

# National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# GAA17CA164 02/28/2017 1345 CST Regis# N422BR Prentiss, MS Apt: Prentiss-jefferson Davis Count M43  
Acft Mk/Mdl AIR TRACTOR INC AT 802 Acft SN 802A-0362 Acft Dmg: SUBSTANTIAL Rpt Status: Factual Prob Caus: Pending  
Eng Mk/Mdl P&W CANADA PT6A-67AG Acft TT 2880 Fatal 0 Ser Inj 0 Flt Conducted Under: FAR 137  
Opr Name: AIRBOURN AVIATION LLC. Opr dba: Aircraft Fire: GRD  
AW Cert: SPR

## Summary

The pilot of the tailwheel-equipped airplane reported that, during takeoff in gusting tailwind conditions, as the tailwheel lifted, the airplane drifted to the left and off the runway. He aborted the takeoff and applied "maximum braking" and reverse thrust. During the runway excursion, the airplane impacted a ditch and spun 180°.

The pilot added that, as he exited the cockpit, he observed "dark smoke coming from the exhaust and cowling with smoldering burning grass." He reported that he discharged the onboard fire extinguisher into the engine exhaust, main landing gear, and grass. He added that hydraulic fluid leaking from a severed brake line and fuel leaking from the cowl and lower right wing were feeding the postimpact fire. Shortly thereafter, the local volunteer fire department arrived and extinguished the fire.

The fuselage and both wings sustained substantial damage.

The pilot reported that there were no preaccident mechanical malfunctions or failures with the airplane that would have precluded normal operation.

The pilot reported that the wind was from 180° at 15 knots, gusting to 28 knots. The closest automated weather observation station, located about 38 nautical miles from the accident site, recorded wind from 180° at 14 knots, gusting to 22 knots. The airplane took off from runway 30.

## Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's decision to take off with a gusting tailwind and his subsequent failure to maintain directional control.

## Events

1. Takeoff - Other weather encounter
2. Takeoff - Loss of control on ground
3. Takeoff-rejected takeoff - Runway excursion
4. Takeoff-rejected takeoff - Collision with terr/obj (non-CFIT)
5. Post-impact - Fire/smoke (post-impact)

## Findings - Cause/Factor

1. Personnel issues-Task performance-Use of equip/info-Aircraft control-Pilot - C
2. Personnel issues-Action/decision-Info processing/decision-Decision making/judgment-Pilot - C
3. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Directional control-Not attained/maintained - C
4. Environmental issues-Physical environment-Terrain-Rough terrain-Contributed to outcome
5. Environmental issues-Conditions/weather/phenomena-Wind-Tailwind-Response/compensation
6. Environmental issues-Conditions/weather/phenomena-Wind-Gusts-Response/compensation

## Narrative

The pilot of a tailwheel-equipped airplane reported that during takeoff in gusting tailwind conditions, as the tailwheel lifted, the airplane drifted to the left and off the runway. He aborted the takeoff and applied "maximum braking" and reverse thrust. During the runway excursion, the airplane impacted a ditch and spun 180°.

The pilot added that as he exited the cockpit, he observed "dark smoke coming from the exhaust and cowling with smoldering burning grass." He reported that he discharged the onboard fire extinguisher into engine exhaust, main landing gear, and grass. He added that hydraulic fluid leaking from a severed brake line and fuel leaking from the cowl and lower right wing were feeding the post-impact fire. Shortly thereafter, the local volunteer fire department arrived and extinguished the fire.

The fuselage and both wings sustained substantial damage.

The pilot reported that there were no preaccident mechanical malfunctions or failures with the airplane that would have precluded normal operation.

The pilot reported the wind was 180° at 15 knots with gusts to 28 knots. The closest automated weather observation station, about 38 nautical miles from the accident location, recorded a wind of 180° at 14 knots, gusting to 22 knots. The airplane took off runway 30.

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# National Transportation Safety Board - Aircraft Accident/Incident Database

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Incident Rpt# OPS16IA004	01/29/2016 705 UTC	Regis#	Fort Lauderdale, FL	Apt: Fort Lauderdale/hollywood Intl FLL
Acft Mk/Mdl AIRBUS A321 231-231		Acft SN 2476	Acft Dmg: NONE	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl IAE V2533-A5			Fatal 0 Ser Inj 0	
Opr Name:		Opr dba:		Aircraft Fire: NONE
				AW Cert: STT

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## Events

1. Takeoff-rejected takeoff - Runway incursion veh/AC/person

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## Narrative

On January 29, 2016, about 0200 eastern standard time, a runway incursion occurred on runway 10L at Fort Lauderdale/Hollywood International Airport (FLL), Fort Lauderdale, Florida, when an Airbus A320, registration N587NK, operating as Spirit Airlines flight 371 (NKS371) was cleared for takeoff while an airport maintenance vehicle "Truck54" was on the runway near taxiway "D." The air traffic controller received an Airport Surface Detection System Model X (ASDE-X) alert and canceled the takeoff clearance, and the crew of NKS371 rejected the takeoff. NKS371 was operating under the provisions of Title 14 Code of Federal Regulations (CFR) Part 121 as a regularly scheduled flight to Rafael Hern ndez Airport, Aguadilla, Puerto Rico. There was no damage to the airplane or maintenance vehicle and no injuries were reported. Night visual meteorological conditions prevailed at the time of the incident.

# National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# ANC17LA025	05/22/2017	1805 AKD	Regis# N207CH	Juneau, AK	Apt: N/a
Acft Mk/Mdl AIRBUS AS350-B2			Acft SN 2027	Acft Dmg: SUBSTANTIAL	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl TURBOMECA ARRIEL 1D1			Acft TT 13838	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 135
Opr Name: COASTAL HELICOPTERS, INC.			Opr dba:		Aircraft Fire: NONE
					AW Cert: STN

## Events

1. Maneuvering - Controlled flight into terr/obj (CFIT)

## Narrative

On May 22, 2017, about 1805 Alaska daylight time, an Airbus (formerly Eurocopter) AS350B2 helicopter, N207CH, sustained substantial damage during a collision with remote mountainous snow-covered terrain while en route to Juneau, Alaska, about 21 miles northwest of Juneau. Of the seven occupants on board, the commercial pilot and three passengers sustained minor injuries, and three passengers were not injured. The helicopter was registered to, and operated by, Coastal Helicopters, Inc., Juneau, as a day, visual flight rules (VFR) flight under the provisions of 14 Code of Federal Regulations Part 135 as an on-demand sightseeing tour flight. Degraded visual meteorological conditions were reported on the Herbert Glacier at the time of the accident, and company flight following procedures were in effect. The flight originated from the Juneau International Airport, Juneau at 1743.

During an interview with the National Transportation Safety Board (NTSB) investigator-in-charge (IIC) on May 25, the pilot reported that she departed from the Juneau International Airport to pick up cruise ship passengers from a remote dog sledding camp situated on the Herbert Glacier. The sightseeing tour flight, which the cruise ship passengers had purchased from the cruise line as a shore excursion, overflew remote mountainous snow-covered terrain in the Tongass National Forest, and involved a landing on the Herbert Glacier for a dog sledding tour. At 1757, she landed at the dog sledding camp, picked up six passengers, and headed back to the Juneau International Airport.

While en route back to Juneau, about 3/4 mile from the dog sledding camp, and while descending over an area of featureless, snow-covered ice field, the pilot reported that she could maintain visual reference with a rock wall on the right side of the helicopter. As the flight progressed downslope, she saw an area ahead that was "fogged in" and she chose to return to the dog sledding camp. While conducting a slow 180° turn to the right, the helicopter subsequently struck the snow-covered ice field, and it eventually came to rest inverted.

After all the occupants had egressed from the helicopter, the pilot utilized a handheld radio to request emergency assistance from the dog sledding camp. The personnel at the dog sledding camp contacted the operator's headquarters in Juneau, who sent another company helicopter to extract the pilot and passengers from the accident site.

According to the pilot, in addition to the fog, flat light conditions were present at the time of the accident.

According to NTSB Safety Alert SA-052 Visual Illusions, flat light conditions are characterized, in part as: ".flat light occurs when the sky is overcast, especially over snow-covered terrain and large bodies of water. In flat light conditions, no shadows are cast and terrain features and other visual cues are masked, making it difficult for pilots operating under VFR to perceive depth, distance, or altitude."

The helicopter sustained substantial damage to the fuselage, the main rotor system, the tailboom, and the tail rotor system. The wreckage was recovered and transported to a secure facility.

The pilot reported that there were no preimpact mechanical failures or malfunctions with the airframe or engine that would have precluded normal operation.

# National Transportation Safety Board - Aircraft Accident/Incident Database

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Accident Rpt# CEN17LA043	11/23/2016 1759 CST	Regis# N80RT	Moorhead, MN	Apt: Moorhead Municipal Airport JKJ
Acft Mk/Mdl BEECH 200		Acft SN BB-370	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl PRATT&WHITNEY PT6A-41			Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 135
Opr Name: FLIGHT DEVELOPMENT, LLC		Opr dba:		Aircraft Fire: NONE
				AW Cert: STN

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## Events

1. Approach-IFR final approach - Loss of visual reference
2. Approach-IFR missed approach - Controlled flight into terr/obj (CFIT)

## Narrative

On November 23, 2016, at 1759 central standard time, a Beech 200, N80RT, impacted terrain during a missed approach from runway 30 at Moorhead Municipal Airport (JKJ), Moorhead, Minnesota. The pilot initiated a missed approach after losing visual reference of the runway environment during the final segment of a GPS instrument approach. The pilot and two passengers sustained minor injuries and four passengers were uninjured. The airplane received substantial damage. The airplane was operated by Flight Development, LLC under the provisions of 14 Code of Federal Regulations Part 135 as a single-pilot on-demand passenger flight. The flight was operating on an instrument rules flight plan. Night instrument meteorological conditions prevailed at the time of the accident. The flight departed from Baudette International Airport (BDE), Baudette, Minnesota, at 1714 and was destined to JKJ.

A passenger stated that he and his work crew had been flying between Baudette and Moorhead on a weekly basis for the past 5-6 weeks to build agricultural storage facilities. The passenger stated that the pilot had flown the work crew on one of the previous flights, and the remainder of the flights were flown by the company chief pilot and the company director of operations.

The passenger stated that the accident flight was the first flight in which he was seated in the copilot seat. The passenger stated that he and the pilot were not wearing a shoulder harness. The passenger stated that he was not informed that the airplane was equipped with shoulder harnesses, how to use them, and how to adjust the seats. The passenger stated that he would have adjusted the seat if he would have known that was an option and used his shoulder harness, as he is a safety conscious person.

The pilot stated that before he was handed off from Minneapolis Center to Fargo Approach, he listened to the automated weather observing system (AWOS) at JKJ, which reported that light north winds, a ceiling of 300 feet above ground level, and 1.25 statute mile visibility. He checked in with Fargo Approach and informed them that he had the weather at JKJ and requested the area navigation (RNAV) approach to runway 30 starting at IVEJE, the initial approach fix (IAF). N80RT was not equipped with a wide area augmentation system (WAAS) GPS so he flew the approach as a non-precision lateral navigation (LNAV) approach (straight-in approach minima were: 300 feet above ground level and 1 statute mile visibility). He told Fargo Approach that he realized the weather was deteriorating and would make one attempt at JKJ and then divert to Hector International Airport (FAR), Fargo, North Dakota. Fargo Approach issued a clearance to the IAF, and initial approach altitude, and provided missed approach instructions. The pilot stated that he had flown this approach numerous times and briefed the approach. He stated that the approach was stabilized with the appropriate altitudes and airspeeds throughout and did not notice anything unusual. Upon leveling off at the missed approach altitude of 1,300 feet mean sea level, he looked for the runway. After what seemed like just a few seconds he saw the runway end lights, the strobe lights, and the precision approach path indicator. He disconnected the autopilot and took his hand off the throttles to turn on the landing lights for landing. Before he could even turn on the landing lights, the runway disappeared from sight due to the clouds. He immediately decided to perform a missed approach and applied engine power. He said that he referenced the flight director, but did not recall what it was indicating. He did not feel any sinking feeling indicating that he was losing altitude. He said that it seemed like just a few seconds before the airplane impacted the ground. The airplane struck the ground in somewhat of a nose-up, level bank attitude. The airplane slid along the ground and turned slightly to the right before coming to rest.

The passenger stated that prior to departure, the pilot said they needed to get going because the weather was getting bad in Fargo. While en route, the passenger heard Fargo Air Traffic Control Tower advise weather was not good, and the pilot stated he would try to fly to JKJ first and then fly to FAR, if that did not work. The passenger said the pilot asked him to be on the lookout for the runway and about 3,600 feet the airplane banked to line up for the approach. The passenger said he heard an audible "too low" warning three times, saw some runway lights at eye level, and then the airplane impacted the ground. The passenger said he did not think the pilot initiated a go-around, and he did not see him adjust engine power settings or move the control yoke. The passenger stated that he received facial injuries that required stitches.

The pilot reported that there was no mechanical malfunction/failure with the airplane.

The pilot's safety recommendation on how the accident could have been prevented was:

"Stick to my normal personal weather minimums and not attempt a non-precision approach to minimums. It would of been so easy to go to Fargo and do the ILS. I have always lectured to my students on the advantage of having two pilots when things are challenging. This is a prime example of such [an accident]. Over confidence is always something that we have to try to keep in check."

A review of the pilot's training records showed that the pilot completed the company's Federal Aviation Administration (FAA) approved ground and flight training program, dated August 17, 2016. The ground training was conducted by the company director of operations and the company chief pilot. The pilot's flight training, which was 10.8 hours in duration, was conducted by the company chief pilot. The pilot received and passed his most recent Part 135.293 Airman Proficiency Check, dated August 18, 2016, which was conducted by an FAA inspector from the Fargo Flight Standards District Office. The check was performed using a Beech 200 and was 1.7 hours in flight duration. The pilot received a grade of satisfactory for all of the check's maneuvers/procedures.

FAA Advisory Circular 91-65, Use of Shoulder Harnesses in Passenger Seats, states in part:

On December 17, 1985, the National Transportation Safety Board (NTSB) issued safety recommendation A-85-124, recommending issuance of advisory circular to provide information on crash survivability aspects of small aircraft. The recommendation was the result of an NTSB general aviation airplane crashworthiness project. In the project, the safety board examined 500 relatively severe general aviation airplane accident, to determine what proportion of the occupants would have benefited from the use of shoulder harnesses and energy-absorbing seats. The safety board found that 20 percent of the fatally-injured occupants in these accidents could have survived with shoulder harnesses (assuming the seat belt was fastened) and 88 percent of the seriously injured could have had significantly less severe injuries with the use of shoulder harnesses. Energy-absorbing seats could have benefited 34 percent

of the seriously injured. The safety board concluded that shoulder harness use is the most effective way of reducing fatalities and serious injuries in general aviation accidents.

Part 135.117, Briefing of Passengers Before Flight, states that before each takeoff each pilot in command of an aircraft carrying passengers shall ensure that all passengers have been orally briefed on: the use of seat belts, the placement of seat backs in an upright position before takeoff and landing, location and means for opening the passenger entry door and emergency exits, location of survival equipment, if the flight involves extended overwater operation, ditching procedures and the use of required flotation equipment, if the flight involves operations above 12,000 feet MSL, the normal and emergency use of oxygen, and location and operation of fire extinguishers.

# National Transportation Safety Board - Aircraft Accident/Incident Database

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Accident Rpt# WPR17LA113	05/26/2017 1044	Regis# N24FS	Rockville, ID	Apt: N/a
Acft Mk/Mdl BELL 206B-B		Acft SN 2040	Acft Dmg: SUBSTANTIAL	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl ALLISON 250-C20 SER			Fatal 0 Ser Inj 1	Flt Conducted Under: FAR 137
Opr Name: PAULYS HELICOPTER SERVICES INC		Opr dba:		Aircraft Fire: NONE

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## Events

1. Maneuvering-low-alt flying - Loss of engine power (total)
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## Narrative

On May 26, 2017, about 1044 mountain daylight time, a Bell 206B, N24FS, sustained substantial damage during a forced landing near Rockville, Idaho. The commercial pilot, the sole occupant of the helicopter, was seriously injured. The helicopter was registered to and operated by Pauly's Helicopter Services Inc., Ontario, Oregon, as a 14 Code of Federal Regulations Part 137 aerial application flight. Visual meteorological conditions prevailed and no flight plan was filed for the local flight which originated from a private staging area about 5 minutes prior to the accident.

The pilot reported that after the helicopter was reloaded with chemical, he proceeded to a nearby field to begin an aerial application. The pilot said that he performed two application passes, one to the north, and the second to the south. As he performed a 180-degree turn at an altitude of about 40 to 50 feet above ground level (agl), he heard a grinding noise immediately followed by a loud bang and subsequent loss of power. The pilot stated that he immediately initiated an autorotation landing to a nearby field, however, did not have enough forward airspeed and rotor rpm to flare, which resulted in a hard landing.

Examination of the helicopter by a Federal Aviation Administration inspector revealed that the tailboom was structurally damaged. The helicopter was recovered to a secure location for further examination.

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# National Transportation Safety Board - Aircraft Accident/Incident Database

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Incident Rpt# OPS16IA008B	04/07/2016 1836 CDT	Regis#	Dallas, TX	Apt: Dallas-fort Worth Intl DFW
Acft Mk/Mdl BOEING 737 823-823		Acft SN 33224	Acft Dmg: NONE	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl CFM INTL CFM56-7B24E			Fatal 0 Ser Inj 0	
Opr Name:		Opr dba:		Aircraft Fire: NONE

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## Events

1. Takeoff - Airport occurrence
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## Narrative

On April 7, 2016 at 1836 central daylight time, a runway incursion occurred on runway 35L at Dallas-Fort Worth International Airport (DFW) when a Boeing 737-800, N896NN, was on takeoff roll while an Embraer 505, N304QS, crossed the runway downfield. The closest proximity between the two airplanes was approximately 2,800 feet when the speed of the Boeing was about 120 knots. The Boeing was operated by American Airlines under the provisions of Title 14 Code of Federal Regulations (CFR) Part 121 as a regularly scheduled passenger flight, AAL2408, and the Embraer was operated by Executive Jet Aviation under the provisions of 14 CFR Part 91K as a fractional ownership flight, EJA304. Visual meteorological conditions prevailed and there were no injuries to the passengers or crew of either flight.

# National Transportation Safety Board - Aircraft Accident/Incident Database

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Incident Rpt# OPS15IA017A	04/12/2015 821 EDT	Regis#	Miami, FL	Apt: Miami Intl MIA
Acft Mk/Mdl BOEING 767 34AF-34AF		Acft SN 37865	Acft Dmg: NONE	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl GE CF6-80C2B6F			Fatal 0 Ser Inj 0	
Opr Name:		Opr dba:		Aircraft Fire: NONE
				AW Cert: STT

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## Events

1. Approach-IFR final approach - Near midair/TCAS alert/loss of separation

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## Narrative

On April 12, 2015 at 0821, a loss of required air traffic control separation occurred when United Parcel Service (UPS) flight 357, a Boeing 767-300, overflew N900QS, a Cessna C750 Citation holding in position on runway 8L at Miami International Airport (MIA), Miami, Florida. The conflict was detected when the tower's airport surface detection equipment, model X (ASDE-X) alarmed. The local controller (LC) instructed UPS357 to go around and turn 10 degrees left. UPS357 was at an altitude of 200 feet and approximately « mile from the runway 8L threshold when the crew was told to go-around. UPS357 overflew N900QS by 475 feet. Visual meteorological conditions prevailed at the time.



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# National Transportation Safety Board - Aircraft Accident/Incident Database

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Accident Rpt# GAA17CA311	05/23/2017	830 AKD	Regis# N754KP	Skagway, AK	Apt: N/a
Acft Mk/Mdl CESSNA 208-B			Acft SN 208B1264	Acft Dmg: SUBSTANTIAL	Rpt Status: Prelim Prob Caus: Pending
				Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 135
Opr Name: KALININ PARTNERS LLC			Opr dba:		Aircraft Fire: NONE

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# National Transportation Safety Board - Aircraft Accident/Incident Database

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Incident Rpt# OPS16IA009B	02/26/2016 1548 HST	Regis#	Honolulu, HI	Apt: Honolulu Intl HNL
Acft Mk/Mdl CESSNA 208B-B		Acft SN 208B0996	Acft Dmg: NONE	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl P&W PT6A SER			Fatal 0 Ser Inj 0	
Opr Name:		Opr dba:		Aircraft Fire: NONE
				AW Cert: STN

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## Events

1. Approach-VFR go-around - Air traffic event

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## Narrative

On Friday, February 26, 2016 at 1548 Hawaii standard time (HST), a runway incursion occurred at Daniel K Inouye International Airport, Honolulu, Hawaii, when a Cessna 208B, registration N865MA, over flew a Cessna 172, registration N269ME in line up and wait on runway 22L at the taxiway P intersection. The C208B was operating under the provisions of Title 14 Code of Federal Regulations (CFR) Part 135 and the C172 was operating under the provisions of 14 CFR Part 91. Visual meteorological conditions prevailed and there were no injuries to passengers or crew of either aircraft.

# National Transportation Safety Board - Aircraft Accident/Incident Database

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Accident Rpt# GAA17CA207	03/24/2017 1247	Regis# N551BC	Salt Lake City, UT	Apt: Salt Lake City Intl SLC
Acft Mk/Mdl CESSNA 550-CITATION I		Acft SN 550-242	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl PRATT & WHITNEY CANADA JT15D-4		Acft TT 8575	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: BOULDER CAPITAL INC		Opr dba:		Aircraft Fire: NONE
				AW Cert: STN

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## Summary

The pilot reported that, during approach, a goose struck the airplane's left horizontal stabilizer. The pilot continued the approach and landed without further incident.

A postaccident examination revealed that the airplane had sustained substantial damage to the left horizontal stabilizer.

The pilot reported that there were no preaccident mechanical failures or malfunctions with the airplane that would have precluded normal operation.

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## Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: An in-flight collision with a goose during approach.

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## Events

1. Approach - Birdstrike

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## Findings - Cause/Factor

1. Environmental issues-Physical environment-Object/animal/substance-Animal(s)/bird(s)-Ability to respond/compensate - C

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## Narrative

The pilot reported that during approach a goose struck the airplane's left horizontal stabilizer. The airplane continued the approach and landed without further incident.

A post-accident examination revealed the airplane had sustained substantial damage to the left horizontal stabilizer.

The pilot reported that there were no pre-accident mechanical failures or malfunctions with the airplane that would have precluded normal operation.

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# National Transportation Safety Board - Aircraft Accident/Incident Database

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Incident Rpt# OPS15IA017B	04/12/2015 821 EDT	Regis#	Miami, FL	Apt: Miami Intl MIA
Acft Mk/Mdl CESSNA 750-NO SERIES		Acft SN 750-0123	Acft Dmg: NONE	Rpt Status: Prelim Prob Caus: Pending
			Fatal 0 Ser Inj 0	
Opr Name:		Opr dba:		Aircraft Fire: NONE
				AW Cert: STT

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## Events

1. Taxi-into takeoff position - Runway incursion veh/AC/person

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## Narrative

On April 12, 2015 at 0821, a loss of required air traffic control separation occurred when United Parcel Service (UPS) flight 357, a Boeing 767-300, overflew N900QS, a Cessna C750 Citation holding in position on runway 8L at Miami International Airport (MIA), Miami, Florida. The conflict was detected when the tower's airport surface detection equipment, model X (ASDE-X) alarmed. The local controller (LC) instructed UPS357 to go around and turn 10 degrees left. UPS357 was at an altitude of 200 feet and approximately « mile from the runway 8L threshold when the crew was told to go-around. UPS357 overflew N900QS by 475 feet. Visual meteorological conditions prevailed at the time.

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# National Transportation Safety Board - Aircraft Accident/Incident Database

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Incident Rpt# OPS17IA003	10/21/2016 822 EDT	Regis#	Westfield, MA	Apt: Westfield-barnes Rgnl BAF
Acft Mk/Mdl DOUGLAS DC 9 83-83		Acft SN 49438	Acft Dmg: NONE	Rpt Status: Prelim Prob Caus: Pending
			Fatal 0 Ser Inj 0	
Opr Name:		Opr dba:		Aircraft Fire: NONE
				AW Cert: STT

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## Events

1. Landing-landing roll - Runway incursion veh/AC/person

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## Narrative

On October 21, 2016, at about 0822 eastern daylight time, a runway incursion occurred at the Westfield-Barnes Regional Airport (BAF), Westfield/Springfield, Massachusetts, when a Douglas DC-9-83, registration N425NV, operating as Allegiant Air Flight 4203 (AAY4203) landed on runway 20 while Guard Sweeper 96 was conducting runway sweeping operations on the last 4000 feet of the same runway. After AAY4203 stopped on the runway, the pilot reported they were about 200 feet from the sweeper. There was no reported damage to the aircraft or to the sweeper, and no reported injuries. Instrument meteorological conditions prevailed, and AAY4203 had filed an instrument flight plan for the Title 14 Code of Federal Regulations (CFR) Part 121 repositioning flight from Asheville Regional Airport, Asheville, North Carolina with only crew on board.

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# National Transportation Safety Board - Aircraft Accident/Incident Database

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Incident Rpt# OPS16IA008A	04/07/2016 1836 CDT	Regis#	Dallas, TX	Apt: Dallas-fort Worth Intl DFW
Acft Mk/Mdl EMBRAER S A EMB-505-NO SERIES	Acft SN 50500143	Acft Dmg: NONE	Rpt Status: Prelim Prob Caus: Pending	
Eng Mk/Mdl P&W CANADA PW535E		Fatal 0	Ser Inj 0	
Opr Name:	Opr dba:	Aircraft Fire: NONE		

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## Events

1. Taxi-from runway - Runway incursion veh/AC/person
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## Narrative

On April 7, 2016 at 1836 central daylight time, a runway incursion occurred on runway 35L at Dallas-Fort Worth International Airport (DFW) when a Boeing 737-800, N896NN, was on takeoff roll while an Embraer 505, N304QS, crossed the runway downfield. The closest proximity between the two airplanes was approximately 2,800 feet when the speed of the Boeing was about 120 knots. The Boeing was operated by American Airlines under the provisions of Title 14 Code of Federal Regulations (CFR) Part 121 as a regularly scheduled passenger flight, AAL2408, and the Embraer was operated by Executive Jet Aviation under the provisions of 14 CFR Part 91K as a fractional ownership flight, EJA304. Visual meteorological conditions prevailed and there were no injuries to the passengers or crew of either flight.

# National Transportation Safety Board - Aircraft Accident/Incident Database

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Accident Rpt# GAA17CA167	02/26/2017 1000 PST	Regis# N864MH	Las Vegas, NV	Apt: Mc Carran Intl LAS
Acft Mk/Mdl EUROCOPTER EC130-B4		Acft SN 4616	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl TURBOMECA ARIEL 2B1		Acft TT 9339	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 135
Opr Name: MAVERICK HELICOPTERS INC.		Opr dba:		Aircraft Fire: NONE
				AW Cert: STN

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## Summary

The pilot of the helicopter reported that, during the hover-taxi for departure in the ramp area, he was monitoring another helicopter that had just departed and then "brought [his] eyes inside [the helicopter]" to switch a radio frequency. As the pilot looked back outside, he observed "the nose of a big plane taxiing" from behind another parked airplane to his left. Subsequently, the pilot abruptly applied aft cyclic to stop the helicopter's forward momentum, and the Fenestron struck the ramp. The pilot returned to the ramp area without further incident.

The Fenestron sustained substantial damage.

The pilot reported that there were no preaccident mechanical malfunctions or failures with the helicopter that would have precluded normal operation.

## Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's abrupt cyclic/pitch attitude control movement, which resulted in a Fenestron ground strike.

## Events

1. Taxi-to runway - Abrupt maneuver
2. Taxi-to runway - Collision with terr/obj (non-CFIT)

## Findings - Cause/Factor

1. Personnel issues-Task performance-Use of equip/info-Aircraft control-Pilot - C
2. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Pitch control-Incorrect use/operation - C
3. Personnel issues-Psychological-Attention/monitoring-Monitoring other aircraft-Pilot

## Narrative

The pilot of the helicopter reported that during the hover taxi for departure in the ramp area, he was monitoring another helicopter that had just departed and then "brought [his] eyes inside [the helicopter]" to switch a radio frequency. As the pilot looked back outside, he observed "the nose of a big plane taxiing" from behind another parked airplane to his left. Subsequently, the pilot abruptly applied aft cyclic to stop the helicopter's forward momentum and the Fenestron struck the ramp. The pilot returned to the ramp area without further incident.

The Fenestron sustained substantial damage.

The pilot reported that there were no preaccident mechanical malfunctions or failures with the helicopter that would have precluded normal operation.

# National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# ERA17FA190 05/25/2017 1153 EDT Regis# N62UP New Castle, DE Apt: New Castle ILG  
Acft Mk/Mdl EUROCOPTER DEUTSCHLAND GMBH EC Acft SN 0475 Acft Dmg: DESTROYED Rpt Status: Prelim Prob Caus: Pending  
Eng Mk/Mdl PRATT & WHITNEY CANADA PW206B2 Acft TT 5163 Fatal 1 Ser Inj 0 Flt Conducted Under: FAR 091  
Opr Name: METRO AVIATION, INC. Opr dba: Aircraft Fire: GRD  
AW Cert: STN

## Events

1. Approach-IFR missed approach - Loss of control in flight

## Narrative

On May 25, 2017, at 1153 eastern daylight time, a Eurocopter Deutschland GMBH EC 135 P2, N62UP, was destroyed when it impacted terrain near New Castle, Delaware. The airline transport pilot was fatally injured. The helicopter was registered to the University of Pennsylvania and operated by Metro Aviation as a 14 Code of Federal Regulations Part 91 flight. Instrument meteorological conditions prevailed about the time of the accident, and the flight was operated on an instrument flight rules (IFR) flight plan. The flight originated from Atlantic City International Airport (ACY), Atlantic City, New Jersey, about 1115.

According to the operator, the helicopter was refueled prior to departure, and the purpose of the flight was for the pilot to practice instrument approach procedures.

Preliminary review of radar and voice communication data provided by the Federal Aviation Administration (FAA) revealed that air traffic control cleared the helicopter for the ILS RWY 1 approach at ILG. The radar track depicted the helicopter established on the final approach course about 2,000 ft mean sea level (msl) which was both the assigned altitude and the intermediate minimum descent altitude for the approach. The helicopter maintained 2,000 ft msl as it continued through the glideslope and crossed over the locator outer marker. The published crossing altitude for the outer marker while established on the glideslope was 1,842 ft.

The helicopter continued towards the landing runway about 3 miles beyond the outer marker on course about 2,000 ft msl when the pilot declared a missed approach. The helicopter then climbed on course to 2,525 ft msl before it turned to the right and descended rapidly. Radar contact was lost at 1,625 ft msl.

According to FAA records, the pilot held an airline transport pilot certificate with a rating for rotorcraft-helicopter. Additionally, he held a flight instructor certificate with ratings for helicopter and instrument helicopter, and a private pilot certificate with ratings for airplane single-engine land and instrument airplane. The pilot's most recent second-class medical certificate was issued on October 20, 2016. At that time, he reported 4,200 hours of total flight experience, of which, 100 hours were in the previous 6 months.

According to FAA records, the helicopter was manufactured in 2006, and was equipped with two Pratt & Whitney Canada, PW206B2 engines. According to the helicopter maintenance logbook, the most recent approved aircraft inspection program (AAIP) 100-hour inspection was performed on April 25, 2017, at an airframe total time of 5,152.1 hours. Prior to the accident flight, the helicopter airframe total time was 5,163.1 hours. Also, the left and right engines had been operated for 5,168.9, and 5,155.7 total hours; respectively.

The helicopter came to rest in a water retention ditch about 3,200 ft prior to the threshold of runway 1. It was fragmented and partially consumed by a postimpact fire. All the major components of the helicopter were located in the 30 ft by 20 ft area of the main wreckage. An odor of Jet A fuel was noted at the accident site. A fence located about 15 ft from and parallel to the main wreckage location had a 45° angle cut in the top post. In addition, about 5 ft directly under the cut post was a damaged section of fence that had part of a rotor blade imbedded in it. Furthermore, a section of wood was located that exhibited 45° angle cuts on either end.

The cockpit and forward section of the fuselage were partially consumed by fire. Control continuity of the cyclic and collective was confirmed to the rotor head from the cockpit through several breaks and fractures. The cyclic, collective, and antitorque pedals were separated and located in the main wreckage.

The rotor head and transmission remained attached, but were separated from the airframe due to impact. All four blades of the main rotor remained attached to the rotor head. One blade exhibited impact damage and was not thermally damaged. All other blades were consumed by fire. All pitch links remained attached to the rotor head. The transmission mounts were separated from the helicopter. The tailboom was impact separated and consumed by fire. The fenestron was impact separated. The tail rotor vanes were bent the opposite direction of rotation and several vanes were impact separated. In addition, several of the vanes exhibited leading edge gouging and rotational scoring.



The left engine was impact separated from the engine mounts. The reduction gearbox and the turbomachine were impact separated. The compressor turbine disc and compressor were rotated by hand. The left engine power turbine was removed and the drive shaft exhibited torsional deformation and fractures. In addition, the power turbine wheel exhibited rotational scoring.

The right engine was impact separated from the engine mounts. The right engine power turbine was removed and the drive shaft exhibited torsional twisting deformation and fractures. In addition, the power turbine wheel exhibited rotational scoring.

The central warning panel and Sky Connect tracker unit were retained and sent to the NTSB Recorders Laboratory in Washington, DC for download.

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Accident Rpt# CEN16FA062	12/10/2015 1153 CST	Regis# N145JR	Council Bluffs, IA	Apt: Eppley Airfield OMA
Acft Mk/Mdl PIPER PA46 500TP		Acft SN 4697166	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl P&W CANADA PT6A-42		Acft TT 1047	Fatal 1 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: AIRSEA CHARTERS INC		Opr dba:		Aircraft Fire: NONE
				AW Cert: STN

## Events

1. Approach-VFR pattern base - Controlled flight into terr/obj (CFIT)

## Narrative

### HISTORY OF FLIGHT

On December 10, 2015, at 1153 central standard time, a Piper PA46-500TP airplane, N145JR, impacted power lines and terrain near Council Bluffs, Iowa. The pilot was fatally injured. The airplane was substantially damaged. The airplane was registered to Airsea Charters Inc. and operated by the pilot under the provisions of 14 Code of Federal Regulations Part 91 as a personal flight. Visual meteorological conditions prevailed at the departure airport about the time of the accident, and the flight was operated on an instrument flight rules flight plan. The flight originated from Eppley Airfield (OMA), Omaha, Nebraska, about 1150 and was destined for Perry Stokes Airport (TAD), Trinidad, Colorado.

At 1150, the OMA tower controller cleared the pilot for takeoff and instructed him to fly a 320-degree heading. At 1152:12, the pilot stated that he "needed to return to Eppley." The controller instructed the pilot to enter a right downwind for runway 32R. When asked if he required any assistance, the pilot replied, "negative." The pilot reported that the AHRS had a "miscommunication." (Within the context of the avionics installed on the airplane, AHRS likely referred to the attitude and heading reference system.) At 1153, the controller inquired if the pilot could accept a short approach. The pilot accepted and was subsequently cleared to land. The controller indicated that another airplane was on a 4-mile final for the runway at that time. No further communications were received from the pilot.

Air traffic control (ATC) radar data depicted the airplane entering a right turn after takeoff. At the time that the pilot requested to return to the airport, the airplane was located about 1.75 miles north of the airport on a southeast course, at an altitude of about 2,000 ft mean sea level (msl). The airplane paralleled the runway on a downwind traffic pattern leg. About 20 seconds after requesting to return, the airplane began a descent. The airplane subsequently entered a right turn which appeared to continue until the final radar data point. The final data point was recorded at 1153:36, with an associated altitude of 1,100 ft msl. The data point was located about 400 ft northeast of the accident site.

A witness reported observing the airplane as he was driving southbound on Highway 29. The landing gear extended as the airplane was flying southbound at a "low" altitude immediately east of the highway. The airplane subsequently made a "sharp turn" to the west and struck power lines running along the east side of the highway. The airplane came to rest in the center median area between the north and southbound lanes of the divided highway about 3/4 of a mile east of the airport.

### PERSONNEL INFORMATION

Within the preceding one year, the pilot had logged 296.7 hours in airplanes and an additional 20.0 hours in a flight simulator/flight training device. Of that flight time, 280.7 hours were in the accident airplane. All of the pilot's logged flight time within 90 days of the accident was in the accident airplane. The pilot had completed the Federal Aviation Administration (FAA) Wings Program, Advanced Level - Phase 2, which met the requirements of a flight review.

### AIRCRAFT INFORMATION

The current owner purchased the airplane in January 2011; the accident pilot signed the registration application. In January 2013, the airplane was involved in a nose landing gear collapse and runway excursion event during landing. Maintenance records noted that the engine was removed, disassembled, inspected and repaired. It was subsequently reinstalled in August 2013. An overhauled propeller assembly was installed at that time.

Airplane records indicated that the most recent maintenance was completed on December 8, 2015, at 1,047.2 hours. Three discrepancies were noted related to that maintenance work, including (1) loss of airspeed indication at altitude; (2) propeller deice inoperative; and (3) air noise at the cabin door near the retract cable. The maintenance records indicated that the propeller heat control module was replaced and sealant was applied to the cabin door. In addition, the left

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and right moisture drains were checked; no water was observed. No further action was documented related to the loss of airspeed discrepancy. The airplane was subsequently returned to service.

The pilot's wife reported accompanying the pilot on a trip to Steamboat, Colorado, about one week before the accident. On December 6th, approximately one hour into the return flight to OMA, the airplane "started to act erratically." The pilot turned the autopilot off and descended to a lower altitude. The remainder of the flight proceeded without further incident. The pilot informed her that there was an inconsistency in the instrument indications that would need to be checked when they landed.

## METEOROLOGICAL INFORMATION

## AIRPORT INFORMATION

Glideslope guidance to runway 32R was available from a precision approach path indicator (PAPI). An instrument landing system (ILS) was also installed on runway 32R.

## WRECKAGE AND IMPACT INFORMATION

The accident site was located about 3/4 of a mile east of the OMA runway 32R threshold in the center median area between the north and southbound traffic lanes of Interstate 29. The median was an open area consisting of grass and vegetation. The airplane struck power lines and a support arm about 75 ft above ground level. The power lines were about 520 ft northeast of the accident site. The airplane came to rest inverted. The main wreckage consisted of the fuselage, inboard two-thirds of the right wing, empennage, and engine. The left wing had separated at the wing root and was located about 15 ft west of the main wreckage. The propeller had separated from the engine and was located about 30 ft north of the main wreckage. The right wingtip and fragments of the outboard right wing were located in the vicinity of the power lines.

A post-accident examination of the airframe and engine did not reveal any anomalies consistent with a pre-impact failure or malfunction. A detailed summary of the airframe and engine examinations is included with the docket material associated with this accident case.

## MEDICAL AND PATHOLOGICAL INFORMATION

An autopsy of the pilot was conducted at the Iowa State Medical Examiner's Office. The pilot's death was attributed to blunt force injuries sustained in the accident.

The FAA Civil Aerospace Medical Institute toxicology report stated:

Chlorpheniramine detected in Urine

0.007 (ug/ml, ug/g) Chlorpheniramine detected in Blood (Cavity)

Dextromethorphan detected in Urine

Dextromethorphan NOT detected in Blood (Cavity)

Dextrorphan detected in Urine

Dextrorphan detected in Blood (Cavity)

Diphenhydramine detected in Urine

Diphenhydramine detected in Blood (Cavity)

3.663 (ug/ml, ug/g) Doxylamine detected in Urine

0.085 (ug/ml, ug/g) Doxylamine detected in Blood (Cavity)

Chlorpheniramine, diphenhydramine, and doxylamine are sedating antihistamines available in a variety of over-the-counter allergy products and sleep aids. Dextromethorphan is a cough suppressant also available over-the-counter. It is not considered impairing in normal doses.

## TESTS AND RESEARCH

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Examination of the data acquisition unit revealed no engine exceedance events or engine trend monitoring entries related to the accident flight. Engine trend data are not recorded until the airplane is stabilized in cruise flight at or above 15,000 ft.

Examination of the annunciator panel light bulbs revealed that the left and right bulb filaments associated with the L Fuel Pump advisory indication were stretched. In addition, the right bulb filament associated with the Fuel Pressure caution indication exhibited minor stretching; the left bulb filament appeared to be intact. The remaining bulb filaments were either intact or broken, but none appeared to be stretched. A stretched filament is consistent with the bulb being illuminated at the time of the accident. According to the Pilot's Operating Handbook, with the electric fuel boost pumps in AUTO mode, the left and right boost pumps will be activated when the engine fuel pressure drops below 9 pounds per square inch gauge (psig) for any reason, and will remain on until the fuel pressure increases to 12 psig.

Examination of the standby airspeed indicator revealed that the link arm had separated from the pin on the rocking shaft assembly. No other anomalies were observed. The link arm was re-attached and the indicator was tested. Functional testing determined that the airspeed indications were within the test procedure limits with one exception: at 160 knots, during the decreasing airspeed portion of the test, the indication was 164 knots, which was one knot above the specification limit of 163 knots.

Examination of the attitude heading and reference system (AHRS) units, the air data computer (ADC) units, and the magnetometers did not reveal any anomalies; although, the testing was limited by the capabilities of the test bench. Each unit appeared to be functional and provided valid information. The AHRS units were tested independently and provided attitude (roll, pitch, heading) and acceleration information. The output data appeared to correspond to the orientation of the unit. The ADC units provided valid airspeed and altitude information. The test bench did not support simultaneous testing of the units. As a result, evaluation of any potential miscompare annunciations was not possible.

## ADDITIONAL INFORMATION

Review of the avionics manufacturer's documentation did not reveal any annunciation defined as a "miscommunication" message. However, the primary flight display (PFD) may display a Miscompare Annunciation (MISCOMP) in relation to altitude, airspeed, pitch, or roll data. A MISCOMP annunciation is normally displayed when the airspeed received by each PFD differs by more than 10 knots. For pitch and roll attitude data, a MISCOMP message is normally displayed when the data differs by 5 degrees and 6 degrees, respectively. An altitude MISCOMP annunciation is normally provided when the altitudes differ by 200 feet or more.