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# National Transportation Safety Board - Aircraft Accident/Incident Database

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Accident Rpt# GAA17CA262 04/22/2017 0 MDT Regis# N245DK Park City, UT Apt: NA  
Acft Mk/Mdl BALONY KUBICEK SPOL SRO BB70Z-60 Acft SN 817 Acft Dmg: SUBSTANTIAL Rpt Status: Prelim Prob Caus: Pending  
Fatal 0 Ser Inj 0 Flt Conducted Under: FAR 091  
Opr Name: MILES HIGH INC DBA Opr dba: Aircraft Fire: NONE

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# National Transportation Safety Board - Aircraft Accident/Incident Database

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Accident Rpt# GAA17CA213	04/01/2017 1315 EDT	Regis# N672BA	Key Largo, FL	Apt: N/a
Acft Mk/Mdl ICON AIRCRAFT INC A5-NO SERIES	Acft SN 00010	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual	Prob Caus: Pending
Eng Mk/Mdl ROTAX 912 IS SPORT	Acft TT 129	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091	
Opr Name: ICON FLIGHT CENTER EAST	Opr dba: ICON AIRCRAFT	Aircraft Fire: NONE		
		AW Cert: LTSP		

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## Events

1. Landing - Hard landing
- 

## Narrative

The pilot of the amphibious airplane reported that during a no flap water landing, he noticed a higher descent rate than expected. He added that he applied full power to initiate a go-around, but the airplane landed hard on the water. The pilot and passenger egressed the airplane and were rescued without further incident.

The airplane sustained substantial damage to the fuselage.

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

The pilot reported that he believes the airplane encountered "a windshift/shear to a tailwind as [he] transitioned high to low for landing approach toward the [south-southwest]". A review of recorded data from the automated weather observation station located about 6 miles to the west of the accident site reported that about 17 minutes before the accident the wind was 090ø at 9 knots.

# National Transportation Safety Board - Aircraft Accident/Incident Database

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Accident Rpt# WPR17FA101	05/08/2017 908 PDT	Regis# N184BA	Lake Berryessa, CA	Apt: N/a
Acft Mk/Mdl ICON AIRCRAFT INC A5-NO SERIES	Acft SN 00007	Acft Dmg: SUBSTANTIAL	Rpt Status: Prelim	Prob Caus: Pending
Eng Mk/Mdl ROTAX 912		Fatal 2 Ser Inj 0	Flt Conducted Under: FAR 091	
Opr Name: ICON AIRCRAFT INC	Opr dba:		Aircraft Fire: NONE	
			AW Cert: LTSP	

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## Events

1. Maneuvering-low-alt flying - Abrupt maneuver
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## Narrative

On May 8, 2017, about 0908 Pacific daylight time, an amphibious light sport Icon Aircraft Inc. A5, N184BA, impacted terrain while maneuvering near Lake Berryessa, California. The commercial pilot and passenger were fatally injured, and the airplane sustained substantial damage. The airplane was registered to a private individual and operated by Icon Aircraft Inc., Vacaville, California, as a 14 Code of Federal Regulations Part 91 business flight. Visual meteorological conditions prevailed near the accident site about the time of the accident and no flight plan was filed. The local flight originated from the Nut Tree Airport (VCB), Vacaville, California, at 0852.

Representatives from Icon Aircraft reported that the pilot was conducting a new employee familiarization flight with the passenger, who was recently hired by the company. A witness, who was in a boat on Lake Berryessa, reported observing the accident airplane flying over the lake about 30 to 50 feet above the water, at what seemed to be a low speed. The witness stated that the airplane passed by their position and entered a nearby cove, traveling in a northerly direction. The witness heard the engine "rev up" as the airplane drifted to the right side of the cove. Subsequently, the airplane pitched upward and entered a left turn, just before it traveled beyond the witness's field of view. The witness stated that he heard the sound of impact shortly after losing visual site of the airplane.

Examination of the accident site revealed that the airplane impacted terrain and came to rest upright in the northern area of Little Portuguese Canyon on Lake Berryessa. All major structural components of the airplane were located at the accident site. The fuselage, right wing, and a portion of the empennage were located on the shoreline along a steep embankment, and the outboard portion of the left wing and left side of the empennage were partially submerged in water.

The wreckage 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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Accident Rpt# GAA17CA273 05/05/2017 1815 CDT Regis# N7854M Wellington, KS Apt: Wellington Muni EGT  
Acft Mk/Mdl ADRIAN GEORGE W EUROPA Acft SN A034 Acft Dmg: SUBSTANTIAL Rpt Status: Prelim Prob Caus: Pending  
Fatal 0 Ser Inj 0 Flt Conducted Under: FAR 091  
Opr Name: DANNY C. LACOSS Opr dba: Aircraft Fire: NONE

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# National Transportation Safety Board - Aircraft Accident/Incident Database

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Accident Rpt# GAA17CA198	10/29/2016 730 CDT	Regis# NONE	Blountstown, FL	Apt: Calhoun County F95
Acft Mk/Mdl AEROS 2		Acft SN 04705	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl ROTAX 912 ULS			Fatal 0 Ser Inj 1	Flt Conducted Under: FAR 091
Opr Name: PAUL CURRY		Opr dba:		Aircraft Fire: NONE
				AW Cert: NON

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## Events

1. Initial climb - Loss of control in flight

## Narrative

The noncertificated pilot of a weight-shift controlled trike reported that during the takeoff he was "fighting the wing." He added that the aircraft was about 30 feet above ground, when he "pulled on the control bar," the right wing rose, and the left wing dipped down. The aircraft subsequently impacted the terrain in a left wing down attitude to the left of the runway.

The center fuselage spar and wing sustained substantial damage.

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

The pilot added that the accident flight was his first flight in the unregistered trike. He added that he possessed no pilot certificate and had received no flight training prior to the accident flight. He reported that when he purchased the weight-shift controlled trike, the bill of sale indicated that the aircraft was an "ultralight."

According to the trike's operating manual, the aircraft specifications exceeded the maximum takeoff weight, fuel capacity, and seat limitations stated in 14 Code of Federal Regulations Part 103 for ultralight aircraft.

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# National Transportation Safety Board - Aircraft Accident/Incident Database

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Accident Rpt# GAA17CA258 05/04/2017 1520 EDT Regis# N991TC Stevensville, MD Apt: W29  
Acft Mk/Mdl AUTOGYRO CALIDUS Acft SN US-C00483 Acft Dmg: SUBSTANTIAL Rpt Status: Prelim Prob Caus: Pending  
Fatal 0 Ser Inj 0 Flt Conducted Under: FAR 091  
Opr Name: Opr dba: Aircraft Fire: NONE

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# National Transportation Safety Board - Aircraft Accident/Incident Database

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Accident Rpt# GAA17CA259	05/04/2017 1739	Regis# N514CL	Spanish Fork, UT	Apt: Spanish Fork-springville-woodh U77
Acft Mk/Mdl CURTIS LUND VORTEX-NO SERIES		Acft SN CL001	Acft Dmg: DESTROYED	Rpt Status: Prelim Prob Caus: Pending
			Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: CURTIS LUND		Opr dba:		Aircraft Fire: GRD

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# National Transportation Safety Board - Aircraft Accident/Incident Database

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Accident Rpt# CEN16LA219	06/06/2016 1730 CDT	Regis# N8CX	Decatur, TX	Apt: N/a
Acft Mk/Mdl FLOHR DAVID J R 80 TIGER MOTH-NO S	Acft SN TM36	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual	Prob Caus: Pending
Eng Mk/Mdl CONT MOTOR C90-14F	Acft TT 2983	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091	
Opr Name: DONALD R. GLITTENBERG	Opr dba:	Aircraft Fire: NONE		
		AW Cert: SPE		

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## Events

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

On June 6, 2016, about 1730 central daylight time, an amateur built Flohr David J R-80 Tiger Moth airplane, N8CX, nosed down during an off airport forced landing in Decatur, Texas, following a loss of engine power. The airline transport rated pilot was not injured. The airplane was substantially damaged. The airplane was registered to a private individual and was operated under the provisions of 14 Code of Federal Regulations Part 91 as a personal flight. Visual meteorological conditions prevailed for the flight and no flight plan was filed. The local flight originated from the Lazy G Bar Ranch Airport (90T), Decatur, Texas.

The pilot reported he was flying at an altitude of about 500 ft above the ground over his ranch when the accident occurred. He stated he smelled something burning and about 15 seconds later, the engine lost all power and the propeller stopped spinning. The airplane hit a ditch and nosed over during the forced landing resulting in substantial damage to both lower wings.

The pilot reported the previous owner of the airplane had installed a Facet 150 electric boost pump to increase the fuel flow. The pilot examined the engine after the accident and stated the inline electric boost pump overheated, burned, and shut down the fuel supply to the engine.



# National Transportation Safety Board - Aircraft Accident/Incident Database

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Accident Rpt# CEN17LA066	12/31/2016 740 CST	Regis# N120CG	Lee's Summit, MO	Apt: N/a
Acft Mk/Mdl GOSSELIN CHARLES GLASTAR		Acft SN 5681	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl SUBARU EJ-22		Acft TT 289	Fatal 0 Ser Inj 1	Flt Conducted Under: FAR 091
Opr Name: GOSSELIN CHARLES M		Opr dba:		Aircraft Fire: NONE

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## Events

1. Enroute-climb to cruise - Electrical system malffailure

## Narrative

On December 31, 2016, about 0740 central standard time, an amateur-built Gosselin Glastar airplane, N120CG, was substantially damaged during a forced landing near Lee's Summit Municipal Airport (KLXT), Lee's Summit, Missouri. The private pilot sustained serious injury. The personal flight was conducted under the provisions of 14 Code of Federal Regulations Part 91. Visual meteorological conditions prevailed and no Federal Aviation Administration (FAA) flight plan had been filed for the flight. The flight had departed LXT about 0730 and was en route to Miami County Airport (K81), Paola, Kansas.

According to the written statement provided by the pilot, his preflight inspection did not identify any problems. While attempting to start the airplane engine with the "A ignition system" the engine would turn over but would not start. The pilot switched to the "B ignition system" and had the same result. The pilot used a portable battery to "jump start" the engine; the engine started and ran within normal parameters. During the engine run-up, prior to takeoff, the parameters continued to indicate normal and the voltage indicated 14.2 volts. Several minutes after departure, the engine lost power. The pilot vaguely recalled trying to restore engine power but did not recall any of the events that followed.

According to the FAA inspector who responded to the accident, during the forced landing the tailwheel struck the ground first followed by the main landing gear. The fuselage and both wings were substantially damaged during the impact.

The airframe, engine, and related systems were examined under the auspices of the responding FAA inspector. The airframe was equipped with an "A", "B", and "AB" battery system; however, the batteries were in series and not parallel. The operation of the engine, fuel system, and electronic fuel injection system was dependent on electrical power from both batteries. The examination revealed that one battery had a short and would not take a charge. When that battery was replaced with a known serviceable battery, the fuel boost pumps, and alternator functioned as designed.

# National Transportation Safety Board - Aircraft Accident/Incident Database

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Accident Rpt# ANC16FA065	09/10/2016	1630 AKD	Regis# N62905	Anchorage, AK	Apt: N/a
Acft Mk/Mdl HEFTY POLAR CUB			Acft SN 0001	Acft Dmg: DESTROYED	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl LYCOMING O-320-A2A				Fatal 1 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: CURT HEFTY			Opr dba:		Aircraft Fire: GRD
					AW Cert: SPE

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## Summary

The private pilot departed in his float-equipped, experimental, amateur-built airplane during day visual meteorological conditions. According to a friend of the pilot, the purpose of the flight was to fly over a proposed hunting site and then return.

About 90 minutes later, multiple witnesses saw the airplane complete two, low-level, high-speed, 360° right turns over a residential neighborhood. The witnesses said that the airplane's first 360° turn was accomplished at an altitude between 150 and 200 ft above ground level, but the second turn was much lower. Witnesses near the accident site reported that, as the airplane completed the second, steep, 360° turn, the nose of the airplane pitched down, and the airplane began a rapid nose-down descent. The engine rpm then increased significantly, and the wings rolled level just before the airplane impacted a stand of tall trees adjacent to a home. The airplane subsequently descended onto a neighborhood road and came to rest inverted. A postcrash fire ensued about 30 seconds after impact, which quickly engulfed the entire airplane.

According family members and close friends, this was highly unusual behavior for this pilot.

Postaccident examination of the airplane's exhaust system revealed that the muffler can assembly was cracked around most of its circumference near the inlet portion of the muffler, which would have allowed exhaust gases to enter the cockpit/cabin. Toxicology tests revealed 48% carboxyhemoglobin (carbon monoxide) in the pilot's blood. The pilot was a nonsmoker, and nonsmokers normally have no more than 3% carboxyhemoglobin. The pilot's cause of death was extensive blunt force trauma including lacerations of the aorta, heart, and liver, and there was no soot found in his trachea. Although there was a postimpact fire, given the extensive blunt force injuries the pilot sustained and the lack of soot in his trachea, it is likely that the pilot's elevated carboxyhemoglobin level was from acute exposure to carbon monoxide during the 90-minute flight and not from postimpact fire.

Carboxyhemoglobin levels between 10% and 20% can result in confusion, impaired judgment, and difficulty concentrating, and the pilot's 48% carboxyhemoglobin level likely resulted in severe impairment.

No aircraft maintenance records were located for the airplane, which the pilot had built in 1996, so it is unknown when the muffler was last inspected or maintained. Additionally, due to the extensive postimpact fire, it was not possible to determine if the airplane was equipped with any type of carbon monoxide detection equipment. According to friends of the pilot, he conducted all maintenance on the airplane.

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## Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's severe impairment from carbon monoxide poisoning in flight, which resulted in a loss of control and a subsequent collision with trees and terrain.

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## Events

1. Maneuvering - Loss of control in flight
2. Uncontrolled descent - Collision with terr/obj (non-CFIT)

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## Findings - Cause/Factor

1. Personnel issues-Physical-Impairment/incapacitation-Carbon monoxide-Pilot - C
2. Aircraft-Aircraft power plant-Engine exhaust-(general)-Damaged/degraded - C
3. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Altitude-Not attained/maintained - C

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## Narrative

### HISTORY OF FLIGHT

On September 10, 2016, about 1630 Alaska daylight time, a float-equipped, experimental amateur-built, Hefty Polar Cub airplane, N62905, was destroyed following a loss of control and subsequent impact with tree-covered terrain in a residential neighborhood in Anchorage, Alaska. The private pilot, the sole occupant, was fatally injured. The airplane was registered to and operated by the pilot as a personal local flight under the provisions of 14 Code of Federal Regulations Part 91. Visual meteorological conditions prevailed, and no flight plan was filed. The flight reportedly originated in southwest Anchorage from Jewell Lake about 1500, but the actual departure time and flight route are unknown.

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# National Transportation Safety Board - Aircraft Accident/Incident Database

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According to family and friends of the pilot, the purpose of the flight was to fly over a proposed hunting site near Willow, Alaska, and then return to Anchorage. The friend related that the pilot and a group of friends were planning a fly-in hunt later in the week.

During on-scene interviews conducted by the National Transportation Safety Board (NTSB) investigator-in-charge (IIC) on the day of the accident, multiple witnesses consistently reported that they observed the airplane complete two, low-level, high-speed, 360° right turns over a residential neighborhood. The witnesses said that the airplane's first 360° turn was accomplished at an altitude between 150 and 200 ft above ground level, but the second turn was much lower. One homeowner stated that, as the airplane passed over his home, it was about 50 ft above his roofline. The witnesses also reported that the airplane's bank angle increased significantly on the second 360° right turn. One pilot-rated witness estimated that the airplane's bank angle was in excess of 60° during the second 360° turn. Multiple witnesses reported hearing the airplane's engine operating in a manner consistent with high power settings throughout both 360° turns.

Witnesses near the accident site reported that, as the airplane completed the second, steep, 360° right turn, the nose of the airplane pitched down, and it began a rapid nose-down descent. The engine rpm then increased significantly, and the wings rolled level just before the airplane impacted a stand of tall trees adjacent to a home. During the collision sequence, the airplane's floats were severed, and the airplane subsequently descended onto a neighborhood road, coming to rest inverted. A postimpact fire ensued about 30 seconds after impact, which quickly engulfed the entire airplane.

During a brief on scene interview with the NTSB IIC, a family member, along with a friend of the pilot, both reported that it was highly unusual and uncharacteristic behavior for the pilot to be flying as witnesses described.

## PERSONNEL INFORMATION

The pilot, age 75, held a private pilot certificate with an airplane single-engine land rating; he did not hold a single-engine sea rating. In addition, he held a Federal Aviation Administration (FAA) repairman certificate specifically for the accident airplane. The pilot's most recent third-class, special issuance medical certificate, was issued on May 23, 2007, and contained the limitation: "Not valid for any class after May 31, 2008."

On the pilot's application for medical certificate, dated May 23, 2007, he indicated that his total aeronautical experience was about 2,200 flight hours. No personal flight records were located for the pilot.

## AIRCRAFT INFORMATION

The airplane, which bears a resemblance to a Piper PA-11, had a rectangular, welded steel-tube structure that was covered with fabric. The wings, rudder, and horizontal stabilizer were all fabric covered. At the time of the accident, the airplane was equipped with a set of EDO 2000-series floats.

According to archived documents on file with the FAA certification office located in Oklahoma City, the airplane was built by the pilot from a set of purchased plans and was issued an FAA experimental airworthiness certificate with operating limitations on May 22, 1996. At the time the airworthiness certificate was issued, the airplane was equipped with a Continental Motors C-90-12-F engine.

At the time of the accident, the airplane was equipped with a Lycoming O-320-A2A engine, serial number L-9126-27, and a Catto composite propeller. No installation documentation for either the engine or propeller was located.

No aircraft maintenance records were located for the accident airplane. According to family members of the pilot, the airframe and engine logbooks were likely on board the airplane at the time of the accident. According to a family friend, the accident pilot performed all of the maintenance on the accident airplane.

## METEOROLOGICAL INFORMATION

The closest official weather observation station to the accident site was located at the Ted Stevens Anchorage International Airport, about 10 miles to the east. On September 10, 2016, at 1553, the station was reporting, in part: wind 230° at 4 knots; visibility 10 statute miles; ceiling and clouds, few at 2,500 ft; temperature 63° F; dew point 43° F; altimeter 30.14 inches of mercury.

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## WRECKAGE AND IMPACT INFORMATION

Responding fire department and police personnel reported that, upon arrival, they discovered the inverted and burning wreckage on a neighborhood road, which was surrounded by tall trees. All of the airplane's major components were found at the main wreckage site. The airplane's longitudinal axis was oriented on a heading of 035ø magnetic. Flight control continuity was established from the respective flight controls to the cabin area.

The airplane's first impact point was a stand of tall spruce trees about 120 ft from the wreckage point of rest. Broken tree branches and small portions of aircraft fabric that remained in the treetops marked the area.

The next impact point was a second stand of tall trees about 100 ft from the wreckage point of rest. The airplane's two EDO 2000-series floats were found entangled and suspended in the stand of tall trees.

The right wing was displaced slightly aft of its normal orientation to the fuselage, and the fabric on the underside of the wing was burned away. The aileron and flap remained attached to the wing, and the right flap appeared to be up. The leading edge of the right wing was slightly crushed and flattened in an aft direction, from about midspan to the wingtip. The inboard end of the wing and the right fuel tank were fire damaged.

The left wing was displaced aft about 45ø from its normal orientation to the fuselage, and most of the fabric had burned away. The aileron and flap remained attached to the wing, and the left flap appeared to be up. The leading edge at the outboard end of the wing was flattened and crushed aft, with downward curling of the wingtip. The inboard end of the wing was extensively fire damaged, and the left fuel tank was incinerated.

The entire cockpit, baggage area, and fuselage extending to the vertical stabilizer were consumed by fire. Both wing lift struts remained attached to their respective wing and fuselage attach points.

The propeller hub assembly remained connected to the engine crankshaft, but the composite propeller blades were obliterated due to impact damage. The engine had impact and fire damage to the underside and front portion. Continuity of the drive train was established at the tachometer drive fitting on the accessory case when the propeller hub was moved by hand. The engine's four spark plugs were examined and were dry with no unusual combustion signatures. The carburetor received impact damage. The engine control cables were either attached, or broken, at their respective carburetor control arms.

## MEDICAL AND PATHOLOGICAL INFORMATION

A postmortem examination of the pilot was conducted under the authority of the Alaska State Medical Examiner, Anchorage, Alaska. The cause of death for the pilot was attributed to blunt force injuries. The autopsy also identified extensive lacerations of the aorta, heart, and liver. There was no soot identified in the tracheobronchial tree.

The FAA Bioaeronautical Sciences Research Laboratory performed toxicological examinations, which revealed 48% carboxyhemoglobin (carbon monoxide) in the pilot's blood. Additionally, amlodipine, metoprolol, naproxen, and rosuvastatin were detected in the pilot's blood and urine.

Carbon monoxide is an odorless, tasteless, colorless, nonirritating gas formed by hydrocarbon combustion. Carbon monoxide binds to hemoglobin with much greater affinity than oxygen, forming carboxyhemoglobin; elevated levels result in impaired oxygen transport and utilization. Early symptoms of carbon monoxide exposure may include headache, malaise, nausea, and dizziness. Carboxyhemoglobin levels between 10% and 20% can result in confusion, impaired judgment, and difficulty concentrating.

Nonsmokers may normally have up to 3% carboxyhemoglobin in their blood; heavy smokers may have levels of 10% to 15%. Family members and friends reported that the pilot was a nonsmoker.

Amlodipine is a prescription blood pressure medication also called Norvasc. Metoprolol is a beta blocking prescription medication, often called Lopressor or Toprol, that is used to treat high blood pressure and to prevent heart attacks in patients with coronary artery disease. Naproxen is an anti-inflammatory analgesic available over the counter with a variety of names, including Aleve. Rosuvastatin is a prescription medication to treat high cholesterol and is commonly marketed with the name Crestor. None of these medications adversely affect performance.

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According to the NTSB chief medical officer's review of the pilot's autopsy and medical records obtained from the Veteran's Administration Hospital, Joint Base Elmendorf-Richardson, Anchorage, he had a history of hypertension, high cholesterol, coronary artery disease, and bladder neck obstruction. A copy of the NTSB' chief medical officer's factual report is available in the public docket for this accident.

## TESTS AND RESEARCH

On December 2, 2016, after being notified by the FAA's Bioaeronautical Sciences Research Laboratory of the elevated level of carboxyhemoglobin in the pilot's blood, the NTSB IIC recovered the accident airplane's exhaust system for a detailed examination. The airplane's exhaust system consisted of a muffler covered by an exterior shroud assembly that provided ducted heat to the airplane's cockpit, cabin, and engine carburetor heat system. During the exhaust system examination, the NTSB IIC peeled open the shroud assembly, which revealed a severely degraded and damaged muffler can assembly. The muffler can was cracked around most of its circumference near the inlet portion of the muffler. The entire muffler assembly was then sent to the NTSB's Materials Laboratory for further examination.

The examination revealed that portions of the muffler can material were missing and that areas adjacent to the missing material had white, oxidized exhaust deposits. Cracks and corrosion on the interior surface of the exterior shroud in an area under a riveted doubler were also seen. A copy of the NTSB's Materials Laboratory Factual Report is included in the public docket for this accident.

## ADDITIONAL INFORMATION

FAA Advisory Circular (AC) 91-59A, "Inspection and Care of General Aviation Aircraft Exhaust Systems," emphasizes the safety hazards of poorly maintained aircraft exhaust systems and highlights points at which exhaust system failures occur. In addition, the AC stresses the importance of having carbon monoxide detection equipment installed. Due to the extensive postcrash fire damage to the airplane, the NTSB was unable to determine if the accident airplane was equipped with any type of carbon monoxide detection equipment.

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# National Transportation Safety Board - Aircraft Accident/Incident Database

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Accident Rpt# GAA17CA272	05/07/2017	0 CDT	Regis# N458V	Chesterfield, MO	Apt: Spirit Of St Louis SUS
Acft Mk/Mdl JOHN MURPHY JSX-2-NO SERIES			Acft SN 004	Acft Dmg: SUBSTANTIAL	Rpt Status: Prelim Prob Caus: Pending
				Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: MURPHY JOHN R TRUSTEE			Opr dba:		Aircraft Fire: NONE

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# National Transportation Safety Board - Aircraft Accident/Incident Database

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Accident Rpt# GAA17CA269 05/06/2017 2045      Regis# N47KJ      Spanish Fork, UT      Apt: Spanish Fork-springville-woodh U77  
Acft Mk/Mdl JOHNSON KENNETH SUPER CUB      Acft SN 471D      Acft Dmg: SUBSTANTIAL      Rpt Status: Prelim      Prob Caus: Pending  
Fatal 0      Ser Inj 0      Flt Conducted Under: FAR 091  
Opr Name: BROWN, WALLACE A.      Opr dba:      Aircraft Fire: NONE

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