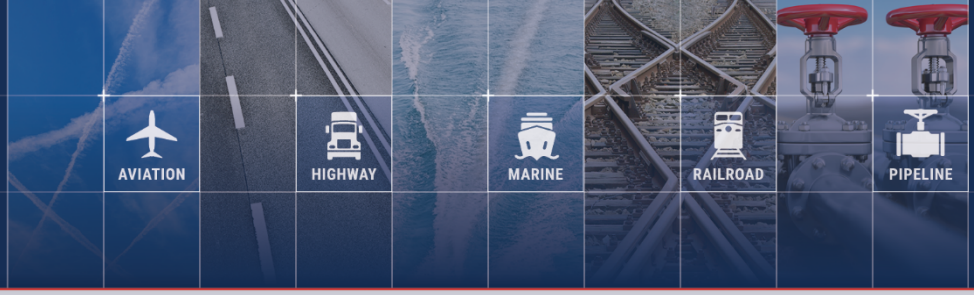

Aviation Investigation Final Report

Location:	Flat Rock, North Carolina	**Accident Number:**	ERA09FA514
Date & Time:	September 10, 2009, 14:15 Local	**Registration:**	N888WD
Aircraft:	Beech A36	**Aircraft Damage:**	Substantial
Defining Event:	Controlled flight into terr/obj (CFIT)	**Injuries:**	1 Fatal
Flight Conducted Under:	Part 91: General aviation - Personal		

Analysis

Although the pilot was instrument rated, the investigation found no record that his rating was current. The pilot advised the air traffic controller before departure that he did not want to execute any instrument landing system (ILS) approaches even though they were in use at the time, and neither transceiver was configured to the localizer frequency. Due to the mountainous terrain surrounding the airport, local air traffic control (ATC) had designated certain mode 3 transponder codes that inhibit minimum safe altitude warning (MSAW) processing for a controller. This was accomplished to prevent repeated nuisance alarms for aircraft operating under visual flight rules (VFR) and not requesting MSAW processing. The pilot did not request MSAW monitoring before departure or at any time during the flight; therefore, the assigned VFR transponder code (0210) inhibited the MSAW. The pilot departed the flight with a reported ceiling of 1,500 feet and 10 miles visibility before proceeding south of the departure airport and electing to return, remaining in constant contact with ATC. While operating only several hundred feet above mountainous terrain, in instrument flight rules conditions due to fog, the pilot did not advise the controller of the weather encountered. While being vectored towards the airport, the airplane impacted trees then terrain at an elevation of approximately 2,809 feet mean sea level. The pilot made no distress call and the controller did not provide a MSAW warning to the pilot. Postaccident examination of the airplane, engine, and engine systems revealed no evidence of preimpact failure or malfunction. While testing of avionics revealed that the “Trim” light bulbs of the autopilot remote mode annunciator and the autopilot and flight director computer were illuminated at the moment of impact, the left pitch trim actuator was found in the neutral position and the circumstances of the accident do not support a pitch trim malfunction. Additionally, the autopilot was not activated at the moment of impact.

Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be: The pilot's attempt to maintain visual flight during instrument meteorological conditions, resulting in controlled flight into mountainous terrain. Contributing to the accident was the pilot's failure to advise the controller of the weather conditions encountered, and his failure to request minimum safe altitude warning (MSAW) monitoring before departure.

Findings

Environmental issues	(general) - Not specified
Environmental issues	Low ceiling - Contributed to outcome
Environmental issues	Low visibility - Contributed to outcome
Personnel issues	Incorrect action performance - Pilot
Personnel issues	(general) - Pilot
Personnel issues	Lack of communication - Pilot

Factual Information

History of Flight

Approach-VFR pattern final	Controlled flight into terr/obj (CFIT) (Defining event)

HISTORY OF FLIGHT

On September 10, 2009, about 1415 eastern daylight time, a Hawker Beechcraft Corporation A36, N888WD, registered to a private individual, collided with trees then terrain in a residential area near Flat Rock, North Carolina. Instrument meteorological conditions prevailed at the time and no flight plan was filed for the 14 Code of Federal Regulations (CFR) Part 91 personal, local flight, from Asheville Regional Airport (AVL), Asheville, North Carolina. The airplane sustained substantial damage and the private pilot, the sole occupant, was killed. The flight originated from AVL about 1403.

According to a transcription of communications with AVL Air Traffic Control Tower ATCT), the pilot established contact with the local control position and advised the controller that he had automated terminal information service (ATIS) victor, with intention of flying locally and to execute, "…some approaches…." The controller questioned the pilot as to what type of approaches, to which he replied that he was not interested in, "…doing any ILS approaches…." He also advised the controller that he wanted to perform landings and fly towards Hendersonville, North Carolina, then return to AVL. The controller cleared the pilot to taxi to runway 34, and confirmed that ATIS information victor was current. The controller then questioned the pilot to verify his flight intentions and he replied that after takeoff he intended to fly towards Hendersonville and fly around there for approximately 10 to 15 minutes, then return to AVL and land. The controller provided the pilot with departure instructions including the departure frequency (124.65 MHz) and transponder code (0210). The flight was cleared for takeoff about 1403, and the pilot was instructed to fly left pattern at or below 3,600 feet and advised the wind was calm. The pilot initially responded acknowledging the altitude but then questioned the controller if he could fly at 3,000 feet. The controller approved the pilot's request to fly at or below 3,600 feet. The pilot then advised the controller that he intended on extending the downwind leg, would be proceeding towards Hendersonville, and the flight was departing the traffic pattern. The controller twice provided a traffic alert to the pilot, and after the second alert the pilot responded that the traffic was not in sight.

Air Traffic Control communications were transferred to the AVL Approach Control Radar East position, which the pilot acknowledged. The transcription of communications with AVL ATCT further indicates at about 1407, the pilot contacted the AVL Approach Control Radar East position controller and advised that he was at 3,100 feet. The flight was radar identified and the pilot was instructed to maintain VFR and to turn left heading 090 degrees for a vector across final for Hendersonville. The pilot acknowledged the heading, and about 1 minute 11

seconds later the approach controller advised the pilot to resume his own navigation on course towards Hendersonville and to report that airport in sight. The pilot responded that he was flying around the city and was going to, "…stay under these clouds if I can"; the controller did not reply. About 1 minute 5 seconds later the pilot contacted the AVL Approach Control Radar East position and advised the controller that he was ready to return to AVL. The controller advised the pilot to fly heading 150 degrees for a vector for landing sequence, which he read back the heading. The Safety Board ATC Factual Report which contains a plot of radar targets reflects the airplane flying in a southeasterly direction consistent with the vector by the controller.

The transcription of communications with AVL ATCT further indicates that controller then instructed the pilot to fly heading 250, which was consistent with the heading depicted in the radar plot contained in the ATC Factual Report. At 1413:11, the transcription of communications indicates the controller instructed the pilot to, "…turn right heading 340…" and to advise when AVL was in sight. The pilot acknowledged the vector by reading back 340 but did not report the airport in sight. The radar plot contained in the Safety Board ATC Factual Report reflects that about the time the controller instructed the pilot to fly heading 340 degrees, the airplane was flying at 3,000 feet mean sea level, and was flying in a northwesterly direction. The radar plot also reflects that for the last 5 radar returns the airplane turned slightly to the left. The last radar return at 1414:15, indicates the airplane was at 3,100 feet msl, and located at 35 degrees 15.224 minutes North latitude and 082 degrees 27.7188 minutes West longitude.

A controller turnover briefing occurred shortly after the pilot acknowledged the 340 degree heading. The transcription of communications indicates that during the controller turnover briefing, the incoming controller was advised that runway 34 was the active runway with ILS approaches being conducted. The incoming controller was advised that the pilot was advised to fly heading 340 degrees and to report AVL in sight. About 1 minute 8 seconds after the start of the turnover briefing, the new controller questioned on the frequency whether the pilot was capable of tracking the localizer, and also asked him to say the airplane's current heading; the pilot did not respond to either question. The controller then enlisted the aid of the pilot of another airplane to attempt to communicate with the accident pilot but he did not respond. At 1416:11, the controller advised the pilot that radar contact was lost about a mile west of the broad river radio beacon, or ten miles south of AVL. The controller attempted to communicate with the pilot on the guard frequency (121.5 MHz) but there also was no reply. Personnel of a fixed base operator at Hendersonville were contacted by the AVL ATCT to determine if the airplane had landed there. The individual reported the airplane was not on their ramp.

An individual who was outside of his residence which was approximately 729 feet east-northeast from the accident site reported hearing a very loud constant engine sound with no variations in rpm which lasted for approximately 4 seconds. He then heard a loud boom type sound and called 911. He reported that at the time of the accident there was fog in the area.

The Fire Chief from the Blue Ridge Fire and Rescue who responded to the scene also reported

fog.

PERSONNEL INFORMATION

The pilot, age 65 held a private pilot certificate with airplane single engine land, and instrument airplane ratings issued February 17, 1977, and held a third class medical certificate with a limitation to have available glasses for near vision issued April 30, 2008.

Review of his third and fourth pilot logbooks which contains entries from April 12, 1992, to the last complete entry in the fourth logbook (October 2008) revealed he logged a total flight time of approximately 2,220 hours. His last logged simulated instrument flight consisting of 1.3 hours occurred on April 29, 2008, which was the date of his last flight review in accordance with 14 CFR Part 61.56(a). His last logged actual instrument flight consisting of 6/10 of an hour occurred in October 2008.

AIRCRAFT INFORMATION

The airplane was manufactured in March 1996 by Beech Aircraft Corporation as model A36, and was designated serial number E-3004. It was powered by a 300 horsepower Teledyne Continental Motors IO-550-B engine and equipped with a McCauley D3A32C409-C three-bladed constant speed propeller.

The airplane was equipped with a Honeywell (formerly King Radio Corporation) KFC 150 series two-axis (pitch and roll) autopilot control system. The system incorporates electric pitch trim which provides autotrim during autopilot operation, and manual electric pitch trim. Trim faults are visually and orally annunciated.

Review of the maintenance records revealed the last recorded annual inspection was signed off as being completed on July 13, 2009. The airplane hour meter reading at that time was recorded to be 1,239.4 hours; the hour meter reading at the time of the accident was 1241.4. The last test of the altimeter, altitude reporting, static system, and transponder were recorded as being completed on July 27, 2009.

METEOROLOGICAL INFORMATION

Automated terminal information service (ATIS) Victor was broadcast as: “Asheville Airport information Victor, time 1754 Zulu automated weather observation, wind one six zero at eight, visibility one zero, sky condition ceiling one thousand five hundred overcast, temperature one eight, dew point one five, altimeter three zero two five, ILS approaches in use, landing and departing runway three four, advise on initial contact you have information Victor.”

AIRPORT INFORMATION

The Asheville Airport is a combined terminal radar approach control (TRACON) and air traffic

control tower (ATCT) FAA level 6 facility. The TRACON was comprised of two radar positions (radar east and radar west), and the flight data position which was located between the two radar positions.

The AVL airport has a single runway designated 16/34, which is 8,001 feet long by 150 feet wide. The AVL airport ATC facility is open from 0630 to 2300 daily. The Asheville airport is located in a valley surrounded by mountainous terrain and numerous minimum vectoring altitude (MVA) areas. With the exception of the approach corridors for runways 16/34, the MVA within Asheville's approximately 40 mile diameter terminal area, was 4,200 feet and the highest was 8,200 feet. Field elevation was 2,165 feet.

Runway 34 is served by ILS, Localizer, or RNAV approaches. The localizer frequency is 110.5 MHz. The minimum altitude to maintain until glide slope intercept is 4,400 feet mean sea level (msl), and the altitude at the final approach fix is 3,700 feet msl. Runway 34 touchdown zone elevation is 2,140 feet msl.

The AVL Daily Record of Facility Operation Log for the accident date indicates no remarks related to the ILS components of runway 34.

WRECKAGE AND IMPACT INFORMATION

The accident site was located at 35 degrees 15.274 minutes North latitude and 082 degrees 27.767 minutes West longitude, or approximately 11 nautical miles and 166 degrees from the approach end of runway 34, and approximately 388 feet and 322 degrees from the last radar target. The airplane crashed in a wooded area located in a residential area. Debris consisting of the right main landing gear, inboard section of the right flap, and section of rudder were located along an energy path oriented on a magnetic heading of approximately 344 degrees. The main wreckage consisting of the fuselage came to rest upright on a magnetic heading of 320 degrees, approximately 137 feet from the first observed tree contact location. Damage to trees consisting of cut tree trunks and limbs with 45 degree cuts were noted along the energy path.

Further examination of the accident site revealed the fuselage impacted the ground of upsloping terrain. The elevation at the accident site as determined by a handheld global positioning system (GPS) receiver was 2,809 feet msl.

Examination of the wreckage revealed both wings, the horizontal and vertical stabilizers were separated but found in close proximity to the main wreckage. The left wing was fragmented in two pieces while the right wing was fragmented in three pieces. There was no evidence of a pre or post impact fire to any portion of the airplane or airplane components. The propeller was separated from the engine and found upslope from the main wreckage. Examination of the flight control cables revealed no evidence of preimpact failure or malfunction. The flaps were retracted as evidenced by the positions of the left and right flap actuators.

Examination of the cockpit revealed an Insight graphic engine monitor was installed in co-pilot's side of instrument panel; the faceplate was separated but located. The fuel flow gauge indicated in the green arc, while the cylinder head temperature indicated just below the green arc. The oil temperature needle was separated and the oil pressure was indicating 20 psi, which was just below the yellow arc. The airspeed indicator needle was at 115 knots; the needle was noted to move. The vertical speed indicator was indicating 700 feet-per-minute climb, and the vacuum gauge was indicating off scale low. Examination of the faceplate of the vacuum gauge using a 15 power eye loop revealed no needle impression. The pitch trim indication was approximately 9 degrees airplane nose-up. The graphic engine monitor and altimeter were retained for further examination.

Further examination of the cockpit revealed the throttle, propeller, and mixture controls were full forward, and the cowl flaps were closed. The landing gear selector was in the down position which correlated with the position of the landing gear actuator. Inspection of the avionics circuit breaker panel revealed the TRIM circuit breaker did not appear to be tripped. The VHF transceivers, directional gyro, flight command indicator, pictoral navigation indicator (HSI), autopilot and flight director computer, and autopilot remote mode annunciator panel were retained for further examination.

Examination of the empennage revealed the left elevator trim tab actuator measured 1.250 inches extended which equates to approximately neutral trim, while the right elevator trim tab actuator was separated and not recovered.

Examination of the engine was performed by a representative of the engine manufacturer with Safety Board oversight. No evidence of preimpact failure or malfunction was noted to the engine and system components. A detailed examination report with accompanying pictures is contained in the public docket for this accident.

Visual inspection of the propeller revealed the propeller spinner exhibited impact damage. One blade marked "A" was loose in the hub, bent aft, and twisted towards low pitch. The blade exhibited leading edge scratches and small nicks. One inch of the blade tip was fractured and not recovered. A second blade marked "B" exhibited s-bending, twisting towards high pitch and leading edge scratches. The third blade marked "C" had about nine inches of the blade tip fractured, was loose in the hub, had a slight forward bend, and was twisted towards low pitch. The blade exhibited leading edge scratches and. A four inch section of propeller blade was recovered from the accident site and found to be twisted with leading edge nicks and dents.

MEDICAL AND PATHOLOGICAL INFORMATION

An autopsy was performed on the pilot on September 11, 2009, by Wake Forest University School of Medicine, Department of Pathology. The autopsy findings included blunt trauma to the head and neck, and the report listed the specific injuries.

Forensic toxicology was performed on specimens of the pilot by the FAA Bioaeronautical

Sciences Research Laboratory (CAMI), Oklahoma City, Oklahoma, and also the Office of the Chief Medical Examiner, Chapel Hill, North Carolina. The toxicology report issued by CAMI stated testing for carbon monoxide and cyanide was not performed, no ethanol was detected, and an unquantified amount of Ibuprofen was detected in urine. The toxicology report by the Office of the Chief Medical Examiner indicated the result was negative in the urine specimen for ethanol.

TESTS AND RESEARCH

Due to the mountainous terrain surrounding AVL, the AVL ATCT had designated specific mode 3 transponder subsets that inhibit minimum safe altitude warning (MSAW) processing. That was accomplished to prevent repeated nuisance alarms for aircraft operating VFR and not requesting MSAW processing. The discreet mode 3 subset assigned to AVL for local use were transponder codes 0201 through 0277. Of those transponder codes, 0201 through 0207 were reserved for IFR, SVFR, and VFR aircraft requesting MSAW processing. Transponder codes 0210 thru 0277 were utilized for local VFR aircraft and were MSAW inhibited.

When entering flight data into the automated radar terminal system (ARTS), a controller would select IFR+ on the ARTS keyboard for an IFR, SVFR or VFR aircraft requesting MSAW processing. That would automatically assign the next available mode 3 transponder code available between 0201 and 0207 with MSAW processing capability. Conversely, an aircraft departing VFR not requesting MSAW processing would be assigned a MSAW inhibited code from 0210 to 0277.

Further review of the transcript of communications revealed the pilot did not request MSAW monitoring before departure or at any point during the flight. As previously reported, the flight was assigned transponder code 0210. Because of this, the MSAW was inhibited, and there was no low altitude (LA)/MSAW warnings generated for the flight.

A section in Chapter 4 of the FAA Aeronautical Information Manual (AIM) contains information for pilots indicating terrain or obstruction alerts by a controller for VFR aircraft will occur with an operational system and if the pilot requests MSAW monitoring. The FAA AIM also indicates that with respect to radar vectors, the controller may vector VFR aircraft, not at an ATC assigned altitude, at any altitude. In these cases, terrain separation is the pilot’s responsibility.

According to the Safety Board Air Traffic Control Factual Report, the controller assigned to the Radar East/West combined position just prior to the accident reported the airplane was radar identified based on the position he expected the airplane to be located. The controller verified the mode C altitude because the pilot stated he was at 3,200 feet but the mode C indicated 3,100 feet, and he confirmed that the MSAW was inhibited. He provided a vector for sequencing behind a larger airplane that was inbound, and then several radar vectors to the accident airplane with the final vector being 340 degrees which would place the airplane on a straight-in on the extended centerline for runway 34. He stated that if he perceived there was a dangerous situation he would have issued a safety alert regardless if the airplane was VFR or

IFR. The controller also stated that he previously reported giving terrain based safety alerts to VFR aircraft operating near the accident site when he felt there was a danger. The controller was familiar with the call sign of the airplane, and he had provided ATC services to the pilot of that airplane several times previously. The controller considered the weather conditions at the time of the accident (ceiling of 1,500 and 10 miles visibility) as marginal VFR. He reported he was aware of the Emergency Obstruction Video Map (EOVM) but did not utilize it in that case because he did not believe an emergency was occurring until after the aircraft had crashed.

Safety Board interview of the controller assigned to the Radar East/West combined position at the time of the accident reported prior to assuming the position, he monitored it for 2 minutes per the procedures. When he plugged in to monitor the position, he heard the pilot requesting to come back to AVL. He proceeded to conduct his position relief duties by pulling up the checklist for the position relief. During the relief briefing, the relieved controller advised him that the pilot had been given a 340 heading. After assuming the position, he first performed a scan of his area, handed an aircraft off to Greer approach (an ATC facility adjacent to AVL), and then noticed that the pilot was not tracking his last assigned heading of 340 degrees. He then asked the pilot if he was capable of tracking the localizer but the pilot did not respond. He noticed that the radar target disappeared, so he solicited the pilot of another airplane operating in the vicinity to attempt to contact the pilot for a radio check but this was unsuccessful. After the third failed response to his transmission, he became concerned that something had happened with the aircraft and he then contacted Asheville tower to see if the aircraft had switched to their frequency, but the pilot had not. At that point he broadcasted a radar contact loss transmission to the pilot.

FAA Order 7110.65, titled, “Air Traffic Control” which contains air traffic control procedures, revealed paragraph 2-1-2, states “Give first priority to separating aircraft and issuing safety alerts as required in this order. Good judgment shall be used in prioritizing all other provisions of this order based on the requirements of the situation at hand.” Paragraph 2-1-6 of the order states; “Issue a safety alert to an aircraft if you are aware the aircraft is in a position/altitude which, in your judgment, places it in unsafe proximity to terrain, obstructions, or other aircraft. Once the pilot informs you action is being taken to resolve the situation, you may discontinue the issuance of further alerts. Do not assume that because someone else has responsibility for the aircraft that the unsafe situation has been observed and the safety alert issued; inform the appropriate controller.” The order also states that pertaining to terrain or obstructions, to immediately issue / initiate an alert to an aircraft if you are aware the aircraft is at an altitude which, in your judgment, places it in unsafe proximity to terrain/obstructions.

Examination of the Insight Graphic Engine Monitor (GEM) by the Safety Board’s Vehicle Recorders Division located in Washington, D.C., revealed the unit does not store or retain any data.

Examination of the encoding altimeter was performed at the manufacturer’s facility with FAA oversight. Operational testing of the altimeter in a pressure chamber was attempted but hand movement did not occur with pressure changes. Disassembly of the unit revealed no evidence

of preimpact failure or malfunction. A detailed examination report with accompanying pictures is contained in the public docket for this accident.

Examination of the retained avionics which consisted of the Nos. 1 and 2 transceivers, directional gyro, pictoral navigation indicator (HSI), flight command indicator, autopilot and flight director computer, and autopilot remote mode annunciator was performed at the manufacturer's facility with FAA oversight. The in-use communication frequency of the Nos. 1 and 2 transceivers were 124.65 MHz, while the in-use navigation frequencies of the Nos. 1 and 2 transceivers were 111.10 and 110.90 MHz, respectively. Functional testing of the directional gyro revealed no faults were detected. Impact damage to the pictoral navigation indicator (HSI), flight command indicator, autopilot and flight director computer, and autopilot remote mode annunciator precluded operational testing. Inspection of the pictoral navigation indicator (HSI) revealed the displayed heading was approximately 330 degrees, and the heading bug was set to approximately 337 degrees. Inspection of the flight command indicator revealed the rotor rotated smoothly, and exhibited rotational marks on the rotor surface. Inspection of the light bulb filaments of the autopilot remote mode annunciator panel and autopilot and flight director computer revealed the filaments of the "TRIM" bulbs of both components exhibited major coil stretching. The bulb filaments associated with the autopilot of the autopilot remote mode annunciator panel and autopilot and flight director computer exhibited very minor coil stretching. A detailed examination report with accompanying pictures is contained in the public docket for this accident.

According to the avionics manufacturer, the trim warning lights (TRIM) of the autopilot remote mode annunciator panel and autopilot and flight director computer illuminates continuously whenever trim power is not on, or the system has not been preflight tested. Additionally, the TRIM warning light of the autopilot remote mode annunciator and the autopilot and flight director computer will illuminate when a power interruption approximately 200 miliseconds occurs, the TRIM circuit breaker is pulled, a manual electric pitch trim malfunction occurs, or an autopilot pitch trim fault occurs. The manual pitch trim malfunction occurs when the manual electric pitch trim is operating either uncommanded, or opposite the direction of pilot input. By design, in the event of uncommanded electric pitch trim or trim application opposite of pilot input, system self testing will detect and disable the manual electric pitch trim.

The airplane flight manual supplement associated with the autopilot system contains limitations, preflight, normal, and emergency procedures sections. The emergency procedures section outlines the steps to accomplish in the event of an electric trim malfunction for either manual electric or autotrim. The steps listed for autopilot malfunction indicate to simultaneously grasp the control wheel and maintain control of the airplane while pressing and holding the autopilot disconnect/trim interruption switch, and finally, to release the autopilot disconnect/trim interrupt switch. The steps listed for the electric trim malfunction indicate to press and hold the autopilot disconnect/trim interruption switch, pull the TRIM circuit breaker, and then to manually retrim the airplane.

Pilot Information

Certificate:	Private	**Age:**	65,Male
Airplane Rating(s):	Single-engine land	**Seat Occupied:**	Left
Other Aircraft Rating(s):	None	**Restraint Used:**	
Instrument Rating(s):	Airplane	**Second Pilot Present:**	No
Instructor Rating(s):	None	**Toxicology Performed:**	Yes
Medical Certification:	Class 3 With waivers/limitations	**Last FAA Medical Exam:**	April 30, 2008
Occupational Pilot:	No	**Last Flight Review or Equivalent:**	April 29, 2008
Flight Time:	2220 hours (Total, all aircraft)		

Aircraft and Owner/Operator Information

Aircraft Make:	Beech	**Registration:**	N888WD
Model/Series:	A36	**Aircraft Category:**	Airplane
Year of Manufacture:		**Amateur Built:**	
Airworthiness Certificate:	Utility	**Serial Number:**	E-3004
Landing Gear Type:	Retractable - Tricycle	**Seats:**	6
Date/Type of Last Inspection:	July 13, 2009 Annual	**Certified Max Gross Wt.:**	3650 lbs
Time Since Last Inspection:	2 Hrs	**Engines:**	1 Reciprocating
Airframe Total Time:	1239 Hrs as of last inspection	**Engine Manufacturer:**	CONT MOTOR
ELT:	C91A installed, activated, did not aid in locating accident	**Engine Model/Series:**	IO-550-B
Registered Owner:	YOUNGBLOOD LARRY J	**Rated Power:**	300 Horsepower
Operator:	YOUNGBLOOD LARRY J	**Operating Certificate(s) Held:**	None

Meteorological Information and Flight Plan

Conditions at Accident Site:	Instrument (IMC)	**Condition of Light:**	Day
Observation Facility, Elevation:	AVL,2165 ft msl	**Distance from Accident Site:**	11 Nautical Miles
Observation Time:	13:54 Local	**Direction from Accident Site:**	346°
Lowest Cloud Condition:		**Visibility**	10 miles
Lowest Ceiling:	Overcast / 1500 ft AGL	**Visibility (RVR):**	
Wind Speed/Gusts:	10 knots /	**Turbulence Type Forecast/Actual:**	/
Wind Direction:	170°	**Turbulence Severity Forecast/Actual:**	/
Altimeter Setting:	30.25 inches Hg	**Temperature/Dew Point:**	18°C / 15°C
Precipitation and Obscuration:	No Obscuration; No Precipitation		
Departure Point:	Asheville, NC (AVL)	**Type of Flight Plan Filed:**	None
Destination:	Asheville, NC (AVL)	**Type of Clearance:**	None
Departure Time:	14:05 Local	**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:**	35.254444,-82.462776

Administrative Information

Investigator In Charge (IIC):	Monville, Timothy
Additional Participating Persons:	Hector L Vazquez; FAA/FSDO; Charlotte, NC Hector L Vazquez; FAA/FSDO; Charlotte, NC Vicki L Gordon; FAA MIDO; Wichita, KS Marvin R Trease; FAA/FSDO; Kansas City, MO Brian J Weber; Hawker Beechcraft Corporation; Wichita, KS Sara Irwin; Teledyne Continental Motors; Mobile, AL Phil Goettel; Honeywell; Olathe, KS Toshio Kawawa; United Instruments, Inc.; Wichita, KS
Original Publish Date:	June 27, 2011
Last Revision Date:	
Investigation Class:	Class
Note:	The NTSB traveled to the scene of this accident.
Investigation Docket:	https://data.ntsb.gov/Docket?ProjectID=74703