

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# CEN17FA364	09/24/2017 1845 CDT	Regis# N5958C	Camden, AR	Apt: Harrell Field Airport CDH
Acft Mk/Mdl BEECH C35-NO SERIES		Acft SN D-3319	Acft Dmg: DESTROYED	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl CONT MOTOR E185 SERIES			Fatal 2 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: BROWN RUFUS F		Opr dba:		Aircraft Fire: GRD
				AW Cert: NON

Events

1. Maneuvering - Loss of engine power (total)

Narrative

On September 24, 2017, about 1845 central daylight time, a Beech C35 airplane, N5958C, impacted terrain on the Harrell Field Airport (CDH), Camden Arkansas. A post impact fire ensued. The two commercial pilots on board were fatally injured and the airplane was destroyed. The airplane was owned by a private individual and being operated without a flight plan as a 14 Code of Federal Regulations Part 91 personal flight. Visual meteorological conditions prevailed for the local flight that was originating at the time of the accident.

The airplane was departing the airport when it turned back toward the runway. The airplane then departed controlled flight and impacted the ground in a field on the airport.

An examination of the airplane wreckage at the scene showed it impacted the ground in a flat, upright spiral. The fire consumed the forward fuselage aft of the engine, the cabin section, the inboard portions of the left and right wings, the landing gear, the baggage compartment, and the aft fuselage just aft of the baggage compartment. A 10-foot long outboard section of the right wing, two 4-to-5-foot sections of the outboard left wing, an 8-foot long section of the aft fuselage, and the V-tail empennage survived the fire. The right outboard wing was broken upward at the leading edge at mid span. The forward portion of the right tip fuel tank was consumed by fire. The left wing was broken aft at mid span. The leading edge of the inboard portion was crushed upward and aft at mid span. The outboard section was twisted upward and broken aft. The end of the wing where the right tip fuel tank was located was charred and melted. The right tip fuel tank was broken aft and separated from the wing. It rested on the ground aft of the wreckage and was charred and consumed by fire.

The airplane's engine, engine cowling and propeller hub with one blade was located at the front of the wreckage. The cowling was broken open. The engine was intact and broken downward at the mounts. Several of the engine accessories suffered fire damage. The propeller hub was intact. One blade remained with the hub and was bent aft 70 degrees approximately 68 inches outboard of the hub. The blade showed no signs of S-bending or chordwise scratches. The spinner was crushed aft to the hub. The other propeller blade was broken out of the hub and showed no signs of torsional bending.

The airplane's surviving aft fuselage section was rest upright supported by the airplane's left stabilator. It was fractured circumferential aft of where the baggage compartment was located. There was charring from fire at and aft of the fracture. The empennage was not damaged.

Flight control continuity was confirmed from the forward cabin area to the control surfaces. The airplane wreckage was retained for further examination.

At 1835, the automated weather observation station at CDH, located near the accident site recorded wind calm, visibility 10 miles, clear skies, temperature 28ø C, dew point 23ø C, and altimeter setting 29.89 inches of mercury.

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Accident Rpt# GAA17CA330	06/03/2017 1020 EDT	Regis# N218DL	Williamson, GA	Apt: Alexander Memorial GA2
Acft Mk/Mdl BOEING B75N1-N1		Acft SN 75-7389	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl JACOBS B755			Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: EVELYN, RICHARD G		Opr dba:		Aircraft Fire: NONE
				AW Cert: STN

Events

1. Landing-landing roll - Nose over/nose down
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Narrative

The pilot of the tailwheel equipped airplane reported that he was performing a wheel landing on a turf surface runway. He recalled that he was too aggressive and too early moving the stick forward during the touchdown and landing roll. The airplane's tail ascended, the nose pitched down and the propeller struck the ground. The airplane nosed over and came to rest inverted. The airplane sustained substantial damage to the vertical stabilizer and the rudder.

Per the National Transportation Safety Board Pilot Aircraft Accident Report, the pilot reported that the accident could have been prevented, "by not being so early moving the stick forward in a taildragger during a wheel landing."

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

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Accident Rpt# CEN18FA001	10/01/2017 1447 EDT	Regis# N2284U	Midland, MI	Apt: N/a
Acft Mk/Mdl BRANTLY B 2B		Acft SN 454	Acft Dmg: SUBSTANTIAL	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl LYCOMING IVO-360-A1A			Fatal 1 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: PAUL W PANGBORN		Opr dba:		Aircraft Fire: NONE
				AW Cert: STN

Events

1. Landing - Loss of control in flight
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Narrative

On October 1, 2017, at 1447 eastern daylight time, a Brantly B-2B helicopter, N2284U, was substantially damaged during landing in an open field near Midland, Michigan. The pilot sustained fatal injuries and the passenger sustained minor injuries. The helicopter was registered to Attitude Toys, Inc. and operated by the pilot as a 14 Code of Federal Regulations Part 91 personal flight. Day visual meteorological conditions prevailed. The flight was not operated on a flight plan. The local flight originated from the same open field shortly before the accident.

A witness reported flying with the accident pilot from the Jack Barstow Airport (KIKW), about 10 miles east-northeast from the accident site, earlier in the day. The pilot landed near the southwest corner of the field in order to attend a family gathering at a home adjoining the field. This witness stated that some minor turbulence was encountered, but that the flight was otherwise uneventful.

The passenger stated that during the gathering, he decided to take a flight around the field with the pilot. He recalled that the helicopter "shook" a little on takeoff, which he thought was related to local winds. He noted that the tail of the helicopter started to "sway" as they flew over the house located along the east edge of the field, but that the pilot subsequently steadied the helicopter. Near the northeast corner of the field, the helicopter began descending, slowly at first and then more rapidly. He again attributed this to local wind conditions. The rotor speed increased, but the helicopter impacted the ground and subsequently rolled onto its left side before coming to rest. He added that the engine did not quit and that he turned it off with the ignition/magneto key after the accident.

The field was about 900 feet (north to south) by 800 feet (east to west). The accident flight departed from near the southwest corner of the field. The home the helicopter flew over was located along the eastern edge of the field, about 300 feet from the northern boundary. The accident site was located at the north boundary of the field, which was about 0.16 mile north-northeast from the departure point. The helicopter came to rest on its left side oriented on a northwesterly bearing.

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Accident Rpt# CEN18LA006	10/07/2017 900 MDT	Regis# N29922	Albuquerque, NM	Apt: Balloon Fiesta Park
Acft Mk/Mdl CAMERON N-105		Acft SN 5225	Acft Dmg: NONE	Rpt Status: Prelim Prob Caus: Pending
			Fatal 0 Ser Inj 1	Flt Conducted Under: FAR 091
Opr Name: CHRIS CLIVER		Opr dba:		Aircraft Fire: NONE
				AW Cert: STB

Events

1. Landing-flare/touchdown - Hard landing
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Narrative

On October 7, 2017, about 0900 mountain daylight time, a Cameron N-105 balloon, N29922, landed hard in a field located on the Kirtland Air Force Base, Albuquerque, New Mexico. The pilot and two passengers were not injured, and one passenger received serious injuries. The balloon was not substantially damaged. The balloon was owned by an individual and operated by HDP Aviation under the provisions of the 14 Code of Federal Regulations Part 91 as a personal flight. Visual meteorological conditions prevailed at the time of the flight, which was not on a flight plan. The flight departed the Balloon Fiesta Park in Albuquerque about 0800 on a local flight.

At 0852, the surface weather observation at the Albuquerque International Sunport Airport (ABQ), Albuquerque, New Mexico was wind 340 degrees at 8 knots; sky clear; 10 miles visibility; temperature 12 degrees C; dew point -5 degrees C; and altimeter 30.16 inches of mercury.

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Accident Rpt# GAA17CA318	06/04/2017 1024 MST	Regis# N50526	Payson, AZ	Apt: Payson PAN
Acft Mk/Mdl CESSNA 172-M		Acft SN 17264211	Acft Dmg: DESTROYED	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl LYCOMING O-320		Acft TT 5321	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: CLASSIC AIR AVIATION LLC		Opr dba:		Aircraft Fire: GRD
				AW Cert: STN

Events

1. Approach-VFR go-around - Aerodynamic stall/spin
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Narrative

The pilot reported that during an approach to runway 22, the airplane drifted to the right of the runway centerline. He initiated a go-around by turning off the carburetor heat, he applied full throttle, he increased the flaps from 30° to 20°, and he pushed forward on the yoke to increase airspeed. He noticed that the airplane began to settle into ground effect. He saw that the terrain began to rise and he recalled that the noise abatement procedure called for a right turn to 270°, so the pilot turned to the right before establishing a climb. The airplane descended into rising terrain, struck trees and impacted the ground and became engulfed in flames. The post-crash fire destroyed the airplane's fuselage.

The METAR reported that the wind was variable at 4 kts. and the temperature was 84° Fahrenheit. The field elevation was 5,504 ft. and the altimeter setting was 30.14. The density altitude was 8,255 ft.

Per the National Transportation Safety Board Pilot Aircraft Accident Report, the pilot reported that the accident could have been prevented by reviewing the airplane's performance data and atmospheric conditions, especially density altitude and its effect on performance per the manufacturer pilot operating handbook. In the future, the pilot vowed to place greater emphasis on performance planning as an essential activity during flight planning.

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

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Accident Rpt# GAA17CA341	06/14/2017 1100	Regis# N9912Q	Galena, ID	Apt: Smiley Creek U87
Acft Mk/Mdl CESSNA 172-M		Acft SN 17265856	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl LYCOMING O-360		Acft TT 9661	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: PONDEROSA AERO CLUB		Opr dba:		Aircraft Fire: NONE
				AW Cert: STN

Events

1. Takeoff - Abrupt maneuver
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Narrative

The pilot in the airplane reported that he attempted to perform a crosswind, soft-field take off from a dry turf airstrip. The pilot configured the airplane with full throttle application, flaps 10ø, and a nose high attitude until the stall warning horn sounded. He then relaxed pressure on the yoke until the stall warning horn subsided. Shortly after rotation the airplane entered a power-on stall and the pilot lost directional control of the airplane. The airplane impacted a barbed wire fence and sustained substantial damage to the right wing strut.

Per the National Transportation Safety Board Pilot Aircraft Accident Report, the pilot reported that the accident could have been prevented, if he had received instruction from a Federal Aviation Administration Certificated Flight Instructor that was specific to the accident airplane, specifically for a soft-field takeoff because each individual aircraft has nuances that can affect the operation.

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

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Accident Rpt# GAA17CA389	07/03/2017 830 CDT	Regis# N2173Z	Shreveport, LA	Apt: Shreveport Downtown DTN
Acft Mk/Mdl CESSNA 172-R		Acft SN 17281216	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl LYCOMING IO-360-L2A		Acft TT 8015	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: TUBREAUX AVIATION SERVICES LLC.	Opr dba:			Aircraft Fire: NONE
				AW Cert: STN

Events

1. Landing-flare/touchdown - Hard landing
-

Narrative

The solo student pilot reported that, during the first approach to land, the airspeed was about 10 kts. fast. He added that, during the flare he attempted to correct the airspeed by "pitching back," but the airplane bounced hard and then porpoised on the runway. He further added that, he initiated a go-around and subsequently completed a normal landing after two additional go-arounds.

The right elevator, fuselage, and firewall sustained substantial damage.

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

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Accident Rpt# GAA17CA300	05/14/2017 1245 CDT	Regis# N53460	Clarksville, TN	Apt: Outlaw Field CKV
Acft Mk/Mdl CESSNA 172-S		Acft SN 172S9351	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl LYCOMING IO-360-L2A			Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: L & W LEASING LLC		Opr dba:		Aircraft Fire: NONE
				AW Cert: STN

Events

1. Landing-flare/touchdown - Abnormal runway contact
-

Narrative

The pilot reported that during his approach, he made his turn to base too early. His approach glide angle was too high and, "I reduced power but also nosed the plane over in order to descend." The airplane's airspeed increased and the airplane ballooned during the landing flare. The airplane touched down hard, it porpoised on the runway and a propeller strike occurred. He taxied to parking and noticed that substantial damage was sustained to the fire wall.

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Accident Rpt# GAA17CA548 09/04/2017 1512 EDT Regis# N565AD Williamsport, PA Apt: Williamsport Rgnl IPT
Acft Mk/Mdl CESSNA 172-S Acft SN 172S9991 Acft Dmg: SUBSTANTIAL Rpt Status: Prelim Prob Caus: Pending
Fatal 0 Ser Inj 0 Flt Conducted Under: FAR 091
Opr Name: FRANCIS P. KELLEY Opr dba: Aircraft Fire: NONE

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Accident Rpt# WPR17FA213	09/22/2017 1634 MST	Regis# N7070Q	Perkinsville, AZ	Apt: N/a
Acft Mk/Mdl CESSNA 172L		Acft SN 17260370	Acft Dmg: DESTROYED	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl LYCOMING O-360 SERIES			Fatal 2 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: SPENCER A KIHLLSTROM		Opr dba:		Aircraft Fire: GRD
				AW Cert: STN

Events

1. Maneuvering - Unknown or undetermined

Narrative

On September 22, 2017, about 1634 mountain standard time, a Cessna 172L, N7070Q, collided with mountainous terrain near Perkinsville, Arizona. The private pilot and passenger sustained fatal injuries and the airplane was destroyed by post impact fire. The airplane was registered to Peach Flyers LLC., and operated by the pilot under the provisions of 14 Code of Federal Regulations Part 91 as a personal flight. The local flight departed Ernest A Love Field Airport, Prescott, Arizona, at 1621. Visual meteorological conditions prevailed and no flight plan had been filed.

On the day of the accident, the pilot told his father that he was planning to fly with his friend, the passenger, and stay in the traffic pattern at Prescott performing touch-and-go takeoffs and landings.

Preliminary radar and audio data provided by the Federal Aviation Administration (FAA) revealed that on the day of the accident, after making contact with Prescott ground controllers, the pilot switched to the tower frequency, and requested a departure to the northeast. The clearance was granted, and after taking off from runway 21R, a radar target which was presumed to be that of the accident airplane, entered the right downwind traffic pattern and departed to the northeast (Image 1). Over the next 2 « minutes the target climbed to an altitude of 7,175 ft mean sea level (about 2,100 ft above field elevation), leveling off 2.75 miles northeast of the airport.

For the next 8 minutes, the target began a gradual descent, while maintaining the northeast track. The last target was recorded at 1632:47, at an altitude of 4,550 ft, above the Verde River, and about 1,500 ft west of the entrance to Verde Canyon. The canyon followed the meandering path of the river to the east.

The following morning, family and friends of the pilot became concerned when they had not heard from him since the night before. They alerted the local Sheriff's department, and at 1108 the FAA issued an Alert Notice (ALNOT). The Sheriff's department initiated a search, and the wreckage was located by a captain from the air support unit at about 1300. The airplane was equipped with an emergency locator transmitter (ELT), and the captain stated that although he was performing grid searches southwest of the accident site for about 3 hours, he did not hear the ELT signal until he was almost directly over the wreckage site.

The wreckage was located on the north face of the canyon wall, at an elevation of 4,290 ft msl, about 200 ft below the canyon top, and 1.8 miles east-southeast of the last recorded radar target (Image 2). The airplane had come to rest inverted, with the cabin on a heading of about 030ø magnetic. The tailcone had rotated 90ø to the airplanes right, and fire had consumed the main cabin, and most of the left wing; the right wing and empennage remained largely undamaged.

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Accident Rpt# WPR17LA216	09/25/2017	1715 LCL	Regis# N5448K	Tamuning, GU	Apt: Guam International Airport GUM
Acft Mk/Mdl CESSNA 172P-P			Acft SN 17274115	Acft Dmg: SUBSTANTIAL	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl LYCOMING 0-320 SERIES			Acft TT 9875	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: SKY GUAM AVIATION INC			Opr dba:		Aircraft Fire: NONE
					AW Cert: STN

Events

2. Enroute-cruise - Loss of engine power (total)

Narrative

On September 25, 2017, about 1715 LCL, a Cessna 172P, N5448K, sustained substantial damage when it impacted terrain following a loss of engine at Guam International Airport (GUM), Tamuning, Guam. The airplane was registered to and operated by Sky Guam Aviation, Inc. under the provision of Title 14 Code of Federal Regulations Part 91. The pilot and two passengers were not injured. Visual meteorological conditions prevailed and no flight plan had been filed for the flight that originated from GUM at 1650.

The pilot reported that the accident flight was scheduled as a 20-minute local sightseeing flight and that it was his last flight of the day. He conducted a normal preflight and reported no issues during the beginning of the flight. While enroute, the pilot noticed sparks on his left side and smoke started to fill up the cabin. The pilot opened the left window to disperse the smoke. He did not observe fire but the smoke continued to accumulate in the cockpit. Shortly after, the engine lost power and the airplane started to shake violently. The pilot decided to return to the airport and made a mayday call to inform the tower of the engine failure. While enroute to the airport, he attempted to restart the engine but he was unsuccessful. The pilot realized he did not have a sufficient altitude to land on the runway and initiated a forced landing to a nearby field. The airplane landed short of the airport perimeter fence.

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Accident Rpt# WPR16FA084	03/13/2016 227 MST	Regis# N2230G	Alpine, WY	Apt: Alpine 46U
Acft Mk/Mdl CESSNA 182A-A		Acft SN 51530	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl CONTINENTAL MOTORS O-470-L		Acft TT 2505	Fatal 4 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: VISSER JAMES R		Opr dba:		Aircraft Fire: GRD
				AW Cert: STN

Events

1. Initial climb - Loss of control in flight

Narrative

HISTORY OF FLIGHT

On March 13, 2016, at 0227 mountain standard time, a Cessna 182A airplane, N2230G, collided with terrain shortly after departing from Alpine Airport, Alpine, Wyoming. The private pilot and three passengers sustained fatal injuries, and the airplane sustained substantial damage. The airplane was registered to and operated by a private individual as a 14 Code of Federal Regulations Part 91 personal cross-country flight. The flight was departing from Alpine with an assumed destination of Rigby Airport, Rigby, Idaho. Visual meteorological conditions existed at the departure airport about the time of the accident, and no flight plan had been filed.

A resident, who lived on the east side of the runway at Alpine Airport, stated that he heard the airplane land on March 12 about 1930 and heard the airplane depart about 0230 the next day. He stated that the departure sounded normal but without the typical "slow fade away of the prop noise." The noise had just suddenly stopped, which he thought was unusual enough that he looked out the window and only observed some stars with a few clouds.

According to a saloon employee, the pilot and passengers had visited Alpine on numerous occasions, where they would usually have dinner at the Bull Moose Saloon; it is unknown how many flights they had conducted to Alpine previously, but they had driven there many times. She recalled that they arrived about 2000 and left about 0200. She stated that they were in a good mood the entire time and did not notice any anomalies. She stated that the pilot did not drink alcohol while he was at the tavern.

A Garmin GPSMAP 396, battery-powered portable GPS receiver was located in the wreckage. The unit included a built-in Jeppesen database and was capable of receiving XM satellite radio for flight information. The unit stored date, route-of-flight, and flight-time information; all recorded data were stored in nonvolatile memory.

Recorded data plots were recovered for the timeframe that matched the airplane's anticipated flight track after departing from Alpine. The track indicated that the airplane departed from runway 31 at 0224:35. After becoming airborne, the airplane continued over the runway until reaching the departure end, where it made a climbing 360° left turn from about 5,650 to 6,075 ft mean sea level (msl or about 20 to 425 ft above ground level [agl], respectively). The airplane maintained a northwest heading for about 30 seconds, never climbing above 6,200 ft msl (550 ft agl).

The last four data points of the flight track occurred over 7 seconds from 0226:33 to 0226:40. During that time, the speed increased from 71 to 104 knots, and the altitude decreased about 350 ft while entering a descending right turn (the direction of travel changed from 300° true to 32° true). The last recorded point was timestamped 0226:40 and showed the airplane about 500 ft southwest of the accident site at 5,859 ft msl with a groundspeed of 104 knots.

PERSONNEL INFORMATION

The pilot held a private pilot certificate with a single-engine land rating. His third-class medical certificate was issued on April 12, 2012, with no limitations. The pilot's personal flight records were not recovered.

The airplane's owner stated that the pilot had recently obtained his pilot's license and started borrowing the airplane about 2 months before the accident. The pilot was checked out in the airplane by a flight instructor and was free to use it as he pleased. The pilot sent the owner a text at 1912 on the night of the accident stating that he was going to take the airplane flying.

AIRPLANE INFORMATION

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The airplane, serial number 51530, was manufactured in 1958. It was equipped with a Continental Motors O-470-L engine, serial number 68518-8-L. A review of the airplane's maintenance logbooks revealed that the airframe's last annual inspection occurred on December 03, 2015, at a total time of about 2,505.6 hours, at which time the engine underwent its last 100-hour inspection, at a tachometer time of 1,393.6 hours.

According to the airport manager, the airplane was not refueled in Alpine. The airplane owner estimated that, at the time of the accident, the airplane would have had about 48 gallons of fuel. The amount of fuel in each wing tank could not be determined.

METEOROLOGICAL INFORMATION

A METAR generated by an Automated Surface Observation System at the airport indicated that, about the time of the accident, the conditions were as follows: wind was from 060ø at 4 knots, temperature 6øF, dew point -1øF, and altimeter setting 29.87 inches of mercury.

According to the U.S. Naval Observatory, on the morning of the accident, the sun rose at 0739. At the time of the accident, the moon was about 28ø below the northwestern horizon; the phase of the moon was waxing crescent with 25% of the moon's visible disk illuminated.

WRECKAGE AND IMPACT INFORMATION

The accident site was located on hard snow-and-gravel terrain along the shoreline of the Palisades Reservoir, located about 1 mile northwest of the runway. The entire wreckage sustained thermal damage, and the cockpit was consumed by fire. The debris field stretched from west to east and was about 50 yards long and 35 yards wide. At the beginning of the debris field, the propeller was found embedded in a crater about 3 ft deep and 8 ft wide.

The destination airport in Rigby, Idaho (elevation 4,845 ft msl), was about 47 nautical miles (nm) from Alpine Airport (elevation 5,630 ft msl) on a bearing of about 310ø. A valley extended between the two airports with peaks on either side reaching up to 8,000 ft msl. The surrounding area was unpopulated with few lights in the immediate vicinity. The flight data indicated that the airplane had flown between the airports on prior occasions; however, it could not be determined if the pilot flew those trips.

TESTS AND RESEARCH

Following recovery, the wreckage was examined at a facility in Greeley, Colorado. The wreckage was partially consumed by fire. The intensity of the thermal damage in the cockpit area prohibited investigators from being able to establish complete flight control continuity.

An external examination of the engine revealed that all cylinders were secured to the crankcase. Both the exhaust and induction systems sustained impact damage. The carburetor had separated, and only a portion of the bowl remained attached to the mixture cable in the lower cowlage wreckage. The carburetor throttle plate and control arm remained attached to the damaged throttle cable. The throttle control arm remained attached to the carburetor base and throttle plate shaft.

Removal of the top spark plugs revealed that the No. 3 plug was covered in mud. According to the Continental Motor's Group representative, the remaining spark plugs revealed evidence of normal wear conditions and combustion deposits. Engine internal continuity was confirmed by manually rotating the engine. The pistons moved normally inside the cylinders. The rear accessory gears rotated normally. Thumb compression could not be achieved due to impact damage. The combustion chambers remained mechanically undamaged, and there was no evidence of foreign object ingestion (preimpact) or detonation. The valves were intact and undamaged. No evidence of valve-to-piston face contact was observed.

The engine oil sump was crushed upward against the internal engine components. The engine oil pump remained attached. The oil screen was removed and inspected, and no abnormal contaminants were found on the oil screen. The oil cooler had separated but was recovered. Both the right and left magnetos had separated from their mounts but remained attached to the ignition harness. Both magnetos exhibited thermal damage. The magnetos could not be functionally tested due to thermal damage. Both magnetos were partially disassembled to examine the internal components, and all components were thermally damaged.

The propeller had separated from the engine crankshaft. Both propeller blades remained attached to the hub but were loose in the hub housing. Both blades exhibited chordwise scratching and gouging with deep gouging along the leading edge of one of them. Both propeller blades were bent rearward and thermally

damaged.

There was no evidence of mechanical malfunction or failure with the airframe or engine that would have precluded normal operation. A complete examination report is contained in the public docket for this accident.

MEDICAL AND PATHOLOGICAL INFORMATION

The Lincoln County Coroner's Office stated that it was unable to conduct an autopsy of the pilot due to the thermal damage.

The FAA's Bioaeronautical Sciences Research Laboratory performed toxicological tests on specimens from the pilot. According to the toxicological report, the results were negative for ethanol (alcohol) and other tested drugs.

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Accident Rpt# GAA17CA346	06/12/2017 1030	Regis# N305CM	Rexberg, ID	Apt: Rexburg-madison County RXE
Acft Mk/Mdl CESSNA 305C (0 1E)-E		Acft SN 24558	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl CONTINENTAL O-470-11		Acft TT 3511	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: LEGACY FLIGHT MUSEUM		Opr dba:		Aircraft Fire: NONE
				AW Cert: STN

Events

1. Landing-landing roll - Loss of control on ground

Narrative

The pilot in the tailwheel equipped airplane reported that he attempted a crosswind landing to the asphalt surface of runway 35. He had about 300 hours of total tailwheel flight time and he had 5 hours of flight time in the accident airplane. This was the pilot's first flight as the pilot in command. He recalled that the Automated Surface Observing System reported that the wind was from 050ø at 5 kts. gusting to 21 kts. During the landing roll, the airplane encountered a gust of wind from the right and the tail ascended. The pilot lost directional control of the airplane and airplane faced southeast when another gust of wind lifted the left wing and the right wing struck the ground. The wind gust subsided and the airplane came to rest upright but it sustained substantial damage to the right wing, the right aileron and the elevator.

Per the National Transportation Safety Board Pilot Aircraft Accident Report, the pilot reported that the accident could have been prevented, if he had received more instruction from a Federal Aviation Administration Certificated Flight Instructor in the accident airplane that was specific to crosswind landings. "But more important, I should have flown the airplane to an airport with a runway that was more in line with the wind."

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

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Accident Rpt# ERA18FA004	10/04/2017 1745 EDT	Regis# N401HH	Salters, SC	Apt: Pvt
Acft Mk/Mdl CESSNA 401B-UNDESIGNAT		Acft SN 401B0004	Acft Dmg: DESTROYED	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl CONT MOTOR TSIO-520-E8			Fatal 2 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: HENRY HADDOCK		Opr dba:		Aircraft Fire: GRD
				AW Cert: STN

Events

1. Maneuvering - Loss of control in flight

Narrative

On October 4, 2017, about 1745 eastern daylight time, a Cessna 401B, N401HH, was destroyed after it impacted terrain while maneuvering near Salters, South Carolina. The commercial pilot and a passenger were fatally injured. Visual meteorological conditions prevailed and no flight plan was filed for the local flight. The personal flight was conducted under the provisions of 14 Code of Federal Regulations Part 91.

A witness at the airport reported seeing the airplane takeoff. About 10 minutes later, the pilot made a low pass over the grass strip and then began a steep climb. The witness stated the airplane rolled left, the left wing dropped and the airplane was inverted and descending in a nose low attitude. The airplane's wings were level before it disappeared behind trees. The airplane was located in an open field that was surrounded by trees about 1 mile southwest from the departure airport.

The airplane was examined at the accident site and all major components were accounted for at the scene. The wreckage path began in trees about 50 ft above the ground, and was oriented about 280° magnetic. The main wreckage came to rest inverted, facing 230° and was consumed by a postcrash fire.

The outboard portion of the left wing was located at the initial tree strike. Fragments of the airframe were located at a second tree strike, about 350 ft from the initial tree strike. The outboard portion of the right wing was located about 320 ft beyond the second tree strike. The main wreckage was about 930 ft from the initial tree strike, the right engine was about 90 ft past the main wreckage.

The flaps and the landing gear were in the up position. Flight control cable continuity was confirmed from the all flight control surfaces to the cockpit area. Flight control cable continuity within the cockpit could not be confirmed due to fire damage. All cockpit instrumentation was destroyed by fire.

The left engine was separated from the nacelle and the wing, and found inverted by the left wing. All six cylinders remained attached at their bases, the cooling fins sustained impact damage. The engine was manually rotated, thumb compression was obtained on all cylinders. A borescope inspection of the cylinders revealed the tops of all pistons and all intake and exhaust valves exhibited normal combustion signatures. The propeller separated from the engine at the attachment bolts.

The right engine was separated forward of the main wreckage; it was found inverted and attached to the wing nacelle. All six cylinders remained attached; Nos. 2, 4 and 6 had cooling fin impact damage. The engine was manually rotated and thumb compression was obtained on all cylinders. A borescope inspection of the cylinders revealed the tops of all pistons and all intake and exhaust valves exhibited normal combustion signatures. The propeller was separated from the engine at the propeller flange.

The six-seat, low-wing, retractable-gear equipped airplane was manufactured in 1969. It was powered by two Continental TSIO-520E, 300-horsepower engines, driving McCauley three-bladed, constant speed, full feathering propellers.

The pilot held a commercial pilot certificate with an airplane single and multiengine land, and rotorcraft/helicopter ratings. He also held ratings for single and multiengine instrument airplane, and airframe and powerplant mechanic. His most recent Federal Aviation Administration second-class airman medical certificate was issued on July 27, 2017, with the limitation, "must have glasses for near vision." At that time, he reported 15,000 total flight hours.

At 1735, the weather reported at Williamsburg Regional Airport (CKI), Kingstree, South Carolina, about 14 miles north of the accident site, included wind calm, visibility 10 statute miles; scattered clouds at 4,700 ft, scattered clouds at 6,500 ft; temperature 26° C, dew point 17° C, and altimeter 30.28 inches of mercury.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# CEN15FA425 09/25/2015 1550 CDT Regis# N301JA Wichita, KS Apt: Wichita Dwight D Eisenhower Na ICT
Acft Mk/Mdl CESSNA T310Q-Q Acft SN T310Q-0611 Acft Dmg: DESTROYED Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl CONTINENTAL MOTORS TSIO-520-B12B Acft TT 188 Fatal 1 Ser Inj 0 Flt Conducted Under: FAR 091
Opr Name: AARON WATERS Opr dba: Aircraft Fire: NONE

Events

1. Initial climb - Flight control sys malf/fail

Narrative

HISTORY OF FLIGHT

On September 25, 2015, about 1550 central daylight time, a Cessna T310Q airplane, N301JA, experienced a flight control malfunction during takeoff initial climb and impacted the ground near Wichita, Kansas. The commercial pilot was fatally injured, and the airplane was destroyed. The airplane was registered to Celestial Knights, LLC, and operated by the pilot under the provisions of 14 Code of Federal Regulations Part 91 as a personal flight. Visual meteorological conditions prevailed for the flight, and an instrument flight rules (IFR) flight plan had been filed. The flight originated at Wichita Dwight D Eisenhower National Airport (ICT), Wichita, Kansas, and was destined for Centennial Airport (APA), Denver, Colorado.

According to witnesses, the airplane appeared to be flying normally, and then it suddenly pitched down and entered a rapid descent. The descent angle was described by witnesses as "greater than 45 degrees" and "50 to 70 degrees." The witnesses reported hearing both engines at "full throttle" during the descent. The airplane impacted the ground on the east side of Cowskin Creek about 2 nautical miles northeast of ICT.

PERSONNEL INFORMATION

The pilot held a commercial pilot certificate with airplane multi-engine land, airplane single-engine land, glider, and instrument airplane ratings. No pilot logbooks were recovered during the investigation. The pilot's most recent Federal Aviation Administration (FAA) second-class medical certificate was issued on June 23, 2015, with the limitation: "must wear lenses for distant, have glasses for near vision." On his medical certificate application, the pilot reported that he had about 470 total hours of flight time.

AIRCRAFT INFORMATION

According to FAA records, the six-seat airplane, serial number T310Q0611, was manufactured by the Cessna Aircraft Company (now Textron Aviation). The FAA issued its original airworthiness certificate on October 16, 1972, and the airplane was registered to the pilot on September 26, 2014. According to aircraft maintenance records, the last annual inspection was completed on May 8, 2015, at a recorded tachometer time of 187.7 hours.

METEOROLOGICAL INFORMATION

The 1553 recorded weather observation at ICT, included calm winds, visibility 10 miles, scattered clouds at 6,000 ft, broken ceiling at 8,000 ft, broken ceiling at 12,000 ft, broken ceiling at 15,000 ft, temperature 29°C, dew point 14°C; barometric altimeter 30.06 inches of mercury.

WRECKAGE AND IMPACT INFORMATION

Impact marks at the accident site were consistent with a steep nose-down, right-wing-low attitude, with the right wingtip striking the ground first. The fuselage and wings came to rest on the west side of the creek in an inverted position with the right wing folded under the fuselage section. The fuselage from the aft baggage compartment through the tail section was intact but exhibited substantial impact damage. The fuselage forward of the aft baggage compartment through the cabin compartment was substantially damaged. The right and left engines were underwater, imbedded in the soil at the bottom of the creek. The right and left propeller assemblies, a section of the left wing including the left main landing, and the nose landing gear were found underwater in the creek bed. The landing gear actuator was found in the fully retracted position.

The right elevator remained partially attached to its attachment points. The elevator was separated spanwise outboard of the elevator trim tab, and the inboard portion of the elevator was distorted. The trim tab remained attached to the elevator at its hinge. The elevator trim pushrod was found attached to the trim tab

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but not attached to the trim tab actuator. The bolt, washer, castellated nut, and cotter pin securing the elevator trim tab pushrod to the actuator were missing. The elevator trim actuator remained attached to its attachment point on the horizontal stabilizer and was extended about 5/8 inch, which corresponded to a position outside its normal limits.

Flight control cable continuity was established for the rudder, right aileron, and elevators. The left aileron, all trim systems, and the right and left flaps exhibited control cable overload separations.

The engines were recovered from the creek bed, rinsed with water, and examined on-scene. The engine examinations revealed no evidence of preimpact anomalies or malfunctions.

The left engine's propeller flange was distorted. All six of the propeller bolts remained with the propeller flange, and the bolt threads contained remnants of the propeller hub threads. The propeller flange was manually rotated, and crankshaft and camshaft continuity were confirmed to the pistons. The left engine's magnetos were separated from their respective mounting pads but remained attached to the engine via the ignition harness. All of the ignition terminal ends remained attached to their respective sparkplugs. The magnetos and ignition harness were removed as were the top sparkplugs for each cylinder. The top sparkplugs were covered with mud, water, and oil. After being rinsed with freshwater, each electrode displayed a normal worn condition when compared to the Champion Aviation Service Manual (AV6-R). No internal, pre-accident anomalies were observed with the magnetos. The cylinders were photographed internally with a borescope. Each cylinder contained mud and water from the creek and exhibited normal combustion deposits. No preaccident anomalies were noted with the cylinders, valves, valve seats, rockers, or springs.

The engine-driven fuel pump was attached to the back of the engine and its drive coupling remained intact. Manual rotation of the drive coupling while installed in the driveshaft resulted in rotation of the driveshaft with a gritty feel to the rotation, but no binding was noted. The fuel pump was disassembled, and no preaccident anomalies were noted with any of the internal components. The throttle body/fuel metering unit remained attached to the engine via the fuel line between the fuel pump and the metering unit. The metering unit fuel inlet filter was removed and no obstructions or blockage were noted, but mud and dirty water were observed. The metering unit was disassembled, and no preaccident anomalies were noted with the internal components. The fuel manifold valve was disassembled, and aviation gasoline, mud and water were noted in the manifold. No pre-accident anomalies were noted with the diaphragm, plunger, spring, or screen.

The left propeller hub was fractured, and only two of the three blades were recovered with remnants of the hub remaining attached to one of the blades. The two blades displayed S-bending, and both were twisted toward low pitch.

The right engine's propeller flange was distorted; five of the six propeller bolts remained with the propeller flange; and the bolt threads contained remnants of the propeller hub threads. The propeller flange was manually rotated, and crankshaft and camshaft continuity were confirmed out to each piston. The right engine's magnetos were separated from their respective mounting pads and only the right magneto was recovered from the creek bed. No internal, preaccident anomalies were observed with the right magneto. All of the ignition terminal ends remained attached to their respective sparkplugs. The ignition harness remnants were removed as were the top sparkplugs for each cylinder. The top sparkplugs were covered with mud, water, and oil. All electrodes displayed a normal worn condition when compared to the Champion Aviation Service Manual (AV6-R). The cylinders were photographed internally with a borescope. Mud, water, and combustion deposits consistent with normal operation were noted within each of the cylinders. No preaccident anomalies were noted with the cylinders, valves, valve seats, rockers, or springs.

The engine-driven fuel pump was attached to the backside of the engine. The drive coupling was intact, and rotation of the drive coupling while installed in the driveshaft resulted in rotation of the driveshaft with no binding noted. The fuel pump was disassembled, and no preaccident anomalies were noted with any of the internal components. The throttle body/fuel metering unit remained attached to the engine nacelle. The metering unit fuel inlet filter was removed, and no obstructions or blockage was noted, but mud and dirty water were observed. The metering unit was disassembled, and no preaccident anomalies were noted with the internal components. The fuel manifold valve was disassembled, and aviation gasoline, mud and water were noted in the manifold. No preaccident anomalies were noted with the diaphragm, plunger, spring, or screen.

The right propeller hub was fractured, and two of the three blades remained attached to the hub. The separated blade was recovered. All of the blades' pitch change links were fractured. All three blades were twisted toward low pitch. One blade displayed heavy S-bending, leading edge gouging, and was bent into a U-shape.

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MEDICAL AND PATHOLOGICAL INFORMATION

The Regional Forensic Science Center, Sedgwick County, Kansas, conducted an autopsy of the pilot. The cause of death was attributed to "multiple blunt force injuries."

The FAA Bioaeronautical Sciences Research Laboratory, Oklahoma City, Oklahoma, performed toxicology testing on specimens from the pilot. The toxicology results were negative for carbon monoxide, cyanide, and drugs. The toxicology was positive for ethanol detected in muscle tissue, and no ethanol was detected in the liver.

TESTS AND RESEARCH

On September 28, 2015, the right elevator, trim tab, and trim actuator were taken to Textron Aviation's laboratory in Wichita, Kansas, where they were examined under the supervision of National Transportation Safety Board (NTSB) investigators. A portion of the elevator's upper skin was removed to examine witness marks on the elevator's leading-edge spar, the trim tab pushrod, and the trim actuator. Witness marks were found on the pushrod, the actuator, and the elevator spar that were consistent with the pushrod moving both fore and aft relative to the actuator. Scrape marks on the aft side of the elevator spar below the guide hole for the trim tab pushrod were consistent with the pushrod's forward (disconnected) end hitting against the spar's aft side after the pushrod separated from the actuator and became trapped behind the elevator spar.

Measurements taken from an exemplar Cessna 310 indicated that, if the pushrod is disconnected from the actuator, the elevator trim tab deflects 39° trailing edge up (TEU) when the forward end of the pushrod is positioned aft of the spar. Additional measurements indicated that, if the pushrod is properly connected, the elevator trim tab deflects about 12° TEU when the actuator is fully extended. The TEU elevator trim tab position pushes down on the elevator's trailing edge, which produces an airplane nose-down pitching moment.

ADDITIONAL INFORMATION

On August 10, 1973, Cessna Aircraft Company issued multi-engine service letter ME73-15, "Inspection and Replacement of Self-Locking Fasteners," which was applicable to the accident airplane. This service letter recommended the replacement of self-locking nuts used in primary and secondary control systems with a self-locking castellated nut and cotter pin.

On February 13, 1978, Cessna Aircraft Company issued multi-engine service letter ME77-34 (Supplement #1), "Trim Control System," which was applicable to the accident airplane. This service letter provided information for conducting a general inspection of the aileron, elevator, and rudder trim systems. The letter specified an inspection procedure that "places particular emphasis on the mounting and security of the trim tab actuator and associated linkage" and stated that the inspection should be completed at the next 100 hour or annual inspection, whichever came first, and repeated every 100 hours thereafter. The inspection items included "inspect push rod attach bolt at the actuator and trim tab horn for proper safetizing of nut with cotter pin."

On August 1, 1979, Cessna Aircraft Company issued multi-engine service letter ME79-28, "Trim Tab Actuator Inspection," which was applicable to the accident airplane. This service letter changed the inspection/lubrication interval for the aileron, elevator, and rudder trim actuators from every 1,500 hours to every 1,000 hours or 3 years, whichever comes first. Inspection/lubrication of a trim actuator requires that it be removed from the airplane, which requires removal of the bolt, nut, and cotter pin that attaches the pushrod to the actuator.

Given the 3-year or 1,000-hour overhaul cycle specified in ME79-28, an overhaul of the elevator trim actuator on the airplane would have been due no later than 2014. A review of the aircraft logbook of maintenance actions performed from February 2006 through August 2015 revealed no entries of an elevator trim actuator overhaul. Manufacturers' service letters are not mandatory for Part 91 operators; only FAA issued airworthiness directives (AD) require mandatory compliance.

In response to this accident, on February 29, 2016, Textron Aviation issued multi-engine service bulletin MEB-27-02, "Flight Controls - Elevator Trim Push-Pull Rod Hardware Replacement," that required the hardware securing the elevator trim pushrod be replaced in airplane models including the accident airplane model. The service bulletin stated that the hardware replacement "must be accomplished at the next 100-hour or 12-month (annual-type) inspection, whichever occurs first." The service bulletin specified that use of the correct cotter pin (part number MS24665-132) was critical to the installation and warned that the use of a different cotter pin could result in the hardware becoming loose. The attachment hardware of the elevator trim pushrod to the elevator trim tab is visible

during preflight inspections, however, inspection of the attachment hardware is not included in Textron Aviation's preflight inspection checklist.

Subsequently, the FAA issued AD 2016-07-24 that required replacement and repetitive inspections of the hardware securing the elevator trim pushrod per MEB-27-02. Initial replacement of the hardware was required within 90 days of the publication of the AD with repetitive inspections of the hardware at every 100-hour or annual maintenance check. The AD explained that, following the loss of the attachment hardware connecting the elevator trim tab actuator to the elevator trim tab pushrod, the elevator tab may jam in a position outside the normal limits of travel and create an unsafe condition that could result in a loss of ability to control the airplane.

Shortly after AD 2016-07-24 was issued, it was superseded by AD 2016-17-08 due to comments received from industry professionals indicating difficulties with the specified bolt installation and requesting revision to the repetitive inspection intervals to coincide with established inspection intervals. Textron Aviation issued Revision 1 to MEB-27-02 to modify the hardware specified. No other changes were made to the service bulletin.

Similar Accidents

On May 25, 1988, in West Columbia, South Carolina, a Cessna 402B, N8493A, was involved in a fatal accident after the pilot radioed shortly after takeoff that he was having a problem with the elevator that required "full back pressure" to keep the nose up (NTSB accident number ATL88FA186). While attempting to return to land, the airplane pitched 70-80° nose down and descended into terrain. A postaccident examination revealed that the bolt securing the elevator trim tab push rod to the actuator was missing. The rod had become wedged inside the elevator, which led to an "extreme tab up" (nose down) condition.

On July 28, 1995, in Wenatchee, Washington, a Cessna 402B, N51816, experienced a "greater than normal" nose-down trim and impacted terrain during an attempted emergency landing, resulting in substantial damage (NTSB accident number SEA95LA159). The operator reported that the elevator trim actuator rod failed during takeoff. A postaccident examination by FAA investigators found the elevator trim pushrod jammed behind the elevator spar. The elevator was in the extreme nose-down position, and the cockpit trim wheel was found in the extreme nose-up trim position. The trim wheel was tested with no effect.

On April 26, 2001, in Del Rio, Texas, a Cessna 402B, N80Q, was involved in a fatal accident after the pilot reported that he would circle the airport a few times "because he was having trouble with his autopilot" (NTSB accident number FTW01FA104). A witness observed the airplane turn onto final and stated that the airplane "suddenly stalled and slammed into the ground from about two hundred feet." During the investigation, the elevator trim tab was found to be in the 28° tab-up position (airplane nose-down). According to the airplane manufacturer's specifications, the maximum tab-up travel limit (when connected) is 5°. The trim tab would not move freely by hand forces and appeared to be jammed. The elevator skin was cut open to observe the trim tab connecting hardware. The clevis end of the trim tab pushrod was wedged against the front spar of the elevator's internal structure. Additionally, the bolt that connected the clevis end of the pushrod to the actuator was missing. After further inspection, neither the bolt nor the nut were found in the cavity of the elevator structure or the surrounding area. The clevis end of the pushrod and the actuator were not damaged, and no impact damage was apparent on the trim tab. The operator's maintenance records showed that the right elevator had been replaced 10 flight hours before the accident.

On November 7, 2001, in Winston Salem, North Carolina, a Cessna M310Q, N7648Q, was involved in a fatal accident after the pilot radioed that he was experiencing oscillations in the airplane's controls (NTSB accident number ATL02FA010). He then radioed that the problem was under control, but shortly after he radioed that he was experiencing a lot of down pressure on the yoke. The airplane crashed shortly after this transmission. The elevator trim tab assembly, the elevator trim tab pushrod, and part of the elevator were cut from the airplane at the crash site and brought back to Cessna's laboratory for examination. The forward end of the pushrod had separated from the actuator. The following observations were made during the examination: (1) the dry, oxidized condition of the pushrod's forward end was consistent with the attaching bolt likely being missing for some time before the crash; (2) rub marks on the opening in the forward elevator spar corresponded to rub marks found on the underside of the pushrod; and (3) the geometry of the disconnected pushrod allowed it to pass behind the forward elevator spar. The observed damage was consistent with the elevator trim tab being in the full TEU position at the time of the crash.

Textron Aviation personnel stated that the company is working with the FAA on a design change to prevent the elevator trim tab pushrod from jamming behind the forward elevator spar in the event that the pushrod becomes disconnected from the actuator. Textron Aviation personnel further stated that, when the design change is completed, the company plans to issue a service bulletin.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# ANC17LA053	09/04/2017	1430 AKD	Regis# N16GP	Kodiak, AK	Apt: Trident Basin T44
Acft Mk/Mdl CESSNA U206G-G			Acft SN U20604467	Acft Dmg: SUBSTANTIAL	Rpt Status: Prelim Prob Caus: Pending
			Acft TT 1576	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: MAGOFFIN DAVID			Opr dba:		Aircraft Fire: NONE
					AW Cert: STN

Events

1. Takeoff - Loss of control on ground
-

Narrative

On September 4, 2017 about 1430 Alaska daylight time, an amphibious float-equipped Cessna U206 airplane, N16GP, sustained substantial damage while attempting to depart the water at Trident Basin Seaplane Base, Kodiak, Alaska. The airplane was registered to and being operated by the pilot as a 14 Code of Federal Regulations Part 91 visual flight rules flight. The certificated airline transport pilot and three passengers were not injured. Marginal visual meteorological conditions existed and no flight plan had been filed.

In a written statement to the National Transportation Safety Board (NTSB), the pilot stated that during the takeoff run the airplane encountered small swells, and began to lose speed while simultaneously pitching forward. In an effort to correct for the forward pitching moment, the pilot applied full aft elevator. Shortly thereafter, he aborted the takeoff, but the airplane continued to pitch forward when it was struck by a larger swell. The right forward float strut fractured and the airplane rolled to the right, which resulted in substantial damage to the right wing's lift strut. An initial examination of the airplane by the pilot revealed that the left nose wheel was partially deployed with the landing gear handle in the up position.

The airplane was equipped with EDO 3500 amphibious floats.

A detailed wreckage examination is pending.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# WPR18FA001	10/01/2017 1043 PDT	Regis# N6083D	Klamath Falls, OR	Apt: N/a		
Acft Mk/Mdl CIRRUS DESIGN CORP SR22-NO SERIES	Acft SN 0612	Acft Dmg: DESTROYED	Fatal 2	Ser Inj 0	Rpt Status: Prelim	Prob Caus: Pending
Eng Mk/Mdl CONT MOTOR IO-550 SERIES					Flt Conducted Under: FAR 091	
Opr Name: JUAN CARLOS CANOPII	Opr dba:				Aircraft Fire: NONE	
					AW Cert: STN	

Events

1. Maneuvering-low-alt flying - Loss of control in flight

Narrative

On October 1, 2017, about 1043 Pacific daylight time, a Cirrus Design Corp SR22, N6083D, was destroyed after impacting terrain while maneuvering at a low altitude in a remote mountainous area about 24 nautical miles west-northwest of Klamath Falls, Oregon. The private pilot and the sole passenger received fatal injuries. The airplane was registered to Cascade Forestry Inc., Gold Hill, Oregon. Instrument meteorological conditions were reported in the area at the time of the accident. The personal cross-country flight was being operated in accordance with 14 Code of Federal Regulations Part 91, and a flight plan was not filed. The flight departed Crater Lake-Klamath Regional Airport (LMT), Klamath Falls, Oregon, at about 1030, with the destination being Rouge Valley International-Medford Airport (MFR), Medford, Oregon.

In a postaccident interview with the National Transportation Safety Board (NTSB) investigator-in-charge (IIC), a local Oregon State Trooper, who was conducting fish and wildlife surveillance in the area at the time of the accident, reported hearing the airplane pass overhead near his location. The trooper stated that the airplane was on a westerly heading at a very low altitude, in the clouds, "the engine was screaming," and that the clouds at the time were at tree-top level. The trooper further reported that as the airplane passed over his position it started a turn to the left, and continued to turn left with the "engine still screaming." This was followed shortly by the sound of a crash. The trooper opined that he and another trooper began searching for the downed airplane, however, by this time the clouds were at ground level, which hindered the ability to locate the airplane. The airplane was subsequently located the following morning on a ridge populated by thick tree growth and other vegetation.

In a postaccident interview with the NTSB IIC, an acquaintance of the accident pilot reported that he had spoken with the pilot at LMT prior to his departure for MFR on the morning of the accident. The acquaintance, who is a retired US Air Force F-15 pilot, stated that he had pointed out the clouds to the west, which were in the same direction that the accident pilot would be taking to MFR. The pilot replied that if he needed to, he would climb above the clouds and look for a hole to get down through. If he could not find a hole, then he would return to LMT.

On October 3rd and 4th, representatives from the NTSB, the Federal Aviation Administration, Continental Motors, Inc., and Cirrus Aircraft surveyed the accident site. The airplane had initially impacted a 40-foot tall tree at about the 25-foot level on a northeast heading, then impacted the base of a second tree. It then continued northeast on about a 15° downslope before coming to rest about 100 ft. from the initial impact point. The airplane was highly fragmented during the accident sequence.

All airplane flight control surfaces were accounted for at the accident site. The airplane's parachute system was observed to have separated from its secured location by impact forces, and was unfurled and located about 40 ft. northeast of the main wreckage and in line with the linear debris path; the parachute rocket motor had not discharged. There was no postcrash fire. The wreckage was recovered from the accident site to a secured storage facility for further examination.

At 1053, the weather reporting facility at LMT, located about 24 nm east-southeast of the accident site, reported wind 310° at 9 knots (kts), gusts to 16 kts, visibility 10 miles, overcast clouds at 4,500 ft., temperature 11° C, dew point -01° C, and an altimeter setting of 30.14 inches of mercury.

At 1053, the weather reporting facility at MFR, located about 27 nm west-southwest of the accident site reported wind calm, visibility 10 miles, scattered clouds at 3,400 ft., broken clouds at 6,000 ft., temperature 14° C, dew point 6° C. and an altimeter setting of 30.19 inches of mercury.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# GAA17CA572 09/27/2017 1130 Regis# N53XC Kalispell, MT Apt: Glacier Park Intl GPI
Acft Mk/Mdl CUB CRAFTERS INC CC19-180-NO Acft SN CC19-0014 Acft Dmg: SUBSTANTIAL Rpt Status: Prelim Prob Caus: Pending
Fatal 0 Ser Inj 0 Flt Conducted Under: FAR 091
Opr Name: SCHLOSS, BURKHART S. Opr dba: Aircraft Fire: NONE

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# GAA17CA295	05/21/2017 1300 EDT	Regis# N25329	Catlett, VA	Apt: Maples Field VG57
Acft Mk/Mdl FAIRCHILD 24R-40		Acft SN R40-404	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl RANGER R440		Acft TT 210	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: WILLIAM A. HARGREAVES		Opr dba:		Aircraft Fire: NONE
				AW Cert: STN

Events

1. Landing - Abnormal runway contact
-

Narrative

The pilot in the tail-wheel equipped airplane reported that he accomplished an approach to land on a grass airstrip. During the approach he avoided powerline wires and buildings that were located at the approach end of what he perceived to be the runway. Prior to the landing flare he realized that what he perceived as the runway was a wheat field. The airplane's main landing gear became entangled with the wheat stocks and the airplane impacted the ground. The airplane nosed over and came to rest inverted. Substantial damage was sustained to the engine mounts, the rudder, the vertical stabilizer and the wing strut.

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

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# GAA17CA247	03/28/2017 1700 EDT	Regis# N9613L	Flushing, MI	Apt: Dalton 3DA
Acft Mk/Mdl GRUMMAN AMERICAN AVN. CORP. AA-1BA	Acft SN AA1B0113	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual	Prob Caus: Pending
Eng Mk/Mdl LYCOMING O-320 B2B	Acft TT 3426	Fatal 0	Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: MITCHELL F. BARMAN	Opr dba:	Aircraft Fire: NONE		AW Cert: STN

Events

1. Landing-landing roll - Runway excursion
-

Narrative

The pilot reported that, during the landing he was "going to[too] fast", over ran the runway, and impacted trees.

The airplane sustained substantial damage to both wings.

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

Accident Rpt# GAA18CA004 10/07/2017 851 EDT Regis# N7884V Topping, VA Apt: Hummel Field W75
Acft Mk/Mdl MOONEY M20C-NO SERIES Acft SN 2846 Acft Dmg: SUBSTANTIAL Rpt Status: Prelim Prob Caus: Pending
Fatal 0 Ser Inj 0 Flt Conducted Under: FAR 091
Opr Name: KEITH M. ROXO Opr dba: Aircraft Fire: NONE

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# WPR17LA212	09/22/2017 2157 PDT	Regis# N34BE	Glendale, CA		
Acft Mk/Mdl MOONEY M20E-NO SERIES		Acft SN 1031	Acft Dmg: SUBSTANTIAL	Rpt Status: Prelim	Prob Caus: Pending
Eng Mk/Mdl LYCOMING IO360 SER			Fatal 0	Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: RYAN C HARSHMAN		Opr dba:		Aircraft Fire: NONE	
				AW Cert: STN	

Events

1. Enroute-cruise - Loss of engine power (total)
-

Narrative

On September 22, 2017, about 2157 Pacific daylight time, a Mooney M20E, N34BE, struck trees and collided with the ground in Glendale, California, following a loss of engine power. The private pilot and passenger sustained minor injuries and the airplane sustained substantial damage to the left wing and fuselage. The airplane was registered to Cleared Direct Aviation LLC., and operated by the pilot under the provisions of 14 Code of Federal Regulations (CFR) Part 91, as a personal flight. The cross-country flight departed Redlands Municipal Airport, Redlands, California, about 2130 with a planned destination of Bob Hope Airport, Burbank, California. Visual meteorological conditions prevailed and no flight plan had been filed.

After departing Redlands, the pilot configured the airplane for level cruise at 4,500 ft msl, direct to Burbank. The flight was uneventful, and as the airplane approached Burbank, the pilot began to initiate a descent to about 3,000 ft msl. He reached the Rose Bowl (11 miles east of Burbank) at 2152, and made the first radio call to Burbank control tower. The controller directed him to enter the left traffic pattern for a landing on runway 15.

About 90 seconds later, at an altitude of about 2,500 ft mean sea level (1,800 ft above ground level) the engine lost power. The pilot declared an emergency, and after scanning the instruments concluded that the engine was most likely experiencing a partial loss of power. He pitched the airplane for best glide speed, and began to perform trouble shooting procedures. The engine did not respond, and after referring to the display of his handheld electronic navigation device (which provided a glide distance radius) he concluded that he would not be able to make the runway. He then began to look for a suitable landing site, and because all highways and major streets were clogged with automobiles, he elected to land on the darkest street that he could see. As he approached the street, the left wing struck a tree, and the airplane spun around, coming to rest upright on the pavement at the parking entrance of an apartment complex.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# ERA18FA006	10/07/2017 1345 EDT	Regis# N90866	Front Royal, VA	Apt: Front Royal FRR
Acft Mk/Mdl PIPER PA 25-235-UNDESIGNAT		Acft SN 25-8156005	Acft Dmg: DESTROYED	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl LYCOMING O-540-B2C5		Acft TT 8265	Fatal 1 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: SKYLINE SOARING CLUB		Opr dba:		Aircraft Fire: GRD
				AW Cert: SPR

Events

1. Initial climb - Miscellaneous/other

Narrative

On October 7, 2017, about 1345 eastern daylight time, a Piper PA-25-235, N90866, was destroyed when it impacted terrain during initial climb from Front Royal-Warren County Airport (FRR), Front Royal, Virginia. The airline transport pilot was fatally injured. The airplane was operated by the Skyline Soaring Club as a glider-tow flight conducted under the provisions of 14 Code of Federal Regulations Part 91. Visual meteorological conditions prevailed and no flight plan was filed for the local flight.

According to the flight instructor in the glider that was being towed, he was providing an introductory glider flight to a passenger in the glider. The passenger was seated in the front seat and the instructor was seated in the rear seat. He stated that the takeoff from runway 28 was normal and he momentarily looked away from the tow airplane at a low altitude. When he looked back, he did not immediately see the airplane and then noted that it was below and to the right of the glider. Additionally, the flight instructor noticed slack in the cable attaching the glider to the airplane. He then released the cable, performed a 180° turn, and landed on runway 10 uneventfully. While approaching the runway, the flight instructor saw a fireball from where the airplane had been descending. Several witnesses at the airport stated that the takeoff appeared to be normal, but then the airplane pitched down, descended below the glider and turned right before impacting terrain.

The wreckage was consumed by a postcrash fire and located in the backyard of a residence, about 1,600 ft northwest of the departure end of runway 28. A small crater was observed in the grass, consistent with engine contact and fragments of the propeller were also located near the crater. The main wreckage came to rest upright, on a magnetic heading of 315°, about 65 ft north of the crater. The tow cable was also located along the debris path. The left main landing gear had separated and was located left of the main wreckage. The right main landing gear and tailwheel remained attached. All major components of the airplane were accounted for at the scene. The flaps and ailerons were located with their respective wing, but the wings were consumed by fire. Control cable continuity was confirmed from the left and right ailerons to the control stick in the cockpit. Continuity was also confirmed from the elevator and rudder to the control stick and rudder pedals, respectively. No readable instruments were recovered from the cockpit.

The engine separated from the airframe and was resting in front of it. The four wooden propeller blades separated from the hub and two of the propeller blade roots remained attached to the hub.

The single-seat, low-wing, fixed tailwheel airplane was manufactured in 1981. It was powered by a Lycoming O-540, 235-horsepower engine, equipped with a Hoffman four-blade, fixed-pitch wooden propeller. Review of the maintenance records revealed that the airplane's most recent annual inspection was completed on February 2, 2017. At that time, the airframe had accumulated about 8,265 total hours of operation and the engine had accumulated 468 hours since overhaul.

The pilot held an airline transport pilot certificate with a rating for airplane multiengine land. He also held a commercial pilot certificate with a rating for airplane single-engine land. Additionally, the pilot held a flight instructor certificate with ratings for airplane single-engine, airplane multiengine, and instrument airplane. His most recent Federal Aviation Administration second-class medical certificate was issued on October 1, 2015. At that time, the pilot reported a total flight experience of 11,953 hours.

The recorded weather at FRR, at 1355, was: wind from 230° at 10 knots, gusting to 15 knots; visibility 10 statute miles; clear sky; temperature 29° C; dew point 14° C; altimeter 30.01 inches of mercury.

The wreckage was retained for further examination. The flight instructor in the glider recorded a video of most of the flight. While the recording did not capture the actual impact of the airplane, it captured portions of the airplane's flight just prior to impact. A copy of the recording was forwarded to the NTSB Vehicle Recorders Laboratory, Washington, DC, for further examination.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# GAA17CA336	06/08/2017 1300 CDT	Regis# N4543R	Auburn, IN	Apt: Mooney Field 22IN
Acft Mk/Mdl PIPER PA 28-140		Acft SN 28-21248	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl LYCOMING O-320-E2A		Acft TT 2872	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: MOONEY, MICHAEL E.		Opr dba:		Aircraft Fire: NONE
				AW Cert: STN

Events

3. Takeoff - Runway excursion

Narrative

The pilot in the airplane reported that he attempted to take off from his turf airstrip. He attempted to force the airplane into the air and after a brief ascent the airplane descended to the ground and touched down hard. The pilot continued to the previous sequence until he determined that he would not be able to clear the trees at the end of the runway. He made a left turn, and the airplane traveled through a bean field, a hay field, and hit a ditch and collided with a barn. The airplane sustained substantial damage to both wings. Per the National Transportation Safety Board Pilot Aircraft Accident Report, the pilot reported that the accident could have been prevented, if he had aborted the takeoff after the first bounce the accident never would have happened.

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

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# CEN18LA008	10/06/2017 706 CDT	Regis# N4136D	Sugar Grove, IL	Apt: Aurora Muni ARR
Acft Mk/Mdl PIPER PA 34-220T-220T		Acft SN 3449101	Acft Dmg: SUBSTANTIAL	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl CONT MOTOR TSIO-360 SER			Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name:		Opr dba:		Aircraft Fire: NONE
				AW Cert: STN

Events

1. Initial climb - Loss of engine power (partial)
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Narrative

On October 6, 2017, about 0706 central daylight time, a Piper PA34-220T airplane, N4136D, sustained substantial damage during a forced landing in a corn field following a loss of engine power on its right engine. The pilot and passenger were not injured. The airplane received substantial damage to its fuselage, and both wings. The aircraft was registered to Echo Bravo LLC, and operated by the pilot under the provisions of 14 Code of Federal Regulations Part 91 as a personal flight. Instrument meteorological conditions prevailed for the flight, which operated on an instrument flight rules flight plan. The flight was originating from the Aurora Municipal Airport (ARR), near Sugar Grove, Illinois, and the Wichita Dwight D Eisenhower National Airport (ICT), Wichita, Kansas, was the intended destination.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# CEN17CA346	07/20/2017	1000 CDT	Regis# N192E	Logan, IA	Apt: N/a
Acft Mk/Mdl ROBINSON HELICOPTER COMPANY R44	Acft SN 10989			Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl LYCOMING IO-540				Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 137
Opr Name: AIRBOURN AVIATION LLC	Opr dba:				Aircraft Fire: NONE
					AW Cert: SPR

Events

1. Maneuvering-low-alt flying - Low altitude operation/event
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Narrative

The commercial pilot was performing an agricultural application flight, and completed two reconnaissance passes and orbit of the field he was about to spray. The pilot did not note any power lines that posed a danger for the flight. While maneuvering at a low altitude during a pass turn, the helicopter struck a wire that he did not see. After the helicopter struck the wire, the helicopter windscreen failed and the helicopter violently shook. The pilot entered an autorotation to the field, and the helicopter impacted terrain and came to rest on its right side. The helicopter sustained substantial damage to the fuselage, tail boom, and main rotor blades. The pilot reported no mechanical failures or malfunctions of the helicopter. The accident was reported to the National Transportation Safety Board on September 11, 2017.