



National Transportation Safety Board Aviation Accident Final Report

Location:	Rio Grande, PR	Accident Number:	ERA09FA078
Date & Time:	12/03/2008, 1205 AST	Registration:	N318WA
Aircraft:	ROCKWELL INTERNATIONAL 690B	Aircraft Damage:	Destroyed
Defining Event:	Controlled flight into terr/obj (CFIT)	Injuries:	3 Fatal
Flight Conducted Under:	Part 135: Air Taxi & Commuter - Non-scheduled		

Analysis

The charter flight departed for the destination, where the passengers would connect with another airline flight. The instrument-rated pilot may have felt pressured as the flight departed late. The accident airplane approached the destination airport from the east, descending at 250 knots ground speed from 8,800 feet above mean sea level (msl), on a 270 degree assigned heading, and was instructed to enter the right downwind for runway 10. The airplane's altitude readout was then observed by the approach controller to change to "XXX." The pilot was queried regarding his altitude and he advised that he was descending to 3,200 feet msl. The pilot was asked to confirm that he was in visual flight rules (VFR) conditions and was advised that the minimum vectoring altitude (MVA) for the area was 5,500 feet msl. The pilot responded that "We just ahh," at which time the controller advised that she missed his transmission and asked him to repeat it. The pilot stated "Ahh roger, could we stay right just a little, we are in and out of some clouds right now." The controller advised the pilot to "Maintain VFR" and again of the MVA. The controller then made multiple attempts to contact the pilot without result. The wreckage was discovered on the side of a mountain, where the airplane impacted after entering instrument meteorological conditions. Because aircraft operating in VFR flight are not required to comply with minimum instrument altitudes, aircraft receiving VFR radar services are not automatically afforded Minimum Safe Altitude Warning services except by pilot request. The controller's query to the pilot about his altitude and flight conditions was based on her observation of the loss of altitude reporting information. The pilot had not indicated any difficulty in maintaining VFR flight or terrain clearance up to that point. His comment that the aircraft was "in and out of some clouds" was her first indication that the pilot was not operating in visual conditions, and came within seconds of impact with the terrain. The controller was engaged in trying to correct the situation, and despite having been advised of the minimum vectoring altitude, the pilot continued to descend. The airplane was equipped with a terrain avoidance warning system but it could not be determined if it was functional. The pilot owned the charter operation. Documents discovered in the wreckage identified the pilot and airplane as operating for a different company since the pilot did not have the permissions necessary to operate in the United Kingdom Overseas Territories.

Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be:
The pilot's continued visual flight into instrument meteorological conditions, which resulted in an in-flight collision with terrain.

Findings

Personnel issues	Decision making/judgment - Pilot (Cause) Use of policy/procedure - Pilot (Cause)
Environmental issues	Clouds - Effect on personnel Low visibility - Effect on personnel Obscuration - Effect on personnel Rain - Effect on personnel Fog - Effect on personnel

Factual Information

HISTORY OF FLIGHT

On December 3, 2008, about 1205 Atlantic standard time, a Rockwell International 690B, N318WA, operated by Websta's Aviation Services Inc., was destroyed when it impacted terrain while maneuvering about 4 nautical miles southeast of Rio Grande, Puerto Rico. The certificated airline transport pilot and two passengers were killed. Day instrument meteorological conditions prevailed in the area of the accident. No flight plan had been filed for the flight, which departed Beef Island International Airport (TUPJ), Tortola, British Virgin Islands destined for Luis Munoz Marin International Airport (TJSJ), San Juan, Puerto Rico. The commercial flight was conducted under 14 Code of Federal Regulations (CFR) Part 135.

According to voice and radar data provided by the Federal Aviation Administration (FAA), the accident airplane was inbound to TJSJ from the east, descending at 250 knots ground speed from 8,800 feet above mean sea level (msl), on a 270 degree assigned heading and was instructed to enter the right downwind for runway 10 at TJSJ. The airplane's altitude readout was observed by the approach controller to change to "XXX."

The pilot was queried by the approach controller regarding his altitude and the pilot advised that he was descending to 3,200 feet msl. The pilot was then asked to confirm that he was in visual flight rules (VFR) conditions and was advised by the approach controller that the minimum vectoring altitude (MVA) for the area was 5,500 feet msl. The pilot responded that "We just ahh," at which time the approach controller advised the pilot that she had missed his transmission and could he repeat it again. The pilot then stated "Ahh roger, could we stay right just a little, we are in and out of some clouds right now." The approach controller then advised the pilot to "Maintain VFR" and once again advised him of the MVA. The approach controller then made multiple attempts to make contact with the pilot of the accident airplane without result. Moments later another pilot requested an instrument flight rules clearance "to get in to San Juan" as he was observing precipitation.

According to witness statements, just prior to the accident, an airplane was heard flying at low altitude over El Yunque National Forest on an approximate heading of 260 degrees near state road 191. Moments later an explosion was heard.

After a search by multiple local, state, and federal agencies, the wreckage was discovered inside the national forest on the southeast side of a mountain.

PERSONNEL INFORMATION

According to FAA records, the pilot held an airline transport pilot certificate with multiple ratings including airplane multi-engine land and an airframe and powerplant certificate. His most recent FAA first-class medical certificate was issued on April 8, 2008. He reported 9,600 total hours of flight experience on that date.

The pilot was also the owner of Websta's Aviation Services Inc. however; an airport security badge that was discovered in the wreckage identified him as a "Pilot/Mechanic" for Rainbow International Airlines Inc.

AIRCRAFT INFORMATION

The accident aircraft was a high wing, pressurized, twin-engine airplane of conventional

construction. It was configured to carry 8 passengers. It was powered by two Garrett TPE331-5-252K single-shaft turbopropeller engines. Each engine produced 776 shaft horsepower. The airplanes maximum cruise speed was 284 knots. Maximum range was 1,467 nautical miles. It was certificated for flight in instrument meteorological conditions.

The airplane was also equipped with an L-3 Communications Landmark TAWS 8100, Terrain Avoidance Warning System (TAWS). According to maintenance records the TAWS unit was installed on March 29, 2005. Post accident examination of the unit revealed that it had received heavy crush and fire damage. No information could be extracted from the unit and it could not be determined if the unit was functional prior to the accident.

According to FAA and airplane flight log records, the airplane was manufactured in 1977. The aircraft had carried several registration numbers, including D-IFAC, N1KC, and N690TG, prior to be registered as N318WA in October of 2003. Maintenance logbook entries after this date were noted as being performed by Websta's Aviation Services Inc. The logbook entries and description of maintenance actions performed were vague with minimal information provided. It was not possible to determine if all required maintenance actions were completed, which included service bulletins and airworthiness directives. It was also noted that some of the aircraft phase inspections were conducted in accordance with "Rainbow International Airlines procedures."

A total of 20 daily flight log sheet forms found at the accident site also indicated that the operator of the airplane was Rainbow International Airlines. The sheets indicated that in the 2 1/2 years prior to the accident the airplane had only accrued approximately 50 hours of operation, and that as of March 27, 2008, the airplane had accrued 5,286 total hours of operation.

Engine time and cycles recorded referred to the time and cycles since a 1997 engine overhaul and did not include time and cycles since new. In addition to the daily flight logs, the log sheet forms contained information on engine trend monitoring. A total of 16 of the 20 flight log sheet forms had data for engine trending, however all 16 entries had the exact same parameters. There were no entries for non-engine parameters such as airspeed, altitude, and outside air temperature for any of the 16 entries.

METEOROLOGICAL INFORMATION

The reported weather at TJSJ, approximately 14 miles northwest of the accident site, at 1156, included: wind, 070 at 11 knots, visibility 10 miles, few clouds at 3,000 feet, scattered clouds at 7,000 feet, temperature 28 degrees Celsius, dew point 18 degrees Celsius, altimeter setting of 30.00 inches of mercury, and showers to the distant southeast.

According to witness statements however, at the time of the accident, fog and rain were present in the area surrounding the accident site and the mountains were obscured from view.

According to the US Forest Service, low clouds and fog were the norm in the national park. Humidity would remain high all year-round and El Yunque's 28,000 acres would receive up to 240 inches of precipitation a year.

WRECKAGE AND IMPACT INFORMATION

Examination of the accident site revealed that the main wreckage had come to rest

perpendicular to a cliff face at an elevation of 2,310 feet. There was no wreckage path. The main wreckage displayed heavy crush and fragmentation damage and a post crash fire had occurred. Examination of the cliff face revealed sooting in a vertical direction. Fragments of the wing structure, nose section, cockpit, flight controls, fuselage, and engine gear boxes were found against the cliff. Fragmented structure, fragmented system components, propeller components and the power sections of both engines were also discovered approximately 200 feet below the cliff perpendicular to the face of the mountain, which sloped downward at approximately 50-degrees. A palm tree located near the base of the cliff, exhibited damage consistent with a propeller strike, and broken limbs and branches existed throughout the accident site. Further examination of some of the limbs and branches revealed multiple breaks and cuts consistent with propeller strikes.

Examination of the wreckage revealed that the landing gear was in the up position. Control continuity could not be established; however no evidence of any preimpact flight control or structural failure was discovered.

Examination of the engines power sections revealed that both were missing their accessory gearboxes.

The left engine's power section was located on the up slope side of the base of a tree. The front of the engine including the gearbox forward of the first stage compressor impeller was missing. The first stage impeller was exposed and showed bending of the blades in the direction opposite rotation.

The right engine's power section was also located in the lower debris field with the aft end buried in the ground. The aft end of the power section exhibited heavy compression damage. The third stage turbine rotor was exposed and exhibited heavy damage. Approximately half of the blades of the third stage turbine rotor were missing with the remaining blades bent in the direction opposite rotation. The second stage impeller was also exposed with the blades showing bending opposite the direction of rotation. The forward curvics were also heavily smeared.

One of the two 3-bladed propeller hubs was located down slope from the left engine's power section. The hub was located with only one blade attached. The second propeller hub was also located, with a single blade attached. Another propeller blade and spring assembly was also found in the surrounding vegetation. All of the propeller blades that were discovered exhibited varying degrees of damage including leading edge gouging, polishing, chordwise scratching, twisting, curling, and S-bending.

AIR TRAFFIC SERVICES

N318WA was receiving VFR radar traffic advisory services from San Juan Center Approach Control Facility (CERAP) when the accident occurred.

Review of the voice and radar data provided by the CERAP revealed that The pilot first contacted San Juan at 1548:23, reporting over Beef Island en route to San Juan International Airport. The controller instructed the pilot to set his transponder to code 4701, issued the St. Thomas altimeter setting, and radar identified the aircraft 11 miles northeast of St. Thomas.

At 1554:06, the controller attempted to obtain the pilot's intended cruising altitude, but the pilot replied that he would be, "...continuing to climb" and was currently at "eight point eight" [8,800 feet.] N318WA was transferred to another controller, and at 1600:18 contacted the new controller and reported descending through 8,000 feet. The controller acknowledged the pilot's initial contact, and instructed him to fly heading 270, maintain VFR at or above 2,500 feet, and enter right downwind south of Plaza Carolina for runway 10. The pilot correctly read back the heading, altitude, and VFR restriction.

At 1603:00, the controller advised N318WA that the altitude restriction was deleted, and the pilot acknowledged.

At 1604:10, the controller asked the pilot to report his altitude, and the pilot replied that he was descending through 3,200 feet. According to her post-accident statement, the query resulted from her observation that the aircraft's altitude readout had changed to XXX. According to the FAA, this can occur when aircraft descend at a rate that the radar data processing system assesses as excessive and possibly incorrect.

At 1604:16, the controller asked the pilot to confirm that he was operating in VFR conditions, and advised that the minimum vectoring altitude in the area was 5,500 feet.

At 1604:23, the pilot replied, "whiskey alpha we are just <unintelligible>." The controller asked the pilot to repeat his transmission, and at 1604:42, the pilot transmitted, "...roger could we steer right <unintelligible> will be in and out of some clouds right now."

At 1604:46, the controller transmitted, "...be advised ah your maintain VFR the minimum vectoring altitude in your area is 5,500 feet." There was no response from the pilot.

Review of radar data showed that the last target for the aircraft detected by the SJU radar was received at 1604:41, indicating 2,400 feet and located just east of the point of impact.

Review of the Aeronautical Information Manual (AIM) revealed that it addresses radar assistance to VFR aircraft as follows:

4-1-17. Radar Assistance to VFR Aircraft

- a. Radar equipped FAA ATC facilities provide radar assistance and navigation service (vectors) to VFR aircraft provided the aircraft can communicate with the facility, are within radar coverage, and can be radar identified.
- b. Pilots should clearly understand that authorization to proceed in accordance with such radar navigational assistance does not constitute authorization for the pilot to violate CFRs. In effect, assistance provided is on the basis that navigational guidance information issued is advisory in nature and the job of flying the aircraft safely, remains with the pilot.
- c. In many cases, controllers will be unable to determine if flight into instrument conditions will result from their instructions. To avoid possible hazards resulting from being vectored into IFR conditions, pilots should keep controllers advised of the weather conditions in which they are operating and along the course ahead.
- d. Radar navigation assistance (vectors) may be initiated by the controller when one of the following conditions exist:

1. The controller suggests the vector and the pilot concurs.
2. A special program has been established and vectoring service has been advertised.
3. In the controller's judgment the vector is necessary for air safety.

AIM paragraph 4-1-18(e) also states, in reference to VFR radar services at class C airports such as San Juan and other locations:

"e. PILOT RESPONSIBILITY. THESE SERVICES ARE NOT TO BE INTERPRETED AS RELIEVING PILOTS OF THEIR RESPONSIBILITIES TO SEE AND AVOID OTHER TRAFFIC OPERATING IN BASIC VFR WEATHER CONDITIONS, TO ADJUST THEIR OPERATIONS AND FLIGHT PATH AS NECESSARY TO PRECLUDE SERIOUS WAKE ENCOUNTERS, TO MAINTAIN APPROPRIATE TERRAIN AND OBSTRUCTION CLEARANCE, OR TO REMAIN IN WEATHER CONDITIONS EQUAL TO OR BETTER THAN THE MINIMUMS REQUIRED BY 14 CFR SECTION 91.155. WHENEVER COMPLIANCE WITH AN ASSIGNED ROUTE, HEADING AND/OR ALTITUDE IS LIKELY TO COMPROMISE PILOT RESPONSIBILITY RESPECTING TERRAIN AND OBSTRUCTION CLEARANCE, VORTEX EXPOSURE, AND WEATHER MINIMUMS, APPROACH CONTROL SHOULD BE SO ADVISED AND A REVISED CLEARANCE OR INSTRUCTION OBTAINED." (capitalization in original.)

The AIM further addresses assistance to VFR aircraft encountering unexpected instrument conditions as follows:

6-2-1. Radar Service for VFR Aircraft in Difficulty

- a. Radar equipped ATC facilities can provide radar assistance and navigation service (vectors) to VFR aircraft in difficulty when the pilot can talk with the controller, and the aircraft is within radar coverage. Pilots should clearly understand that authorization to proceed in accordance with such radar navigational assistance does not constitute authorization for the pilot to violate CFRs. In effect, assistance is provided on the basis that navigational guidance information is advisory in nature, and the responsibility for flying the aircraft safely remains with the pilot.
- b. Experience has shown that many pilots who are not qualified for instrument flight cannot maintain control of their aircraft when they encounter clouds or other reduced visibility conditions. In many cases, the controller will not know whether flight into instrument conditions will result from ATC instructions. To avoid possible hazards resulting from being vectored into IFR conditions, a pilot in difficulty should keep the controller advised of the current weather conditions being encountered and the weather along the course ahead and observe the following:
 1. If a course of action is available which will permit flight and a safe landing in VFR weather conditions, noninstrument rated pilots should choose the VFR condition rather than requesting a vector or approach that will take them into IFR weather conditions; or
 2. If continued flight in VFR conditions is not possible, the noninstrument rated pilot should so advise the controller and indicating the lack of an instrument rating, declare a distress condition; or
 3. If the pilot is instrument rated and current, and the aircraft is instrument equipped, the pilot should so indicate by requesting an IFR flight clearance. Assistance will then be provided on the basis that the aircraft can operate safely in IFR weather conditions.

Additionally, FAA order 7110.65, "Air Traffic Control," paragraph 2-1-6, "Safety Alert," states in part:

2-1-6. SAFETY ALERT 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.

NOTE

1. The issuance of a safety alert is a first priority...once the controller observes and recognizes a situation of unsafe aircraft proximity to terrain, obstacles, or other aircraft. Conditions, such as workload, traffic volume, the quality/limitations of the radar system, and the available lead time to react are factors in determining whether it is reasonable for the controller to observe and recognize such situations. While a controller cannot see immediately the development of every situation where a safety alert must be issued, the controller must remain vigilant for such situations and issue a safety alert when the situation is recognized.

2. Recognition of situations of unsafe proximity may result from MSAW/E-SAW/LAAS, automatic altitude readouts, Conflict/Mode C Intruder Alert, observations on a PAR scope, or pilot reports.

3. Once the alert is issued, it is solely the pilot's prerogative to determine what course of action, if any, will be taken.

a. Terrain/Obstruction Alert. 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. Issue the alert as follows:

PHRASEOLOGY

LOW ALTITUDE ALERT (call sign),

CHECK YOUR ALTITUDE IMMEDIATELY.

THE (as appropriate) MEA/MVA/MOCA/MIA IN YOUR AREA IS (altitude), or if an aircraft is past the final approach fix (nonprecision approach), or the outer marker, or the fix used in lieu of the outer marker (precision approach), and, if known, issue THE (as appropriate) MDA/DH IS (altitude).

MEDICAL AND PATHOLOGICAL INFORMATION

A postmortem examination was performed on the pilot by the Puerto Rico Institute of Forensic Sciences.

Toxicological testing of the pilot was conducted at the FAA Bioaeronautical Sciences Research Laboratory, Oklahoma City, Oklahoma

TESTS AND RESEARCH

Foreign Operator Permissions

Air Safety Support International (ASSI) is a not-for-profit, wholly-owned, subsidiary company of the United Kingdom's Civil Aviation Authority, established under Directions from the

United Kingdom's Department for Transport. The company's primary objective is to help provide a more cohesive system of civil aviation safety regulation in the United Kingdom Overseas Territories.

ASSI is responsible for supporting the Overseas Territories' existing authorities in the safety regulation of all aspects of civil aviation, including the licensing of personnel and the certification of aircraft, airlines, airports and air traffic control. In Territories where the civil aviation regulator does not have the resources to undertake the task themselves, ASSI can be designated by the Governor to perform the civil aviation regulatory tasks on behalf of the Governor. These territories included the British Virgin Islands, Anguilla, and Antigua.

According to ASSI, The operator of any aircraft which is not registered in an Overseas Territory or the UK; and is carrying passengers or cargo, into, out of, or within, any UK Overseas Territory for valuable consideration, must have specific permission from the UK Secretary of State or the Governor of the UK Overseas Territory to operate into the specific territory. Operators that are found to be in contravention of the requirement could receive a maximum fine of 5000 Pounds Sterling (roughly US\$10,000) or up to two years in prison or both.

Rainbow International Airlines Inc.

Rainbow International Airlines Inc. held a 14 CFR Part 135 certificate. They were founded in 1996 and were headquartered at Cyril E. King Airport (TIST) St. Thomas, United States Virgin Islands. They operated a Cessna Citation 11-550 twin engine jet, and a Beech King Air A100 twin engine turboprop.

According to ASSI, Rainbow International Airlines Inc. held permission to operate commercial flights to and from the United Kingdom's Overseas Territories.

On December 5, 2008, Rainbow International Airlines Director of Operations (DO) advised the FAA that the accident flight was not associated with Rainbow International Airlines "in any way" and that Websta's Aviation Services Inc. was not given permission to operate any flights under Rainbow International's "Overseas Territory Permit."

On September 29, 2010, Rainbow International Airlines DO advised the NTSB that at one time the pilot and the accident airplane had been on Rainbow International Airlines 14 CFR Part 135 operating certificate but, the pilot had separated from the company once he had received his own 14 CFR Part 135 certificate.

Websta's Aviation Services Inc.

Websta's Aviation Services Inc. received its 14 CFR Part 135 certificate on January 19, 2006. FAA records indicated that the pilot had been employed by Rainbow International Airlines from 2003 until that time.

On July 8, 2006 Websta's Aviation Services opened a fixed base operation at Henry E. Rohlsen Airport (TISX), St. Croix, United States Virgin Islands, providing aircraft maintenance services, aircraft storage services, and on-demand charter utilizing the accident airplane and an Israel Aircraft Industries 1124 "Westwind" twin engine jet.

Websta's Aviation Services Inc. did not however, hold the permission required to operate commercial flights to and from the United Kingdom's Overseas Territories.

Additionally, according to its 14 CFR Part 135 operating certificate, Websta's Aviation Services Inc. was only authorized to conduct operations using the business name which appeared on its

certificate.

Customs Information

Review of General Declaration forms found in the wreckage revealed that the pilot had flown his two passengers to TUPJ on November 29, 2008. Later that day he departed empty from TUPJ and flew to TISX. Further review of the General Declaration forms and other customs documentation revealed that in every case the pilot had listed the operator as Rainbow International Airlines Inc.

Review of tracking data provided by the United States Immigration and Customs Enforcement Agency also revealed that the flights to and from TUPJ that were associated with the accident were not an isolated case, and since the beginning of January of 2006, Websta's Aviation Services Inc., had operated into and out of TUPJ on 7 other occasions.

Further review of the tracking data, also revealed that not only had Websta's Aviation Services Inc. operated into and out of TUPJ but, it had also operated into and out of Antigua on 9 occasions, and Anguilla on at least 60 occasions.

ADDITIONAL INFORMATION

According to Continental Airlines, on the day that the accident occurred the passengers were scheduled to depart TJSJ for a flight to Newark Liberty International Airport (EWR), Newark, New Jersey at 1318.

According to the ground handling company that handled Websta's Aviation Services Inc. at TJSJ, the flight was supposed to have left TUPJ for TJSJ at 1030 but it was operating late, and the passengers would not have made their flight.

According to the pilot's sister, the pilot did not even depart TISX for TUPJ until approximately 1045.

According to a manager at Medical Mutual of Ohio, the passengers may have called the pilot and advised him that they would be late as the passengers may not have left enough time in the their schedule, as the female passenger was "always running late."

"Review of ATC transcripts revealed that the airplane arrived at TUPJ from TISX at approximately 1108. The pilot called for taxi at approximately 1141 and departed for TJSJ at approximately 1146 (1 hour and 16 minutes late).

A review of international arrival procedures for incoming flights revealed that after arrival at TJSJ, the passengers would have been further delayed as they had to clear US Customs, then would have to go through United States Department of Agriculture inspection, and then would have to go through security screening, prior to boarding their flight.

History of Flight

Enroute-descent

VFR encounter with IMC

Controlled flight into terr/obj (CFIT) (Defining event)

Pilot Information

Certificate:	Airline Transport	Age:	52, Male
Airplane Rating(s):	Multi-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 1 With Waivers/Limitations	Last Medical Exam:	04/08/2008
Occupational Pilot:	Yes	Last Flight Review or Equivalent:	06/11/2008
Flight Time:	(Estimated) 9600 hours (Total, all aircraft)		

Aircraft and Owner/Operator Information

Aircraft Manufacturer:	ROCKWELL INTERNATIONAL	Registration:	N318WA
Model/Series:	690B	Aircraft Category:	Airplane
Year of Manufacture:		Amateur Built:	No
Airworthiness Certificate:	Normal	Serial Number:	11444
Landing Gear Type:	Tricycle	Seats:	9
Date/Type of Last Inspection:	02/14/2008, AAIP	Certified Max Gross Wt.:	10325 lbs
Time Since Last Inspection:		Engines:	2 Turbo Prop
Airframe Total Time:	5286 Hours	Engine Manufacturer:	Garrett
ELT:	Installed, not activated	Engine Model/Series:	TPE331-5-252K
Registered Owner:	Webstas Aviation Services	Rated Power:	776 hp
Operator:	Webstas Aviation Services	Air Carrier Operating Certificate:	On-demand Air Taxi (135)
Operator Does Business As:		Operator Designator Code:	W0ZA

Meteorological Information and Flight Plan

Observation Facility, Elevation:		Observation Time:	1205 AST
Distance from Accident Site:	1 Nautical Miles	Condition of Light:	Day
Direction from Accident Site:		Conditions at Accident Site:	Instrument Conditions
Lowest Cloud Condition:	Partial Obscuration / 1000 ft agl	Temperature/Dew Point:	28° C / 18° C
Lowest Ceiling:	Obscured	Visibility	1 Miles
Wind Speed/Gusts, Direction:	11 knots, 70°	Visibility (RVR):	
Altimeter Setting:	30 inches Hg	Visibility (RVV):	
Precipitation and Obscuration:	Moderate - Rain; Mist; Fog		
Departure Point:	Tortola (TUPJ)	Type of Flight Plan Filed:	None
Destination:	San Juan, PR (TSJU)	Type of Clearance:	None
Departure Time:	1136 AST	Type of Airspace:	

Airport Information

Airport:	Luis Munoz Marin Intl Airport (TJSJ)	Runway Surface Type:	Concrete
Airport Elevation:	9 ft	Runway Surface Condition:	Dry
Runway Used:	10	IFR Approach:	None
Runway Length/Width:	8016 ft / 150 ft	VFR Approach/Landing:	None

Wreckage and Impact Information

Crew Injuries:	1 Fatal	Aircraft Damage:	Destroyed
Passenger Injuries:	2 Fatal	Aircraft Fire:	On-Ground
Ground Injuries:	N/A	Aircraft Explosion:	None
Total Injuries:	3 Fatal		

Administrative Information

Investigator In Charge (IIC):	Todd G Gunther	Adopted Date:	01/07/2011
Additional Participating Persons:	Ramon Lopez; FAA/FSDO; San Juan, PR Jose E Ayala; US Department of Agriculture; Rio Grande, PR Dana Metz; Honeywell Aerospace; Phoenix, AZ		
Publish Date:	05/23/2012		
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.nts.gov/pubdms/ .		

The National Transportation Safety Board (NTSB), established in 1967, is an independent federal agency mandated by Congress through the Independent Safety Board Act of 1974 to investigate transportation accidents, determine the probable causes of the accidents, issue safety recommendations, study transportation safety issues, and evaluate the safety effectiveness of government agencies involved in transportation. The NTSB makes public its actions and decisions through accident reports, safety studies, special investigation reports, safety recommendations, and statistical reviews.

The Independent Safety Board Act, as codified at 49 U.S.C. Section 1154(b), precludes the admission into evidence or use of any part of an NTSB report related to an incident or accident in a civil action for damages resulting from a matter mentioned in the report.