinkles outboard of the inboard end of the aileron.

The flap and aileron remained attached and both exhibited compression wrinkles on the upper surfaces. The outboard end of the flap was displaced up approximately 17 degrees, and the outboard portion of the aileron was displaced up approximately 70 degrees. The aileron control cable was continuous from control surface to the chain in the cockpit, while the balance cable exhibited tension overload at the roll servo location; no evidence of preexisting fracture of the cable strands was noted.

The left main fuel tank was empty, and the auxiliary fuel tank contained an estimated 7.5 gallons of blue colored fuel consistent with 100 low lead (100LL); both fuel caps were secure. No contaminants were noted in the recovered sample from the auxiliary fuel tank when checked with water finding paste. The fuel line from firewall fitting to engine driven fuel pump had residual fuel, and the main tank fuel supply line from tank to selector was damaged in wing root area. The auxiliary fuel tank supply line was intact from tank to selector valve, and the fuel line from the selector to the engine was intact. Residual fuel was found in the flexible fuel line from the firewall fitting to the hard line for fuel pressure at the distributor valve.

During removal of the left engine, a mud dauber nest was found clinging to air filter, and residual fuel was noted in the flexible fuel supply line to the engine driven fuel pump. The fuel strainer contained uncontaminated 100LL fuel.

The right wing was fractured at the wing root and also at the outboard end of the flap. The structure and skin of the right wing beginning about midspan of the flap was displaced up approximately 30 degrees and displaced aft approximately 35 degrees.

The right main and auxiliary fuel tanks were empty and both fuel caps were secure. The fuel supply lines from tank to selector were fractured at the wing root. The flap remained attached, but the aileron was separated. The right engine remained partially attached to the wing.

The right main landing gear was found in the extended position; however, the hydraulic line was broken. The flexible fuel supply line from the firewall fitting to engine driven fuel pump was moist with fuel. Inspection of the fuel strainer revealed the drain hose was plugged by dirt. After removal of the dirt, a small amount of water and debris was found in the strainer which appeared consistent with the open lines. Most of the liquid found in the strainer was

consistent in color and smell to 100LL and no other evidence of contamination was noted. Rust was noted inside the strainer.

The aileron control cable was secure to the bellcrank at the control surface and continuous to the wing root where it displayed evidence of tensile overload failure. The remainder of the control cable was continuous to the aileron control chain. The balance cable was connected at the bellcrank near control surface and continuous to the center fuselage section where it displayed evidence of tensile overload. The aileron control rod was separated at the aileron rod end. The engine with attached propeller was displaced inboard approximately 10 inches. During removal of the engine, the air induction filter was noted to be dirty.

Examination of the cockpit revealed that the instrument panel was partially separated and found inverted. The throttle quadrant remained attached by the control cables. Both throttle controls were at a low power setting, both propeller controls were in the feathered position, and both mixture controls were in the idle cutoff position; however, they could have been moved during the crash sequence.

Stretching of five of eight filaments of the pilot's flight instruments post lights was noted. No stretching of the filaments of the gear down and locked light, gear in transit light, or gear unsafe light bulb was noted. The landing gear emergency gear extension cover was in place and secure, and the emergency extension handle was in place and secure. Examination of the landing gear electric motor and actuator revealed the position of the jackscrew was consistent with the landing gear being retracted. The landing gear selector handle was broken.

The airspeed indicator needle indicated approximately 140 miles-per-hour. All magnetic switches of the autopilot console (pitch, roll, heading, and altitude) were in the down or off position, and the pitch command wheel was in a slight nose down position. The pitch servo effort meter (trim) which indicates the position of the pitch command wheel with relation to the attitude being flown depicted a nearly level position. The horizontal situation indicator (HSI) indicated the magnetic heading was approximately 320 degrees, the omnibearing selector (OBS) was set to approximately 215 degrees, and the course deviation indicator (CDI) was centered. The "HDG" and "GS" flags were displayed. The No. 2 very high frequency omni-directional range (VOR) receiver OBS was set to 065 degrees, the "NAV" and "GS" flags were displayed. The CDI and glideslope needles were displaced to the right and down, respectively.

Examination of the left and right fuel selector valves revealed that the left valve was between the auxiliary and main fuel tank positions, while the right valve was in the auxiliary fuel tank detent position. No impact damage was noted to either handle, and the mechanical linkage of both were connected at both ends.

Examination of the vacuum gauge revealed that the glass was broken, and impact damage to the faceplate near the left button was noted. The left button was behind the faceplate and the right button was extended. Additionally, the needle was off scale low. The attitude indicator, directional gyro, altimeter, vacuum gauge, two communication transceivers, two navigation

receivers, a panel mounted global positioning system (GPS) receiver, and a portable flight computer were retained for further examination.

Examination of both engines revealed crankshaft, camshaft, and valve train continuity. The engine system components pertaining to fuel, ignition, and lubrication of both engines revealed no evidence of preimpact failure or malfunction. Examination of the fuel system components for both engines revealed fuel in the fuel lines, and the fuel system components consisting of the engine-driven fuel pump, servo fuel injector, and residual fuel was also noted at the distributor valve.

The driven shaft for the left engine vacuum pump was sheared, and one vane inside the pump was noted to be fractured during the initial examination. The left vacuum pump and fractured shaft were retained for further examination. The right engine vacuum pump rotor, vanes, and driven shaft were not damaged.

Examination of the left propeller revealed that a portion of the crankshaft flange remained attached to the propeller flange. The fracture surface of the crankshaft exhibited 45-degree shear lips. Both blades remained secured to the propeller hub. One blade exhibited a slight forward bend of approximately 10 to 15 degrees beginning about midspan, and polishing of the leading edge was noted. The blade exhibited leading edge twisting towards low pitch, and a nick on the leading edge of the blade near the blade tip. The other blade was free to rotate in the hub and was bent aft approximately 35 degrees. The leading edge was twisted towards low pitch, and polishing of the leading edge was noted about midspan.

Examination of the right propeller revealed that both blades remained secured to the propeller hub. One blade was bent aft approximately 90 degrees beginning about 1/3 the span, and exhibited a 3/8 inch gouge on the trailing edge of the blade near the blade tip. The blade also exhibited chordwise polishing on the cambered side of the blade about 2/3 the span, and also leading edge polishing. The other blade was bent aft approximately 45 degrees and exhibited a gouge on the leading edge about 6 inches from the blade tip.

Examination of the vacuum gauge and left vacuum pump was performed by the Safety Board's Materials Laboratory located in Washington, D.C. The buttons of the vacuum gauge were cut from the instrument and examined which revealed marks on both consistent with them being in at the moment of impact. Examination of the left vacuum pump revealed that following removal of the housing, two fractured vanes were noted. Both fractured vanes were missing small sections that were not found inside the pump. Intermittent wear marks were noted on the interior wall of the vacuum pump housing, and at one location the interior wall surface was gouged and a thin ridge of excess metal protruded from the surface. Examination of the driven shaft of the vacuum pump revealed the fracture surface exhibited signatures consistent with ductile torsion overstress.

The GPS receiver and portable flight computer were examined at the Safety Board's Vehicle Recorders Division also located in Washington, D.C. Both components were examined;

however, no data could be recovered from either unit.

The attitude indicator, altimeter, and directional gyro were examined at an FAA-certified repair station under NTSB oversight.

Examination of the attitude indicator revealed that the bezel was separated and the glass was broken. No witness marks were noted from the silhouette against the pitch indicator masks. Following removal of the housing, a broken wire was noted. Examination of the broken wire with a 15 power eye loop revealed an impression in the insulation at the fracture point. The lower/inner rotor housing bracket was separated from the shafts due to impact. The rotor bearings were satisfactory, and no scoring was noted on the rotor or rotor housing.

Examination of the altimeter revealed that the hands did not move when the unit was operationally tested. The kollsman knob was fractured, and the bezel was cracked. All needles remained attached to the pointer shaft. The rocking shaft and assembly sector pivot, and screw pivot were broken consistent with impact damage. The handstaff and spring wheel were not failed.

Examination of the directional gyro revealed that the housing was dented on the left side. The gimball appeared undamaged, and there was no scoring on the rotor or rotor housing. Additionally, there was no obvious frame damage.

Inspection of the communication transceivers and navigation receivers was performed. The active and standby frequencies in the No. 1 communication transceiver were 118.675 and 122.85 MHz, respectively. The active frequency is the same as the AWOS-3 frequency for the destination airport. The active and standby frequencies in the No. 2 communication transceiver were 124.95 and 127.85 MHz, respectively. The frequency in the No. 1 navigation receiver was 111.4 MHz, and only the first two digits (10) of the No. 2 navigation receiver were observed when the unit was powered.

MEDICAL AND PATHOLOGICAL INFORMATION

The pilot’s son reported that his father had a stroke in February or March 2007, followed by coronary artery bypass surgery. Approximately 3 days after the coronary bypass surgery, while hospitalized, his father had another stroke. Both strokes were in the same location and affected the left side of his body. His father was unable to walk until April, and then was able to walk with the assistance of a walker. He then stopped using the walker and in the 6 months preceding the accident, symptoms of the stroke wouldn't be noticeable to a person not having first-hand knowledge of the previous stroke issue.

Friends of the pilot who were with him the week before the accident reported that he appeared in good spirits with no obvious ailments. One friend who was with him the night before the accident reported that he was dancing, and that the pilot went to bed about midnight. The pilot awoke the following morning about 0830, then had breakfast with the friend. The friend that

had breakfast with the pilot stated that the pilot did not advise him of feeling tired nor did he complain of sleeping poorly the night before.

A suitcase located in the wreckage contained multiple prescription containers in the pilot's name. The containers were labeled as containing escitalopram 20 mg (“one tablet by mouth every day”), alprazolam 0.5 mg (“one-half to one tablet by mouth three times a day as needed for nerves”), rosuvastatin 20 mg (“one tablet before bed”), lisinopril 10 mg/hydrochlorothiazide 12.5 mg (“one tablet by mouth every day”), and clopidogrel 75 mg ("take one tablet by mouth…"); and multiple over-the-counter medication containers labeled as containing acetaminophen 325mg/chlorpheniramine 2mg, naproxen 220 mg, famotidine 20 mg, cetirizine 10 mg, oxymetazoline nasal spray, naphazoline nasal drops, and sodium chloride/sodium bicarbonate sinus rinse.

A postmortem examination of the pilot was performed by the Office of the Shelby County Medical Examiner, Memphis, Tennessee. The cause of death was listed as “Multiple Blunt Force Injuries.” The autopsy report noted severe coronary atherosclerosis and multiple coronary artery bypass grafts, one of which was reported as occluded. No other natural disease was noted.

Forensic toxicology was performed on specimens of the pilot by the FAA Bioaeronautical Sciences Research Laboratory (CAMI), Oklahoma City, Oklahoma, and Aegis Sciences Corporation (Aegis), Nashville, Tennessee. The toxicology report from CAMI indicated the results were negative for carbon monoxide, cyanide, and volatiles. The report indicated Acetaminophen (19.93 ug/ml), Alpha-hydroxyalprazolam (0.042 ug/ml), Cetirizine (unquantified amount), Citalopram (unquantified amount), Di-N-Desmethylcitalopram (unquantified amount), Naphazoline (unquantified amount), Naproxen (unquantified amount), and N-Desmethylcitalopram (unquantified amount) were detected in the submitted urine specimen. The CAMI report also indicated that Citalopram (0.173 ug/ml), Di-N-Desmethylcitalopram (0.013 ug/ml), and N-Desmethylcitalopram (0.089 ug/ml) were detected in the submitted blood specimen.

The FAA toxicology report also noted that the threshold values used to report benzodiazepines and antihistamines as .030 micrograms per mL and 0.020 micrograms per mL, respectively. The toxicology testing reported in conjunction with the autopsy did not note testing for antihistamines, and noted a threshold value for benzodiazepines of 25 nanograms per mL.

The toxicology report from Aegis was negative for volatiles and tested drugs in the submitted blood specimen.

ADDITIONAL INFORMATION

On October 16 and 17, 2008, the pilot flew the airplane from Corinth, Mississippi, to Durango, Colorado, with an overnight stop in Borger, Texas. According to a witness, on October 16th, while inbound to land at Hutchinson County Airport, Borger, Texas, the pilot announced on the

frequency that he was unable to extend the landing gear, and that he was going away from the airport. Approximately 30 minutes later, the pilot landed uneventfully and while being marshaled to a parking spot, the individual marshalling the pilot reported he parked the airplane "…at least 20 feet off my guide and at an extreme angle to the tee marker." After exiting the airplane, the individual spoke with the pilot who advised him that after lowering the landing gear, the left wing ran out of fuel followed by the right wing.

An airframe and powerplant mechanic inspected the airplane that same evening and found that the landing gear circuit breaker was tripped. The landing gear jackscrew was re-engaged and the airplane was placed on jacks, cycling the landing gear through five cycles with no further discrepancies noted. The following morning, the same individual who marshaled the pilot the evening before watched the pilot depart from runway 35, but noticed the pilot abort the takeoff when the left engine quit. The pilot restarted the left engine, and departed. The flight continued to Durango, Colorado, where maintenance records indicate the right starter was removed and replaced.

According to the FAA's "Pilot's Handbook of Aeronautical Knowledge," FAA-H-8083-25, "Spatial disorientation specifically refers to the lack of orientation with regard to the position, attitude, or movement of the airplane in space."

Pilot Information

Certificate:	Private	**Age:**	71,Male
Airplane Rating(s):	Single-engine land; Multi-engine land	**Seat Occupied:**	Left
Other Aircraft Rating(s):	None	**Restraint Used:**	
Instrument Rating(s):	None	**Second Pilot Present:**	No
Instructor Rating(s):	None	**Toxicology Performed:**	Yes
Medical Certification:	Class 3 None	**Last FAA Medical Exam:**	October 8, 2004
Occupational Pilot:	No	**Last Flight Review or Equivalent:**	
Flight Time:	3650 hours (Total, all aircraft)		

Aircraft and Owner/Operator Information

Aircraft Make:	Piper	**Registration:**	N7510Y
Model/Series:	PA-30	**Aircraft Category:**	Airplane
Year of Manufacture:		**Amateur Built:**	
Airworthiness Certificate:	Normal	**Serial Number:**	30-574
Landing Gear Type:	Retractable - Tricycle	**Seats:**	4
Date/Type of Last Inspection:	January 18, 2007 Annual	**Certified Max Gross Wt.:**	3600 lbs
Time Since Last Inspection:	47 Hrs	**Engines:**	2 Reciprocating
Airframe Total Time:	1528 Hrs as of last inspection	**Engine Manufacturer:**	LYCOMING
ELT:	C91A installed, activated, did not aid in locating accident	**Engine Model/Series:**	IO-320 SERIES
Registered Owner:	HOPKINS LEROY DBA	**Rated Power:**	160 Horsepower
Operator:	Leroy Hopkins	**Operating Certificate(s) Held:**	None

Meteorological Information and Flight Plan

Conditions at Accident Site:	Instrument (IMC)	**Condition of Light:**	Night/dark
Observation Facility, Elevation:	SZY,610 ft msl	**Distance from Accident Site:**	7 Nautical Miles
Observation Time:	21:29 Local	**Direction from Accident Site:**	49°
Lowest Cloud Condition:		**Visibility**	4 miles
Lowest Ceiling:	Broken / 500 ft AGL	**Visibility (RVR):**	
Wind Speed/Gusts:	/	**Turbulence Type Forecast/Actual:**	/
Wind Direction:		**Turbulence Severity Forecast/Actual:**	/
Altimeter Setting:	30.2 inches Hg	**Temperature/Dew Point:**	9°C / 9°C
Precipitation and Obscuration:	N/A - None - Rain		
Departure Point:	Searcy, AR (SRC)	**Type of Flight Plan Filed:**	None
Destination:	Corinth, MS (CRX)	**Type of Clearance:**	None
Departure Time:		**Type of Airspace:**	

Wreckage and Impact Information

Crew Injuries:	1 Fatal	**Aircraft Damage:**	Substantial
Passenger Injuries:		**Aircraft Fire:**	None
Ground Injuries:	N/A	**Aircraft Explosion:**	None
Total Injuries:	1 Fatal	**Latitude, Longitude:**	35.121944,-88.604721

Administrative Information

Investigator In Charge (IIC):	Monville, Timothy
Additional Participating Persons:	Royce McKie; FAA/FSDO; Memphis, TN Michael C McClure; Piper Aircraft, Inc.; Vero Beach, FL
Original Publish Date:	October 21, 2010
Last Revision Date:	
Investigation Class:	Class
Note:	The NTSB traveled to the scene of this accident.
Investigation Docket:	https://data.ntsb.gov/Docket?ProjectID=69350