National Transportation Safety Board
Aviation Accident Final Report

Location:	Lone Tree, CO	**Accident Number:**	DEN05FA126
Date & Time:	08/13/2005, 2020 MDT	**Registration:**	N425SG
Aircraft:	Cessna 425	**Aircraft Damage:**	Destroyed
Defining Event:		**Injuries:**	4 Fatal
Flight Conducted Under:	Part 91: General Aviation - Personal		

Analysis

During an ILS approach in night instrument meteorological conditions, the airplane impacted terrain and was destroyed by impact forces and postcrash fire. Prior to departure, the pilot obtained a weather briefing, which reported light rain, mist, and instrument meteorological conditions at the destination airport. After approaching the terminal area, the pilot received radar vectors to intercept the localizer for the Runway 35R ILS approach. The pilot's keying of the microphone and the timing of his speech exhibited decreased coordination during the approach phase of flight. After crossing the outer marker and at altitude of 7,700 feet, the pilot asked the controller what the current ceilings were at the airport, and the controller stated 500 feet. With the airplane at an altitude of 6,800 feet, the controller informed the pilot of a "low altitude alert" warning, at which the pilot responded, "Yeah, I am a bit low here." Approximately 20 seconds later, the pilot stated, "I'm back on glideslope." No further communications were received from the accident airplane. The controller issued another low altitude warning, and the radar target was lost. The accident site was located on a hilly, grass field at an elevation of 6,120 feet approximately 2.6 nautical miles from the runway threshold near the extended centerline of the runway. At 2027, the weather conditions at the airport were reported as wind from 360 degrees at 10 knots, visibility 2 statute miles with decreasing rain, scattered clouds at 500 feet, broken clouds at 1,100 feet, and an overcast ceiling at 2,800 feet. An acquaintance of the pilot, who had flown with him on other occasions, provided limited information about the pilot's proficiency, but stated, "a night ILS in IFR conditions would not be [the pilot's] first choice if he had an option." The pilot's logbooks were not located. The pilot did not hold a valid medical certificate at the time of the accident, and post-accident toxicological test revealed the presence of unreported prescription medications. No anomalies were noted with the airframe and engines. Ground inspection and flight testing of the airport's navigational equipment revealed that the equipment functioned satisfactorily.

Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be: The pilot's failure to properly execute the published instrument approach procedure, which resulted in controlled flight into terrain.

Findings

Occurrence #1: IN FLIGHT COLLISION WITH TERRAIN/WATER
Phase of Operation: APPROACH - FAF/OUTER MARKER TO THRESHOLD (IFR)

Findings
1. (C) IFR PROCEDURE - NOT FOLLOWED - PILOT IN COMMAND
2. (C) PROPER GLIDEPATH - NOT MAINTAINED - PILOT IN COMMAND
3. LACK OF CERTIFICATION - PILOT IN COMMAND

Factual Information

HISTORY OF FLIGHT

On August 13, 2005, approximately 2020 mountain daylight time, a Cessna 425 twin-engine turboprop airplane, N425SG, was destroyed when it impacted the terrain near Lone Tree, Colorado, during an instrument approach to the Centennial Airport (APA), near Englewood, Colorado. The private pilot and three passengers were fatally injured. The airplane was registered to SGavit Aviation LLC, Littleton, Colorado, and operated by the pilot. Night instrument meteorological conditions (IMC) prevailed, and an instrument flight rules (IFR) flight plan was filed for the Title 14 Code of Federal Regulations Part 91 personal flight. The cross-country flight departed Sandpoint (SZT), Idaho, at 1627 pacific daylight time.

A review of the air traffic control communications and radar data from the Federal Aviation Administration (FAA) revealed that during the en route portion of the flight, a radar target identified as the accident airplane maintained all assigned altitudes and headings. The accident airplane approached APA from the north and west, and the pilot received radar vectors to intercept the localizer course for the Instrument Landing System (ILS) runway 35R approach.

At 2016, the controller instructed the pilot to turn left to a heading of 010 degrees to join the localizer for runway 35R, and descend to and maintain 8,500 feet. The pilot asked the controller to repeat the instruction. The controller then instructed the pilot to turn to a heading of 360 degrees, descend and maintain 8,500 feet. The pilot did not respond, and the controller asked if the pilot received the clearance. The pilot responded, "Give me a minute."

At 2017, the controller instructed the pilot to descend and maintain 8,000 feet. The pilot acknowledged the instruction, and the controller then cleared the airplane for the ILS runway 35R approach. The pilot read back the clearance, and the controller asked the pilot if he was "starting down on the altitude." The pilot responded affirmatively. The controller then instructed the pilot to contact APA air traffic control tower (ATCT) on frequency 118.9.

At 2018:06, with the airplane at an altitude of 8,500 feet and a groundspeed of 170 knots, the pilot reported to APA ATCT that the airplane was at the outer marker (CASSE). The controller then cleared the airplane to land on runway 35R and stated the wind was from 360 degrees at 8 knots. At 2018:47, at an altitude of 7,700 feet and a groundspeed of 190 knots, the pilot asked the controller, "What's the current ceiling...?" The controller responded, "I'm showing a five hundred foot ceiling."

At 2019:06, with the airplane at an altitude of 6,800 feet and a ground speed of 170 knots, the controller stated, "And five sierra golf, I am getting low altitude, low altitude alert on you." The pilot responded, "Yeah, I am a bit low here." At 2019:32, at an altitude of 7,200 feet and a ground speed of 150 knots, the pilot stated, "I'm back on glideslope." No further communications were received from the accident airplane.

At 2019:56, with the airplane at an altitude of 6,500 feet and a groundspeed of 130 knots, the controller stated, "Twin cessna five sierra golf, check your altitude." At 2020:04, the radar target was lost. At 2020:43, the Denver Approach controller stated to the APA controller, "Everything still okay with five sierra golf, I have low altitude." The APA controller attempted several times to contact the accident airplane with no response.

The accident occurred in a hilly grass field at an elevation of 6,120 feet approximately 2.6 nautical miles from the approach end of runway 35R, and near the extended centerline of the runway.

Review of the radar data depicting the approach, overlaid on a calculated glideslope and localizer, revealed deviations above and below the glideslope, and left and right of the localizer.

PERSONNEL INFORMATION

Pilot Information

The pilot, age 62, who was seated in the left seat, held a private pilot certificate, issued October 23, 1983, with airplane multi-engine land, airplane single-engine land, rotorcraft helicopter, and instrument airplane ratings. The pilot's most recent third-class medical certificate, dated July 16, 2003, was valid through July 31, 2005. On the medical certificate application form, the pilot estimated his total flight time as 5,000 hours and 40 hours within the previous 6 months. According to an insurance form completed by the pilot in November 2004, he reported 1,423 hours in the accident airplane make and model. The pilot's logbooks were not located.

Pilot's Accident History

The pilot was involved in three prior accidents, described below.

On March 6, 1992, the pilot received minor injuries when an Enstrom F28 helicopter he was flying experience a loss of engine power, and impacted a roadway during the attempted autorotation. The Safety Board determined the probable cause of this accident to be the pilot's premature use of collective during the autorotation. The disconnection and subsequent collapse of the helicopter's induction air line was found to have contributed to the accident.

On May 6, 2000, the pilot received serious injuries when a Bell 206 helicopter he was flying impacted a lake while maneuvering at low altitude. The Safety Board determined the probable cause of this accident to be the pilot's failure to maintain control of the helicopter while maneuvering. The high density altitude weather conditions also contributed to the accident.

On May 31, 2003, the pilot was not injured when the Cessna 425 airplane he was flying, N425SG, was substantially damaged when it encountered hail and severe turbulence during cruise flight. The Safety Board determined the probable cause of this accident to be the pilot's inadvertent flight into adverse weather conditions. Severe turbulence and hail also contributed to the accident.

Pilot's Proficiency

Safety Board staff interviewed two pilot acquaintances who had flown previously with the pilot. One acquaintance accompanied the pilot on the May 31, 2003, hail encounter flight, and the second acquaintance had flown with the pilot on other occasions. Both acquaintances voiced concern about the pilot's flying skills, with one stating, "a night ILS in IFR conditions would not be [the pilot's] first choice if he had an option."

According to an acquaintance of the pilot, the pilot completed recurrent training in the accident airplane in November 2004. Details of the recurrent training were not determined.

Pilot's 72-hour History

On August 12, 2005, about 0945, the pilot and three passengers departed from APA and flew to

Sandpoint, Idaho, for meetings with business colleagues. On August 12 and 13, 2005, the group met with business colleagues. The colleagues stated that the pilot's behavior during the meetings appeared normal. According to one colleague, the pilot said there were poor weather conditions at APA on the day of the accident. The colleague offered the pilot and his passengers a place to stay for the night, but the pilot said he needed to return to the Denver area. A passenger's spouse stated that the group planned to depart SZT for APA at 1300, but did not depart until approximately 1730.

AIRCRAFT INFORMATION

The accident airplane, a Cessna 425 (Conquest I), serial number 425-0166, was a low-wing, high performance, semi-monocoque design airplane. The airplane was equipped with two 750-horsepower Pratt & Whitney Canada PT6A-135A turboprop engines (serial numbers PCE-PZ0045 and PCE-PZ0044), and McCauley four-bladed, hydraulically operated, constant-speed, feathering-type propellers.

The airplane was issued a standard airworthiness certificate on March 24, 1982. The airplane was registered to Accutronics, Inc. (pilot was president/owner of the company), Littleton, Colorado, December 27, 2000, under the registration N425WL. On June 28, 2001, the airplane was registered to SGavit Aviation LLC (pilot's aviation company) under the registration N425SG.

The airplane was being maintained in accordance with the manufacturer's inspection program. The airplane's most recent inspection was completed on May 26, 2005, at a total airframe time of 4,003.9 hours.

On September 17, 2003, the aircraft's altimeter and encoding systems were tested and inspected in accordance with Title 14 CFR Part 91.411, paragraphs (a)(2) and (3), and Part 43, appendix E. Also, the ATC transponder systems were tested and inspected in accordance with Part 91.413, and Part 43, appendix F.

A review of the FAA airworthiness records revealed that as of December 17, 2002, the airplane was equipped with at least the following avionics equipment: Bendix/King KLN-90B global positioning system (GPS), Sperry C-1000 autopilot with yaw damper, Collins FIS-70 flight director, Collins ALT-50 radar altimeter, AA-801A Altitude Alert with horn, and Collins WXR-300 Color Stabilized Radar.

METEOROLOGICAL INFORMATION

At 1647, the pilot obtained a weather briefing from Boise Automated Flight. Service Station (FSS). The briefer informed the pilot of the following conditions for the intended route of flight: AIRMET for IFR conditions along route of flight, thunderstorms reported in the Rocky Mountains, Convective SIGMET 28W for southern Wyoming and western Colorado, and cloud layers at 6,000 to 25,000 feet over the foothills and plains. The current conditions at APA were provided as overcast clouds at 2,000 feet. The forecast was for scattered clouds at 800 feet, and an overcast ceiling 1,800 feet, with light rain and mist.

At 2001, the APA automated surface observing system (ASOS) reported the wind from 360 degrees at 10 knots, visibility 2 statute miles with light rain, mist, broken clouds at 500 feet, and overcast clouds at 1,100 feet, temperature 13 degrees Celsius, dew point 12 degrees Celsius, and an altimeter setting of 30.21 inches of mercury.

At 2027, the APA ASOS reported the wind from 010 degrees at 9 knots, visibility 2 statute

miles with light rain, scattered clouds at 500 feet, broken clouds at 1,100 feet, overcast clouds at 2,800 feet, temperature 12 degrees Celsius, dew point 12 degrees Celsius, and an altimeter setting of 30.22 inches of mercury.

At 2033, the APA ASOS reported the wind from 010 degrees at 7 knots, visibility 2 statute miles with light rain, scattered clouds at 500 feet, broken clouds at 1,400 feet, overcast clouds at 3,000 feet, temperature 12 degrees Celsius, dew point 12 degrees Celsius, and an altimeter setting of 30.22 inches of mercury.

AIDS TO NAVIGATION

After the accident, the FAA conducted a ground inspection and flight test of all navigational equipment at APA. The inspection and flight test revealed that the equipment functioned satisfactorily. Prior to the accident airplane's approach, a Beech King Air successfully executed the runway 35R ILS approach.

AIRPORT INFORMATION

The Centennial Airport, APA, is a public, controlled airport located approximately 15 miles southeast of Denver, Colorado, at 39 degrees, 34.207 minutes north latitude, and 104 degrees, 50.957 minutes west longitude, at a surveyed elevation of 5,883 feet. The airport features three asphalt runways, Runway 17L/35R, which is 10,002 feet by 100 feet, Runway 17R/35L, which is 7,004 feet by 77 feet, and Runway 10/28 is 4,800 feet by 75 feet.

Runway 35R was equipped with medium-intensity runway edge lights, runway end identifier lights, and a medium-intensity approach lighting system with runway alignment indicator lights. The runway was also equipped with a 2-box, 3 degree glidepath visual approach slope indicator (VASI) located on the left side of the runway. Runway 35R was configured for precision and non-precision approaches, which included ILS, global positioning system, and non-directional beacon approaches.

The ILS approach to runway 35R at APA included an inbound course with a magnetic heading of 347 degrees. The minimum descent altitude for the inboard section of the approach was 8,000 feet mean sea level (msl) when established on the localizer with a glideslope intercept just south of the CASSE locator outer marker (LOM). The CASSE LOM was located at 8.1 nautical miles (nm) distance measuring equipment (DME) on the approach course. After crossing CASSE LOM on the inbound course, the decision height for the approach was 6,083 feet and was located at the middle marker (MM), which was 0.4 nm from the runway threshold. The distance from the CASSE LOM to the missed approach point (MAP) was 5.9 nm. The published missed approach procedure instructed the pilot to "climb to 6,900, then climbing right turn to 9,000 to intercept I-APA South Course to CASSE LOM/I-APA 8.1 DME and hold."

COMMUNICATIONS

Safety Board staff reviewed recordings of the pilot's air traffic control communications. The pilot appeared to have difficulty obtaining en route weather information. Between 1847 and 1913, the pilot attempted to contact the FAA's en route flight advisory service (EFAS). He told a Salt Lake Center controller he was having difficulty contacting EFAS and asked the controller to recommend a radio frequency. The controller recommended 122.20, which was not a frequency used by EFAS in the Salt Lake Center area. The pilot told the controller he had been

using that frequency. The pilot reported leaving center frequencies on two subsequent occasions to contact EFAS. It is unknown whether the pilot ever obtained en route weather information through EFAS.

Response delays and readback errors were noted in the pilot's communications. The pilot incorrectly read back an altitude clearance and an altimeter setting provided by Denver Air Route Traffic Control Center (ARTCC), and was corrected twice by a controller before reading back the clearance correctly. Later, the pilot failed to respond to a clearance issued by the Denver Terminal Radar Approach Control (TRACON) facility, when instructed to descend, intercept the Runway 35R localizer, and join the approach. Four seconds after the clearance was issued, the pilot stated, "Say again, sir." The controller repeated the intercept clearance with an adjusted heading. The pilot did not respond, but the airplane did begin to turn in the appropriate direction. After 6 seconds, the controller asked, "November five sierra golf, did you get any of that?" The pilot responded, "ah, give me..." After another 8 seconds, the controller issued a new clearance, which the pilot correctly acknowledged.

Decreased coordination between the pilot's keying of the microphone and the timing of his speech was noted during the arrival and approach phases of the flight. Clipping was evident in 5 of the pilot's last 13 radio transmissions. By comparison, clipping rarely occurred during earlier phases of the flight.

WRECKAGE AND IMPACT INFORMATION

The accident site was located in a hilly, grass field adjacent to a set of powerlines and poles, approximately 2.6 nautical miles south of the runway 35R threshold. No evidence of contact between the airplane and powerlines or poles was noted. A GPS receiver recorded the initial impact location as 39 degrees 30.748 minutes north latitude and 104 degrees 50.990 minutes west longitude. The initial impact point included a series of ground scars consistent with the spacing of the left and right main landing gears, fuselage, left and right engine nacelles, and left wing. The ground scar was located approximately 845 feet south of the main wreckage. The initial impact ground scars and wreckage distribution path were orientated on a measured magnetic heading of 012 degrees. A second series of ground scars were located near the crest of a hill approximately 315 feet from the initial impact point. The empennage was located adjacent to the second series of ground scars on the east side of the debris field. The empennage, left and right propeller assemblies, left engine, left and right main landing gears, and additional pieces of airplane structure came to rest in the wreckage distribution path. The main wreckage came to rest on its right side and was located at 39 degrees, 30.875 minutes north latitude and 104 degrees, 50.919 minutes west longitude. The main wreckage consisted of the fuselage, left and right wings, and the right engine, and was partially consumed by a postcrash fire.

The main wreckage came to rest on its right side and the fuselage nose faced in an easterly direction. The cockpit and forward cabin were destroyed by impact forces and postcrash fire. The wing carry through spar came to rest within the cabin structure, laying in a diagonal position. The empennage was separated aft of the aft pressure bulkhead and came to rest in the distribution path. The vertical stabilizer remained attached to the empennage, and the top of the vertical stabilizer was bent to the right. The top 1.25 feet of the rudder was separated, and the remaining rudder remained attached to the vertical stabilizer. The outboard 4 feet of the left horizontal stabilizer and the outboard 1.5 feet of the right horizontal stabilizer were separated. The horizontal stabilizer was partially separated from the empennage structure.

Three feet of the left and 1.75 feet of the right outboard elevators were separated. The remaining elevator remained attached to its respective horizontal stabilizer attach points. Elevator trim was found in the 8-degree tab down position.

The left wing was separated from the fuselage and came to rest upright, facing aft, adjacent to the fuselage. The left wing skin and structure was damaged by impact forces and postcrash fire. The outboard section of the left wing was separated and found in the distribution path. The left aileron was separated, and the left flap remained attached to the wing. The right wing was separated from the fuselage and came to rest inverted, facing forward, adjacent to the fuselage. The right wing was also damaged by impact forces and postcrash fire. The right aileron was separated, and the right flap remained attached to the wing. The flap actuator position corresponded to a flaps up position.

The left engine was separated from the wing and came to rest in the distribution path approximately 420 feet from the initial impact point. The left propeller assembly was separated from the engine and was located in the distribution path. All four propeller blades were found loose in the propeller hub. A 2-foot outboard section of one propeller blade was separated and located in the distribution path. One blade remained partially straight and exhibited chordwise scratching and twisting. Two blades were bent 90 degrees opposite the direction of rotation and displayed chordwise scratching, twisting, and leading edge gouging.

The right engine came to rest adjacent to the right wing and remained attached to the wing via control cables. The engine exhibited damage by impact forces and postcrash fire. The reduction gearbox was separated from the engine, and the right propeller assembly remained attached to the propeller shaft in the reduction gearbox. All four propeller blades were found loose in the propeller hub. Three propeller blades were bent 90 degrees opposite the direction of rotation, and the blades exhibited chordwise scratching, polishing, and leading edge gouging. A 1.5 foot outboard section of one propeller blade was separated and located in the distribution path.

Elevator and rudder control cables were intact from the cockpit to the separation point at the aft pressure bulkhead. The rudder and elevator control cables remained attached to their respective control surfaces. The cables exhibited signatures consistent with overload. Aileron control continuity was established from the cockpit to the aileron sector area located in the middle of the cabin. The aileron sector assembly was destroyed and consumed by fire. Two control cables from the aileron sector to the right aileron were found in the right wing structure. One left aileron cable was separated at the aileron bellcrank and one left aileron cable was separated at the wing root. The left aileron cable separation points exhibited signatures consistent with overload.

MEDICAL AND PATHOLOGICAL INFORMATION

An autopsy was performed on the pilot by the Douglas County Coroner's Office, Castle Rock, Colorado, on August 15, 2005. According to the autopsy, the cause of death was due to head and neck injuries secondary to blunt force trauma sustained in the airplane crash.

Specimens for the toxicological tests were taken from the pilot by the Douglas County Coroner's Office medical examiner. The FAA's Bioaeronatical Sciences Research Laboratory, Oklahoma City, Oklahoma, performed toxicological tests on the pilot's specimens. These tests revealed the presence of bupropion in the pilot's blood specimen, and bupropion, oxazepam, and alpha-hydroxyalprazolam in the pilot's urine specimen. The toxicological tests were

negative for carbon monoxide, alcohol, and a variety of other substances.

The pilot's FAA medical records indicated that he began taking a drug containing the benzodiazepine Librium twice a day for approximately two years, beginning in 1985. He reported taking this drug to treat stomach cramps. After he reported use of this medication, the FAA informed the pilot that his chances for medical certification were not favorable. Soon after, however, the pilot reported discontinuing his use of this medication and was issued a FAA medical certificate. On his July 19, 1989 medical certificate application form, the pilot wrote that he had "been able to get off Librax." The pilot reported no use of antidepressants or benzodiazepines on his 1991, 1993, 1995, 1997, 1999, 2001, or 2003 FAA medical certificate application forms.

On his July 16, 2003, third-class medical application form, the pilot reported no use of medications.

The pilot's primary care medical records revealed that he began taking the medication bupropion for smoking cessation in October 2003, and had filled prescriptions for 60 pills of this medication regularly thereafter, most recently on June 27, 2005. On June 9, 2005, the pilot visited a hospital emergency department for treatment of minor injuries sustained when the pilot was arrested by local police. He reported periodic use of alprazolam to hospital staff at that time. He was administered the benzodiazepine lorazepam 2 mg and the narcotic painkiller Vicodin (hydrocodone / aceaminophen) during the hospital visit, and was provided a prescription for 20 0.25 mg alprazolem tablets, which he filled at a nearby pharmacy on the same day. Information obtained from local pharmacies contained no evidence that the pilot had filled any other prescriptions for benzodiazepine medications (a class of medications including alprazolam) in the 5 years prior to this accident or for any narcotic medications (a class of medications including hydrocodone) in the year prior to the accident.

TESTS AND RESEARCH

On August 15, 2005, at the facilities of Beegles Aircraft Services, Greeley, Colorado, the wreckage was examined by the NTSB investigator-in-charge (IIC) and a representative of the airframe manufacturer. The flight and engine instruments were destroyed by postcrash fire. The cockpit engine control quadrant was destroyed and consumed by fire. One remote directional gyro was disassembled and 360 degree rotational scoring was noted on the rotor. The other directional gyro was destroyed by postcrash fire and was not disassembled. The remote vertical gyro was disassembled and intermittent rotational scoring was noted on the rotor.

On October 5, 2005, at the facilities of Beegles Aircraft Services, the engines were examined by the NTSB IIC, a representative of the engine manufacturer, and a representative of the airframe manufacturer. Earthen debris was noted throughout the compressor section and combustion liners. No anomalies or mechanical deficiencies were noted.

ADDITIONAL INFORMATION

Parties to the investigation included the FAA, Cessna Aircraft Company, and Pratt & Whitney Canada.

The wreckage was released to the owner's representative on October 26, 2005.

Pilot Information

Certificate:	Private	**Age:**	62, Male
Airplane Rating(s):	Multi-engine Land; Single-engine Land	**Seat Occupied:**	Left
Other Aircraft Rating(s):	Helicopter	**Restraint Used:**	Seatbelt, Shoulder harness
Instrument Rating(s):	Airplane	**Second Pilot Present:**	No
Instructor Rating(s):	None	**Toxicology Performed:**	Yes
Medical Certification:	None None	**Last FAA Medical Exam:**	07/01/2003
Occupational Pilot:		**Last Flight Review or Equivalent:**	11/01/2004
Flight Time:	5000 hours (Total, all aircraft), 1450 hours (Total, this make and model)		

Aircraft and Owner/Operator Information

Aircraft Make:	Cessna	**Registration:**	N425SG
Model/Series:	425	**Aircraft Category:**	Airplane
Year of Manufacture:		**Amateur Built:**	No
Airworthiness Certificate:	Normal	**Serial Number:**	425-0166
Landing Gear Type:	Retractable - Tricycle	**Seats:**	6
Date/Type of Last Inspection:	05/01/2005, Continuous Airworthiness	**Certified Max Gross Wt.:**	8275 lbs
Time Since Last Inspection:		**Engines:**	2 Turbo Prop
Airframe Total Time:	4003.9 Hours as of last inspection	**Engine Manufacturer:**	Pratt & Whitney Canada
ELT:	Installed, activated, did not aid in locating accident	**Engine Model/Series:**	PT6A-135A
Registered Owner:	SGavit Aviation LLC	**Rated Power:**	750 hp
Operator:	SGavit Aviation LLC	**Operating Certificate(s) Held:**	None

Meteorological Information and Flight Plan

Conditions at Accident Site:	Instrument Conditions	**Condition of Light:**	Night
Observation Facility, Elevation:	APA, 5883 ft msl	**Distance from Accident Site:**	2 Nautical Miles
Observation Time:	2027 MDT	**Direction from Accident Site:**	350°
Lowest Cloud Condition:	Scattered / 500 ft agl	**Visibility**	2 Miles
Lowest Ceiling:	Overcast / 2800 ft agl	**Visibility (RVR):**	
Wind Speed/Gusts:	9 knots /	**Turbulence Type Forecast/Actual:**	/
Wind Direction:	10°	**Turbulence Severity Forecast/Actual:**	/
Altimeter Setting:	30.22 inches Hg	**Temperature/Dew Point:**	12°C / 12°C
Precipitation and Obscuration:	Light - Rain		
Departure Point:	Sandpoint, ID (SZT)	**Type of Flight Plan Filed:**	IFR
Destination:	Englewood, CO (APA)	**Type of Clearance:**	IFR
Departure Time:	1627 PDT	**Type of Airspace:**	

Wreckage and Impact Information

Crew Injuries:	1 Fatal	**Aircraft Damage:**	Destroyed
Passenger Injuries:	3 Fatal	**Aircraft Fire:**	On-Ground
Ground Injuries:	N/A	**Aircraft Explosion:**	None
Total Injuries:	4 Fatal	**Latitude, Longitude:**	39.502222, -104.835833

Administrative Information

Investigator In Charge (IIC):	Aaron M Sauer	**Report Date:**	10/03/2006
Additional Participating Persons:	Michele Wallentine; Federal Aviation Administration; Denver, CO Henry Soderlund; Cessna Aircraft Company; Wichita, KS Ernest Patterson; Pratt & Whitney; Monument, CO		
Publish Date:			
Investigation Docket:	NTSB accident and incident dockets serve as permanent archival information for the NTSB's investigations. Dockets released prior to June 1, 2009 are publicly available from the NTSB's Record Management Division at pubinq@ntsb.gov, or at 800-877-6799. Dockets released after this date are available at http://dms.ntsb.gov/pubdms/.		