National Transportation Safety Board
Washington, DC 20594

Brief of Accident

Adopted 06/12/2012

CEN10FA443
File No. 29864 | 07/27/2010 | Oshkosh, WI | Aircraft Reg No. N6JR | Time (Local): 18:16 CDT

Make/Model:	Hawker Beechcraft / 390
Engine Make/Model:	Williams International / FJ44-2A
Aircraft Damage:	Substantial
Number of Engines:	2
Operating Certificate(s):	None
Type of Flight Operation:	Business
Reg. Flight Conducted Under:	Part 91: General Aviation

	Fatal	Serious	Minor/None
Crew	0	1	0
Pass	0	1	0

Last Depart. Point:	Ypsilanti, MI
Destination:	Same as Accident/Incident Location
Airport Proximity:	On Airport/Airstrip
Airport Name:	Wittman Regional Airport
Runway Identification:	18R
Runway Length/Width (Ft):	6700 / 150
Runway Surface:	Concrete
Runway Surface Condition:	Dry

Condition of Light:	Day
Weather Info Src:	Weather Observation Facility
Basic Weather:	Visual Conditions
Lowest Ceiling:	None
Visibility:	9.00 SM
Wind Dir/Speed:	200 / 011 Kts
Temperature (°C):	29
Precip/Obscuration:	No Obscuration; No Precipitation

Pilot-in-Command Age: 68

Certificate(s)/Rating(s)
Airline Transport; Multi-engine Land; Single-engine Land

Instrument Ratings
Airplane

Flight Time (Hours)

Total All Aircraft:	9095
Last 90 Days:	62
Total Make/Model:	1406
Total Instrument Time:	967

*** Note: NTSB investigators either traveled in support of this investigation or conducted a significant amount of investigative work without any travel, and used data obtained from various sources to prepare this aircraft accident report. ***

The accident occurred during the Experimental Aircraft Association's Airventure 2010 fly-in convention. Because of the high density of aircraft operations during the fly-in, the Federal Aviation Administration implemented special air traffic control procedures to accommodate traffic demand and maximize runway capacity. Arriving aircraft were issued landing instructions and clearances by a tower controller using a specified tower radio frequency. Departing aircraft were handled by another team of controllers operating on a separate radio frequency that was associated with a mobile operations unit located near the runway.

Air traffic control data indicated that the accident airplane established contact with the tower controller and entered a left traffic pattern for runway 18R. As the accident airplane was turning from downwind to base leg, the controller handling departures cleared a Piper Cub for an immediate takeoff and angled departure (a procedure used by slower aircraft to clear the runway immediately after liftoff by turning across the runway edge). The accident pilot was not monitoring the departure frequency, and, therefore, he did not hear the radio transmissions indicating that the departing Piper Cub was going to offset to the left of the runway after liftoff. The accident pilot reported that, while on base leg, he became concerned that his descent path to the runway would conflict with the Piper Cub that was on takeoff roll. He stated that he overshot the runway centerline during his turn from base to final, and, when he completed the turn, his airplane was offset to the right of the runway. The pilot stated that, at this point, he decided not to land because of a

perceived conflict with the departing Piper Cub that was ahead and to the left of his position. The pilot reported that he initiated a go-around, increasing engine power slightly, but not to takeoff power, as he looked for additional traffic to avoid. He estimated that he advanced the throttle levers "probably a third of the way to the stop," and, as he looked for traffic, the stall warning stick-shaker and stick-pusher systems activated almost simultaneously as the right wing stalled. The airplane subsequently collided with terrain in a nose down, right wing low attitude.

A postaccident review of available air traffic control communications, amateur video of the accident sequence, controller and witness statements, and position data recovered from the accident airplane indicated that the Piper Cub was already airborne, had turned left, and was clear of runway 18R when the accident airplane turned from base to final.

The postaccident examination did not reveal any preimpact mechanical malfunctions or failures that would have precluded normal operation of the airplane. The airplane flight manual states that, in the event of a go-around, the pilot should first advance engine thrust to takeoff power and then establish Vref (reference landing approach speed). The pilot's decision not to select takeoff power during the go-around directly contributed to the development of the aerodynamic stall at a low altitude.
Updated at Jun 21 2012 2:18PM

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OCCURRENCES

Approach-VFR go-around - Loss of control in flight
Approach-VFR go-around - Aerodynamic stall/spin
Uncontrolled descent - Collision with terr/obj (non-CFIT)

FINDINGS

Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Powerplant parameters-Incorrect use/operation - C
Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Airspeed-Not attained/maintained - C
Personnel issues-Task performance-Use of equip/info-Use of policy/procedure-Flight crew - C
Environmental issues-Operating environment-Air traffic/operating proc-Traffic congestion-Effect on operation

Findings Legend: (C) = Cause, (F) = Factor

The National Transportation Safety Board determines the probable cause(s) of this accident to be:
The pilot's decision not to advance the engines to takeoff power during the go-around, as stipulated by the airplane flight manual, which resulted in an aerodynamic stall at a low altitude.