

United States Air Force Accident Investigation Board Report

Class-A Mishap, Hurlburt Field, Florida, 8 July 2008

EXECUTIVE SUMMARY

On 8 July 2008, at approximately 2002 hours local time (L), a Pilatus PC-12 aircraft (serial number 04-0602; tail number N901TR) attached to the 319th Special Operations Squadron, 1st Special Operations Wing, Air Force Special Operations Command, departed Hurlburt Field, Florida, to conduct a local training sortie. While on approach to Hurlburt Field runway 36 at approximately 2335L, at less than 100 feet above ground, the mishap aircraft (MA) departed controlled flight at the approach end of the runway. The MA rolled left along its longitudinal axis in excess of 90 degrees and then partially recovered before striking the ground at approximately 64 degrees angle of bank. The MA traveled 669 feet and spun clockwise 120 degrees before coming to a stop. The mishap crew (MC) experienced minor injuries and conducted an emergency egress without incident. The MA sustained substantial damage.

The mishap occurred approximately 3.5 hours into a scheduled 4 hour sortie. The first half of the mishap flight was a formal syllabus instruction sortie for the mishap additional pilot (MAP) while the second half was a night vision goggle re-currency sortie for the mishap pilot (MP). The aircraft commander was the mishap instructor pilot (MIP) who was on the flight controls at the time of the mishap.

The MC was current and qualified for the flight maneuver flown when the mishap occurred. All maintenance personnel involved with the servicing and launching of the aircraft were trained and qualified. A thorough review revealed that neither the condition of the aircraft, nor any maintenance procedures played any role in the accident.

After a careful and complete investigation, the Accident Investigation Board President determined the cause of this mishap, supported by clear and convincing evidence, was the MIP's failure to insure adequate time separation behind a preceding large aircraft (AC-130U) on approach, thereby encountering wake turbulence which resulted in loss of aircraft control. A light quartering tailwind condition did not allow for the normal dissipation of wake turbulence vortices from the runway. The MIP flew into these stagnant vortices and the MA rolled into a bank from which the MIP could not recover. There was no evidence of a mechanical failure being a factor in the mishap.

There was substantial evidence that the MA's flight approach path and angle, and the lack of any wake turbulence advisory calls by air traffic control were contributing factors in this mishap.

Under 10 U.S.C. 2254(d) any opinion of the accident investigators as to the cause of, or the factors contributing to, the accident set forth in the accident investigation report may not be considered as evidence in any civil or criminal proceeding arising from the accident, nor may such information be considered an admission of liability of the United States or by any person referred to in those conclusions or statements.