

 National Transportation Safety Board PRELIMINARY REPORT AVIATION		NTSB ID: CEN13FA085 Occurrence Date: 12/02/2012 Occurrence Type: Accident	Most Critical Injury: Fatal Investigated By: NTSB
Location/Time Name: City/Place: Greensburg State: IN Zip Code: 46035 Local Time: EDT Time Zone: EDT			
Aircraft Information Registration Number: N92315 Aircraft Manufacturer: PIPER Model/Serial Number: PA 46-350P Type of Aircraft: Airplane Amateur Built Aircraft? No			
Injury Summary Fatal: 4 Serious: 0 Minor: 0 None: 0			
Revenue Flightseeing Flight: No Air Medical Transport Flight: No			
Narrative See separate statement of facts, conditions and circumstances pertinent to the accident/occurrence. *** 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. *** On December 2, 2012, about 1819 Eastern Standard Time (EST), a Piper PA-46-350P, N92315, collided with the terrain while performing the RNAV (GPS) Rwy 36 approach to the Greensburg Municipal Airport (I34), Greensburg, IN. The instrument rated private pilot and three passengers were fatally injured. The airplane was registered to an individual, and operated under the provisions of 14 Code of Federal Regulations Part 91 as a personal flight. Instrument meteorological conditions (IMC) existed at the time of the accident, which was operated on an instrument flight rules flight plan. The flight originated at Destin-Fort Walton Beach Airport (KDSI), Destin, Florida, at 1416 Central Standard Time. Prior to the arrival of the accident airplane, a friend of the pilot flew the same flight in a similarly-equipped airplane. The friend arrived approximately 35 minutes prior to the accident airplane, and then stated that he performed the same approach to its termination point. The friend never broke out of the clouds, performed a missed approach and diverted to an alternate airport. At 1806:16, ATC cleared the accident pilot to perform the RNAV (GPS) Rwy 36 approach. The last communication with the accident pilot was that the airplane was four miles from the no procedure turn (NPT) initial approach fix (IAF), PULIC, and that the accident pilot could change the airport advisory frequency. Weather at the time of the approach was reported as instrument flight rules (IFR) with ceilings estimated by witnesses at approximately 300 feet with fog and mist. A witness subsequently saw the airplane descend out of the clouds with no perceived pitch change or change in engine noise prior to impacting terrain. That witness contacted 911 at 1819 and informed them of the accident. At 1829, Indianapolis Approach Control contacted the Greensburg Police Department 911 dispatch and informed them that the accident pilot had not closed his flight plan. At 1836, 911 dispatch called Indianapolis Approach Control and requested additional information on the accident airplane. The airplane was found by searchers at 2305. The airplane initially impacted a plowed field and traveled 328 feet on a heading of 115 degrees. Approach minimums required 700 feet and 1 mile visibility for a straight-in approach and 800 feet and 1 mile visibility for the circling approach. An eyewitness near the airport reported seeing a very low-flying airplane with landing lights on at the approximate time of the accident occurrence in a slight left bank, flying directly over his house 750 feet east of the approach end of Runway 18. Other witnesses stated that the pilot-controlled runway lighting was not illuminated at the time of the accident. The runway lights were operationally checked following the accident and no anomalies were found. A detailed examination of the airplane and its engine was completed after its recovery and no anomalies were found. Non-volatile memory (NVM) recovered from the aircraft included two panel-mounted GPS navigation devices, and an associated multi-function display. Additionally, three personal data devices with NVM were also recovered. All devices were sent to the NTSB.			
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BEHIND THE AIRPLANE

BY DICK ROCHFORD, ATP, CFIII MASTER INSTRUCTOR

NTSB Identification: CEN13FA085
14 CFR Part 91: General Aviation
Accident occurred Sunday, Dec. 02, 2012, in Greensburg, Ind.
Aircraft: PIPER PA 46-350P, registration: N92315
Injuries: Four Fatal.

This is preliminary information, subject to change, and may contain errors. Any errors in this report will be corrected when the final report has been completed. 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.

On Dec. 2, about 1819 Eastern Standard Time (EST), a Piper PA-46-350P, N92315, collided with the terrain while performing the RNAV (GPS) Rwy 36 approach to the Greensburg Municipal Airport (I34), Greensburg, Ind. The instrument-rated private pilot and three passengers were fatally injured. The airplane was regis-

tered to an individual and operated under the provisions of 14 Code of Federal Regulations Part 91 as a personal flight. Instrument meteorological conditions (IMC) existed at the time of the accident, which was operated on an instrument-flight-rules flight plan. The flight originated at Destin-Fort Walton Beach Airport (KDSI),

Destin, Fla., at 1416 Central Standard Time.

Prior to the arrival of the accident airplane, a friend of the pilot flew the same flight in a similarly equipped airplane. The friend arrived approximately 30 minutes prior to the accident airplane, and then stated that he performed the same approach to its termination point. The friend never broke out of the clouds, performed a missed approach and diverted to an alternate airport. At 1806:36, ATC cleared the accident pilot to perform the RNAV (GPS) RWY 36 approach. The last communication with the accident pilot was that the airplane was four miles from the no-procedure turn (NoPT) initial approach fix (IAF), PULIC, and that the accident pilot could change the airport advisory frequency. Weather at the time of the approach was reported as instrument flight rules (IFR) with ceilings estimated by witnesses at approximately 300 feet with fog and mist. A witness subsequently saw the airplane descend out of the clouds with no perceived pitch change or change in engine noise prior to impacting terrain. That witness contacted 911 at 1819 and informed them of the accident. At 1829, Indianapolis Approach Control contacted the Greensburg Police Department 911 dispatch and informed them that the accident pilot had not closed his flight plan. At 1836, 911 dispatch called Indianapolis Approach Control and requested additional information on the accident airplane. The airplane was found by searchers at 2305.

The airplane initially impacted a plowed field and traveled 328 feet on a heading of 115 degrees. Approach minimums required 700 feet and 1-mile visibility for a straight-in approach and 800 feet and 1-mile visibility for the circling approach. An eyewitness near the airport reported seeing a very low-flying airplane with landing lights on at the approximate time of the accident occurrence in a slight left bank, flying directly over his house 750 feet east of the approach end of Runway 18. Other witnesses stated that the pilot-controlled runway lighting was not illuminated at the time of the accident. The runway lights were operationally checked following the accident, and no anomalies were found.

A detailed examination of the airplane and its engine was completed after its recovery, and no anomalies were found. Non-volatile memory (NVM) recovered from the aircraft included two panel-mounted GPS



navigation devices, and an associated multi-function display. Additionally, three personal data devices with NVM were also recovered. All devices were sent to the NTSB Recorder Lab in Washington, DC, for examination. The remainder of the aircraft was released to the aircraft owner's representative.

No pilot believes that his/her aircraft could end up in an accident report, yet PA-46 fatal accidents continue to happen with disturbing regularity. When asked confidentially "what types of accidents do you fear," the overwhelming response from PA-46 pilots is engine fire, forced landing at night ... in the mountains etc. In other words, pilots tend to fear that which is not within their control. This is human nature, and the thinking pilot should carefully guard against this bias. We sometimes even spend the limited training time we have discussing these topics ad nauseum and, in the process, miss out on the training that is needed most.

I encourage each pilot always to operate procedurally with well-vetted checklists, flows, memory items and SOP the same way every time. Furthermore, do not let anyone or anything interfere with this process.

Most pilots are appreciative and enthusiastic about their new-found competence when they receive and benefit from excellent training. However, some believe they don't need training on fill-in-the-blank scenarios because they will never fly in fill-in-the-blank conditions. This last comment is, of course, a set-up for what the psychologists call a hyper-focus-related accident or pilot-induced loss of situational awareness. I call it "watching the wrong hand." It is true that the aircraft cannot know if you can see or not, but it is also true that the aircraft

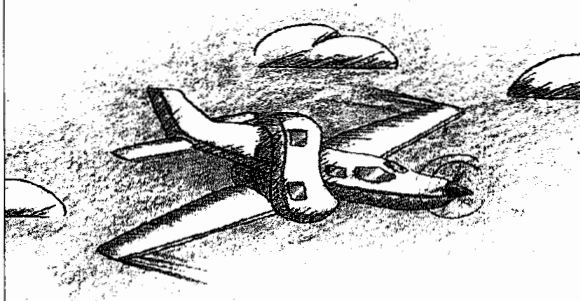
will not, in most cases, complain if you are not established on the three-dimensional thick, black line depicted on the approach procedure.

Consider the following flow when inside the TAA or MSA ring:

- ACTIVATE (the approach on the GPS navigator).
- FLIP (the correct frequency from standby to active). Remember now, a flow item is a consideration not a "to do" so we leave it alone on the RNAV approach

- FLOP (the CDI) from GPS to VLOC ... But not for RNAV right?
- SET (the course needle or verify that it is set).
- ID (the approach).
- ARM (the approach on the coupled autopilot).
- Now ask yourself three questions: Which way? How low? What's next?

If you cannot answer these questions immediately and correctly, you are officially "behind" (Continued on page 51)




Whether insurance is a headwind or tailwind depends on which way you fly.

If it seems every year insurance is becoming more and more of a headwind you can't overcome, you're not alone. The entire aviation industry is having a tough time in our newly risk-sensitive world.

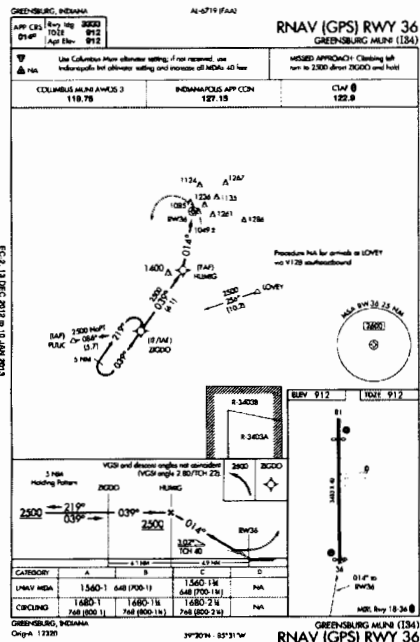
We won't pretend to have all the answers. We're insurance brokers, not fortune tellers. But we can promise we'll actively work to reduce your burden... with risk-management advice, contract reviews to better protect your interests, and a dedicated claims advocate to work on your behalf. And as the largest aviation insurance broker in the world, you can count on the strength of our relationships to work for you.

If this sounds like the kind of wind you want at your back, you're in good company. We're pleased to have earned an annual customer renewal rate of 96%, beating the industry average by 10%. But we'd be even more pleased if we can help you fly in an easier direction.



Take the active.

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(Continued from Page 39) the airplane” and need delaying vectors or a missed approach.

At GS or GP intercept, go down, gear down, one notch of flaps, set power for 120 knots.

Keep things as simple as possible, no simpler (Albert Einstein). Be quick, but don't rush (UCLA basketball coach John Wooden). Be sure you're right, then go ahead (Fes Parker as Davey Crockett). Do the same thing the same way to a high professional standard every time. Set your standard, stick with it, don't violate it and let no outside pressure change it. Discipline is going to keep you alive. (Fred Kaiser, FAAS-Team program manager).

Since pilots are all human, we can only do one thing at a time. Excellent pilots do exactly the right thing at the right time and in the correct sequence. Experience makes this easier, but only when you have had excellent experience. Excellent experience is derived from excellent training.

In 1991, the FAA initiated a Special Certification Review (SCR) in an attempt to discover why there were so many fatal PA-46 accidents occurring. Many of you, I am sure, remember it. Some of you we're probably even affected by it. The reason for this thorough re-examination was to

try to find the alleged problem with the PA-46 aircraft.


The B24 went through a similar process during World War II. Gen. James Doolittle (in 1942) and the NTSB/FAA/Piper/AOPA (in 1991) figured out that it wasn't the aircraft that was causing the problem. In the case of the B24, the fix turned out to be additional mentoring of pilots on combat flights by increasing the number of missions. This was not a popular decision at the time, but it saved many lives.

In the case of the PA-46, additional training was mandated and implemented. However, no real safety improvement was realized. Over the 27 years of production, there has been an average of three fatal PA-46 accidents per year. Over the immediate past five-year period an average of four fatal PA-46 accidents occurred per year. Unfortunately, the concept of a standardized, procedural approach to training has not taken root as it has in similar pilot communities (Bonanza and Cirrus are two such examples). I encourage you to take charge of your own aviation training by choosing to make the paradigm shift and seek excellent training.

The next time you train, ask your instructor to help you construct a set of checklists, flows and memory items which will guide

you through the approach. Use these items — same way each and every time. Have and use well-vetted Standard Operating Procedures. It is within your own SOP that you will find a fast and accurate way to improve your aeronautical decision-making.

Excellent training is aircraft-serial-number-specific training based on the proper use of checklists, flows, memory items and SOP. Insist on excellent training; it doesn't take any longer or cost any more. When you commit to this process, you will become and remain a confident, competent and safe pilot. You owe it to yourself, your family, and the entire General Aviation community. Additional information on this and other important topics is available at the PA-46 Pilot Reference Library at <http://www.rwrpilottraining.com/reference-library.html>

I welcome your comments and suggestions. 



Fly Safely - Train Often

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About the author: Dick Rochfort is a former corporate pilot and primary flight instructor who has been providing excellent training

and related services to PA-46 owners and pilots worldwide for more than 20 years.