

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# GAA17CA084	11/23/2016 1415 CST	Regis# N155WB	Pensacola, FL	Apt: Ferguson 82J
Acft Mk/Mdl AMERICAN LEGEND AIRCRAFT CO	Acft SN AL-1172	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual	Prob Caus: Pending
Eng Mk/Mdl CONTINENTAL O-200-D4B	Acft TT 1141	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091	
Opr Name: JAMES E. WILSON	Opr dba:	Aircraft Fire: NONE		AW Cert: LTSP

Summary

The student pilot reported that he inadvertently pressed down on the right brake during the landing roll. The airplane veered off the runway to the right into soft grass and nosed over.

The airplane sustained substantial damage to the right wing lift strut and empennage.

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

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The student pilot's incorrect brake application during the landing roll, which resulted in a loss of directional control.

Events

1. Landing-landing roll - Loss of control on ground
2. Landing-landing roll - Runway excursion
3. Landing-landing roll - Nose over/nose down

Findings - Cause/Factor

1. Personnel issues-Task performance-Use of equip/info-Use of equip/system-Student/instructed pilot - C
2. Personnel issues-Task performance-Use of equip/info-Aircraft control-Student/instructed pilot - C
3. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Directional control-Not attained/maintained - C
4. Aircraft-Aircraft systems-Landing gear system-Brake-Incorrect use/operation - C
5. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Surface speed/braking-Incorrect use/operation - C
6. Environmental issues-Physical environment-Runway/land/takeoff/taxi surface-Soft surface-Contributed to outcome

Narrative

The student pilot reported that he must have inadvertently pressed down on the right brake during the landing roll. The airplane veered off the runway to the right into soft grass and nosed over.

The airplane sustained substantial damage to the right wing lift strut and empennage.

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

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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

Summary

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 that 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 believed 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 west of the accident site reported that, about 17 minutes before the accident, the wind was from 090ø at 9 knots.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's failure to maintain a proper descent rate during the approach, which resulted in a hard landing.

Events

1. Landing - Hard landing

Findings - Cause/Factor

1. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Descent/approach/glide path-Not attained/maintained - C
2. Personnel issues-Task performance-Use of equip/info-Aircraft control-Pilot - C
3. Personnel issues-Action/decision-Action-Delayed action-Pilot
4. Environmental issues-Conditions/weather/phenomena-Wind-Tailwind-Effect on operation

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.

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Accident Rpt# CEN17LA205	05/26/2017 1720 EDT	Regis# N604KA	Portland, IN	Apt: Portland Municipal PLD
Acft Mk/Mdl AMSTUTZ CURTIS J BD-5B		Acft SN 1	Acft Dmg: SUBSTANTIAL	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl HIRTH 3203E		Acft TT 6	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: AMSTUTZ CURTIS J		Opr dba:		Aircraft Fire: NONE
				AW Cert: SPE

Events

2. Approach-VFR pattern base - Loss of engine power (total)

Narrative

On May 26, 2017, at 1720 eastern daylight time, an Amstutz BD-5B amateur built airplane, N604KA, was involved in an off airport forced landing, following a loss of engine power in Portland, Indiana. The pilot was not injured. The airplane was substantially damaged. The airplane was registered to and operated by an individual under the provisions of 14 Code of Federal Regulations Part 91 as an engineering test flight. Visual meteorological conditions prevailed for the flight, which was not operated on a flight plan. The local flight originated from the Portland Municipal Airport (PLD), Portland, Indiana, at 1650.

The pilot reported the airplane had about 6 flight hours since he completed building it and the purpose of the flight was to obtain rate of climb data. Following the 6th climb, while at an altitude of 3,500 ft above mean seal level, the engine began to run rough. The pilot entered a left downwind and descended for a landing approach. The pilot reported he switched fuel tanks and performed a magneto check, neither of which corrected the engine roughness. As he turned onto base leg, the engine lost all power. The pilot realized he was not going to be able to make it to the runway, so he selected a field in which to land. The field was soft from recent rain and it contained 3 ft tall vegetation. About 170 feet into the landing roll, the landing gear collapsed and the airplane ground looped before coming to rest.

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Accident Rpt# ERA15FA221	05/23/2015 921 EDT	Regis# N42BR	West Columbia, SC	Apt: Columbia Metropolitan Airport CAE
Acft Mk/Mdl BR LEGEND LLC TURBINE LEGEND		Acft SN 127	Acft Dmg: DESTROYED	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl WALTER M601D		Acft TT 428	Fatal 1 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: BR LEGEND LLC		Opr dba:		Aircraft Fire: NONE
				AW Cert: SPE

Summary

The commercial pilot departed on a cross-country flight in the experimental, amateur-built, turboprop airplane. About 3 minutes after takeoff, the pilot initiated a return to the departure airport. About 6.8 nautical miles (nm) from the runway, at an altitude of about 6,500 ft mean sea level, the pilot declared an emergency, stating that he had "lost" the engine. Shortly thereafter, he informed air traffic control that the airplane had experienced a loss of fuel pressure. Witnesses saw the airplane collide with a tree and subsequently impact a pond about 1.2 nm from the runway. They reported no engine sound.

Examination of the airplane revealed no evidence of preimpact failures or malfunctions of the flight controls that would have precluded normal operation. The landing gear and flaps were found retracted. There was no evidence of preimpact failure or malfunction of the engine core. The engine-driven fuel pump showed signs of internal cavitation, while the auxiliary fuel pump, which provided fuel under pressure to the engine-driven fuel pump, flowed nearly 48% less than specified by the manufacturer, and had an inconsistent/intermittent laboring sound during testing. Disassembly revealed an improperly-installed fitting, which resulted in the decreased fuel flow rate, a loss of fuel pressure, and a subsequent engine flame-out. Inspection also revealed that a component of the fuel pump had been replaced after manufacture, but there was no record of this maintenance in the airplane's logbooks.

While it was not known if the pilot attempted to perform an air restart of the engine, a worn ignitor box and ignitor plug may have precluded a successful restart of the engine.

Although the pilot descended the airplane at its published best glide airspeed in his attempt to return to the airport, because the airplane was not equipped with an electrically-operated feathering pump, the propeller blade angle remained where it was set when the engine flame-out occurred, which was likely flat pitch. The flat pitch of the propeller blades significantly decreased the airplane's engine-out glide ratio. Had the pilot promptly feathered the propeller blades to reduce drag following engine flame-out, or had the airplane been equipped with a feathering pump, it is likely the airplane would have been able to reach the intended runway and land uneventfully.

Although an enlarged heart was noted during the autopsy and toxicological testing detected quinine, given that the pilot was actively controlling the airplane just before the accident, there is no evidence that a medical condition or use of quinine contributed to the pilot's inability to fly the airplane.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: An engine flame-out due to fuel starvation as the result of an improperly-installed auxiliary fuel pump fitting, and the pilot's failure to promptly feather the propeller following the engine-flame out, which resulted in decreased glide capability and impact with terrain. Contributing to the accident was the pilot's operation of the airplane with no emergency electric propeller feathering system.

Events

1. Initial climb - Fuel related
2. Initial climb - Fuel starvation
3. Emergency descent - Off-field or emergency landing
4. Maneuvering-low-alt flying - Collision with terr/obj (non-CFIT)

Findings - Cause/Factor

1. Aircraft-Aircraft systems-Fuel system-Fuel pumps-Incorrect service/maintenance - C
2. Aircraft-Fluids/misc hardware-Fluids-Fuel-Not specified - C
3. Personnel issues-Action/decision-Action-Delayed action-Pilot - C
4. Aircraft-Aircraft propeller/rotor-Propeller system-Propeller feather/reversing-Not used/operated - C
5. Aircraft-Aircraft propeller/rotor-Propeller system-Propeller feather/reversing-Not installed/available - F

Narrative

HISTORY OF FLIGHT

On May 23, 2015, about 0921 eastern daylight time, an experimental, amateur-built Turbine Legend, N42BR, collided with trees and a pond about 1.2 nautical

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miles (nm) west of Columbia Metropolitan Airport (CAE), West Columbia, South Carolina. The airplane was destroyed and the commercial pilot was fatally injured. The airplane was registered to BR Legend, LLC and privately operated. Visual meteorological conditions prevailed at the time, and a visual flight rules (VFR) flight plan was filed for the 14 Code of Federal Regulations Part 91 personal flight, which originated about 7 minutes earlier from CAE, and was destined for Asheville Regional Airport (AVL), Asheville, North Carolina.

Air traffic control (ATC) radar and voice communication information indicated that the pilot was cleared to taxi to runway 11 and was provided a VFR clearance. He subsequently contacted the local controller and advised he was ready to depart. At 0913:27, the controller cleared the flight for takeoff and instructed the pilot to turn left heading 050ø, which he acknowledged. Shortly after takeoff, ATC communications were transferred to departure control.

The flight was radar-identified at 0914:56, and the pilot was instructed to turn left on course toward the destination airport. The pilot acknowledged the transmission and proceeded in a north-northwesterly direction until 0917:26, at which time the airplane turned left from its on-course heading and continued to climb. At 0917:56, the pilot declared a mayday, advising the controller that he, ".lost ah my engine." About this time, the airplane was 6.8 nm from the approach end of runway 11 and about 6,500 ft mean sea level (msl). Immediately after the mayday call, the controller asked what aircraft was declaring an emergency, to which pilot replied with the partial call sign and that he was, "trying to make it back to the field." Following the mayday transmission, the pilot turned to a southerly heading.

The controller advised the pilot to enter the left base leg of the airport traffic pattern for runway 11, provided the altimeter setting, and indicated the wind was calm. Coordination between the Radar North controller and the local controller occurred, and at 0918:41, the Radar North controller advised the pilot that CAE was at his 10-to-9 o'clock position and 6 miles, and asked him if the airport was in sight, but the pilot did not reply. About 10 seconds later, the Radar North controller inquired, "and uh 42BR Columbia" to which the pilot replied, "Roger I have it in sight I think I can make it." The controller then instructed the pilot to make a straight-in approach to runway 11, and about 0919:02, the pilot advised the controller that he ".lost my fuel pressure."

The pilot was cleared to land twice; however, he did not reply to either clearance, nor did he establish contact with the local controller. At 0921:06, the Radar North controller asked the local controller if she could see the airplane, to which the local controller responded that the airplane was on short final and she was giving the green light-gun signal to land.

Witnesses reported seeing the airplane impact trees and then a pond; they did not hear any sound from the engine. Three witnesses saw the airplane bank left, and one of those said the airplane pitched up just before it struck the tree. None of the witnesses saw any smoke or fire trailing the airplane.

PERSONNEL INFORMATION

The pilot, age 85, held a Federal Aviation Administration (FAA) commercial pilot certificate with ratings for airplane single and multi-engine land, and instrument airplane. He was issued a second-class medical certificate on February 5, 2015, with a limitation requiring the use of corrective lenses. On the application for his last medical certificate, the pilot reported 10,000 hours total flight experience. Based on maintenance records, it was estimated that the pilot had accumulated about 430 hours in the accident airplane.

Family members reported that the pilot was in excellent health and did not take any medication.

AIRCRAFT INFORMATION

The airplane was manufactured in 2003. The special airworthiness certificate was issued by an FAA Designated Airworthiness Representative (DAR), who also assisted the pilot with building a portion of the airplane. It was powered by a Walters M601D turbine engine that was equipped with a three-bladed Avia V508E-AG/99B/A constant speed, variable pitch, manual feathering, dual-acting, hydraulically-controlled propeller. Propeller blade angle was controlled from the cockpit by a lever that connected via cable to a dual-acting propeller governor, although the feathering circuit at the propeller governor was blanked off with a plate and not available. The airplane was not equipped with an electrically-actuated feathering pump. Although propeller counterweights helped to increase pitch of the propeller blades in the event of oil system failure, they were ineffective in feathering the blades when the propeller was spinning at low rpm due to insufficient centrifugal force generated.

According to the engine maintenance records, the last condition inspection in accordance with the FAA-Approved Turbine Legend Maintenance and Inspection Program was completed on November 29, 2014 at an airplane total time of 428.2 hours. Further review of the maintenance records revealed no entry related to

removal of a feathering pump or installation of a plate on the feathering pump circuit at the propeller governor.

The airplane's fuel system consisted of one integral fuel tank spanning the entire length of the wing, with a fuel filler cap at each wingtip; the standard tank configuration held about 100 gallons. Fuel was gravity-fed from each wing into a sump located on the bottom surface of the wing on the airplane centerline. Attached to the outlet fitting of the sump tank was a manually-activated shutoff valve, which connected via aluminum tubing and a flexible hose to an electrically-controlled auxiliary fuel pump. The outlet of the auxiliary fuel pump connected via a flexible hose to a canister fitted with a pleated paper element and a "T" fitting for reading fuel pressure, then via a flexible hose from the filter to the engine-driven fuel pump.

METEOROLOGICAL INFORMATION

The 0856 surface observation at CAE indicated wind variable at 3 knots, 10 statute miles visibility, and clear skies. The temperature and dew point were 19 and 12ø C, respectively, and the altimeter setting was 30.39 inches of mercury.

FLIGHT RECORDERS

The airplane was equipped with digital instruments that recorded engine parameters, including compressor speed (N1), propeller speed (N2), Torque, inter-turbine temperature (ITT), Oil Pressure/Temperature, and Fuel Level. The instruments were retained and submitted to the NTSB's Vehicle Recorder Division located in Washington, D.C.

The instruments contained data from the last power cycle, and parameters were shown in relation to elapsed time since the application of power to the instrument. Three recorded values were noted for oil pressure and oil temperature at 236 seconds, 472 seconds, and 708 seconds. The oil pressure values were 17 pounds per square inch (psi), 34 psi, and 31 psi; the oil temperature values were 15ø C, 49ø C, and 57ø C, respectively. Torque values at 218 seconds, 436 seconds, and 654 seconds were 14%, 78%, and 17%, respectively. Three values for ITT were recorded at 217 seconds, 434 seconds, and 651 seconds: 485ø C, 620ø C, and 410ø C, respectively. There was only one recorded value for N1(58.4%) and N2 (1950 rpm), which was logged at 163 seconds.

The pilot's first contact with ground control before taxi occurred at 0909:37, and the airplane was last visually spotted by ATC personnel at 0921:07, resulting in an elapsed time of 690 seconds. However, no correlation to real time could be made, because the time between engine start and the pilot's first contact with ground control could not be determined.

According to the engine manufacturer representative, comparing the recorded data with established limits of the engine revealed that all recorded readings for oil pressure and the last two readings for oil temperature were within specified limits. The last two recorded ITT and torque readings were consistent with an engine at flight idle.

WRECKAGE AND IMPACT INFORMATION

The airplane crashed in a pond located adjacent to houses in a residential area. The wreckage was recovered and transferred to a hangar located at Lexington County Airport at Pelion (6J0), Pelion, South Carolina.

According to first responders and FAA personnel, the empennage was partially submerged in the water and was in an inverted position, with the airplane's nose on a magnetic heading of 032ø. The wreckage location was about 1.24 nm and 279ø from the approach end of runway 11 and about 600 ft south of the runway's final approach path.

Further examination of the accident site area revealed no damage to unmarked powerlines located adjacent to the pond. A strong smell of jet fuel and fuel sheen were noted on the west end of the pond. Damage to the top of a pine tree was noted about 70 ft above ground level; the top of the tree was observed in the water adjacent to the tree. Pieces of curved acrylic material were at the base of the tree, and pieces of composite material were in the water at the west end of the pond. There was no evidence of any tree limbs cut by the propeller blades.

Examination of the wreckage following recovery accounted for all primary and secondary flight controls. The one-piece wing was separated from the impact-damaged fuselage. The vertical and horizontal stabilizers remained attached, and the primary and secondary flight control surfaces remained attached to their respective attach points. With the rudder placed in the neutral position, the rudder trim tab was trailing edge left (tail left); with the elevator in the neutral

position, the trim tab was positioned trailing edge up (tail up). Damage to the right horizontal stabilizer was noted on the outboard portion. The engine remained attached to the airframe by the engine mount and the propeller was separated from the engine. There was no evidence of fire.

Examination of the wing revealed extensive impact damage, including fracture of the forward and aft spars of the left wing about 5 ft outboard of the landing gear attachment, and fracture of the aft spar of the right wing. Impact damage was also noted to the left and right ailerons and flaps. The right main landing gear was retracted, and the left main landing gear was extended, although the FAA inspector reported it was retracted when the airplane was recovered. The center section of the wing revealed the flap actuator remained attached to the aft side of the main spar and to the flap torque tube. Continuity was confirmed from the flap torque tube to the control surface for the left flap, but the right flap push/pull rod exhibited bending overload at the rod end. The flaps appeared retracted. The fuel vents of both integral wing tanks were clear of obstructions.

Examination of the flight controls for pitch and yaw revealed both tandem seat controls remained connected and continuity was confirmed from each respective control surface to the cockpit controls. Examination of the aileron flight controls revealed rod ends remained connected for the left and right aileron attachments at the control stick, but both rod ends exhibited bending overload. The left aileron push/pull tube exhibited bending overload outboard of the landing gear location and about 12 inches inboard of the bellcrank near the control surface, but was continuous from the bellcrank to the control surface. The right aileron push/pull tube was continuous from the fracture near the control stick to the aileron control surface.

Examination of the cockpit revealed the lap belt and shoulder harness of the front seat restraint remained latched, but the left side of the lap belt webbing was cut. The fuel shutoff valve was full in, and continuity was confirmed from the cockpit control to the valve. The auxiliary fuel pump switch was in the on position, and the auxiliary fuel boost pump circuit breaker was not tripped. Examination of the throttle quadrant revealed the engine control lever was in the aft position, the propeller control was in the aft position, and the fuel control lever was in the run position. The landing gear selector was in the up position.

Examination of the fuselage fuel system revealed the sump tank was ruptured, and the fuel supply line from the sump tank was separated at the tank attach point. The manually-actuated shutoff valve was fully open at impact based on an impact mark from hardware attached to the lever and adjacent flat of a b-nut. The Facet-type fuel pump at the sump tank was dry, and the sump tank fuel cap was in place. The auxiliary fuel pump and a Facet-type pump associated with the sump fuel tank were connected electrically to a portable, 24-volt power source and both were operational. The auxiliary fuel pump with attached hoses and fittings, part number 2003-B, serial number 103252 was retained for operational testing at the manufacturer's facility.

Examination of the engine revealed the propeller was separated from the propeller shaft. The right side of the firewall was damaged and pushed aft above the right lower engine mount. The fuel supply line from the auxiliary fuel pump to the fuel filter was tight at both ends. The fuel supply line from the filter outlet to the engine-driven fuel pump was tight at the filter and connected at the fuel pump; the B-nut at the fuel pump was safety wired. Approximately 1 ounce of straw-colored fuel consistent with jet fuel was drained from the fuel filter, while a drop of straw-colored fuel was noted in the threads of the inlet of the engine-driven fuel pump. A small amount of metal shavings were noted at the inlet of the engine-driven fuel pump, while a small amount of metal shavings, sludge, and a portion of a plastic tie wrap tip were noted at the inlet area of the fuel filter housing. The engine and ignition exciters were removed for further examination.

Examination of the engine was performed at a facility in the US, while the fuel control unit, engine-driven fuel pump, and propeller governor were examined at the manufacturer's facility in the Czech Republic. There were no pre-existing mechanical anomalies issues found during the engine examination which would have prevented normal operation. Examination of the engine-driven fuel pump revealed evidence of internal cavitation. In addition, one of the two ignitor boxes displayed evidence of internal coil movement, consistent with too long a duty cycle, and the supporting insulation material on one of the ignitor plugs had disintegrated.

Examination of the propeller revealed all bolts that secured the propeller to the propeller shaft were damaged consistent with pull-out. All three blades remained secured inside the propeller hub, and exhibited large radius aft bending about 30°, beginning midspan. Two of the three blades appeared to be in the low-pitch range position with the counterweights trapped by the spinner in the corresponding positions. The third blade was less than the low-pitch position, and the blade tip was torn. The trapping of the propeller spinner and the counterweights was consistent with the blades being in an un-feathered position. Examination of the propeller revealed no anomalies that may have prevented normal operation.

MEDICAL AND PATHOLOGICAL INFORMATION

A postmortem examination of the pilot was performed by the Newberry Pathology Associates, P.A. The cause of death was listed as multiple blunt force

injuries. The autopsy report further indicated that the heart weighed 560 grams.

Forensic toxicology was performed on specimens of the pilot by the FAA Bioaeronautical Sciences Research Laboratory, Oklahoma City, Oklahoma. The toxicology report indicated the results were negative for carbon monoxide and volatiles, and unquantified amounts of Quinine were detected in the submitted urine and iliac blood specimens.

TESTS AND RESEARCH

Examination and operational testing of the auxiliary fuel pump were performed at the manufacturer's facility. According to the report from the manufacturer, examination of the pump revealed that one of the two motor brush caps was red in color, indicating installation of parts by someone other than the manufacturer or factory repair station. For operational testing, the inlet and outlet hoses and their respective fittings remained attached. With a 28-volt electrical supply, the fuel boost pump outlet fuel flow was 55 gallons per hour (gph), which is below the factory requirement of 105 gph. Further examination revealed that the pump outlet adapter fitting was installed deeper than that allowed by the AND10064 specification for this interface, which impeded the maximum open position of the internal no-return poppet valve, thereby restricting the outlet fuel flow. After the incorrectly-installed adapter fitting was removed, the pump performance was 109 gph, an acceptable factory test pressure. During subsequent vacuum testing, the motor had an inconsistent/intermittent laboring sound.

Review of the airplane maintenance records revealed no record of removal, replacement, or repair of the auxiliary fuel pump.

Examination of the annunciator panel was performed by the NTSB Materials Laboratory. The results indicated all bulb filaments were intact, and none exhibited evidence of stretching.

Review of the Pilot Information Handbook revealed an emergency checklist titled, "Engine Flame-out In Flight." The first step specified to move the propeller control lever (PCL) to the feather position. The checklist stated to maintain a minimum airspeed of 130 knots indicated if at a low altitude.

According to FAA Order 8130.2H, Airworthiness Certification of Products and Articles, aircraft inspection guidelines for issuance of a special airworthiness certificate specify, in part, that the flight control system should operate properly and the engine(s), propeller(s), and associated instruments operate in accordance with the manufacturer's instructions. There was no mention for a Designated Airworthiness Representative to determine compatibility of airframe, engine, and propeller systems related to emergency systems.

A review of FAA Advisory Circulars (AC) AC 20-27G titled, "Certification and Operation of Amateur-Built Aircraft" issued September 30, 2009, and AC 90-89B titled, "Amateur-Built Aircraft and Ultralight Flight Testing Handbook" issued April 27, 2015, revealed no guidance for experimental aircraft builders regarding turbine engine installation considerations.

ADDITIONAL DATA/INFORMATION

Performance Study

An NTSB Performance Study indicated that the pilot maintained the airplane's best glide speed of 130 knots following the emergency declaration and during the attempted return to the runway. The airplane's angle of attack (AOA) was between 1 and 2ø before the pilot reported the loss of fuel pressure and between 5 and 10ø after. Based on the radar data, the accident airplane's glide ratio was estimated to be 7.5. The glide ratio with a feathered propeller would have been 12.0, resulting in a power-off glide distance of about 12.8 nm from an initial altitude of 6,500 ft.

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Accident Rpt# GAA17CA259	05/04/2017 1730	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: Factual Prob Caus: Pending
Eng Mk/Mdl ROTAX 582			Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: CURTIS LUND		Opr dba:		Aircraft Fire: GRD
				AW Cert: SPE

Events

1. Landing - Hard landing
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Narrative

The student pilot reported that he flared too high, landed hard, and the gyroplane tipped over on its right side. He added that he evacuated the gyroplane before a post-impact fire ensued and destroyed the gyroplane.

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

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Accident Rpt# WPR17LA110	05/26/2017 1445 PDT	Regis# N4579J	Concord, CA	Apt: Buchanan Field Airport CCR
Acft Mk/Mdl JOHNSON GLASTAR		Acft SN 5819	Acft Dmg: SUBSTANTIAL	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl LYCOMING O-320		Acft TT 206	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: SNAGWOOD CORP		Opr dba:		Aircraft Fire: NONE
				AW Cert: SPE

Events

1. Approach-VFR pattern base - Loss of engine power (total)
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Narrative

On May 26, 2017, about 1445 Pacific daylight time, a Johnson Glastar airplane, N4579J, experienced a total loss of engine power while in the traffic pattern for Buchanan Field Airport (CCR), Concord, California. The student pilot, the sole occupant, sustained minor injuries, and the airplane sustained substantial damage to both wings. The airplane was registered to, and operated by, the pilot as a 14 Code of Federal Regulations Part 91 personal flight. Visual meteorological conditions prevailed and no flight plan was filed for the local flight. The flight originated from CCR about 1443.

The pilot reported that the purpose of the flight was to practice landings. The pilot took off uneventfully and flew the traffic pattern. When on the base leg, the engine suddenly quit without warning or any abnormal noises. He attempted to restart the engine several times, but to no avail. The pilot initiated a forced landing onto a roadway; during landing, the airplane's left wing impacted a light pole. The airplane traversed across an intersection when the nosewheel collapsed and the airplane slid to a rest.

The airplane has been recovered to a secured location for further examination.

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Accident Rpt# GAA17CA183 03/09/2017 1626 EST Regis# N24188 Hendersonville, NC Apt: N/a
Acft Mk/Mdl JOHNSON JERRY WAG AERO/SPT Acft SN 1206 Acft Dmg: DESTROYED Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl CONTINENTAL 85 Acft TT 600 Fatal 0 Ser Inj 0 Flt Conducted Under: FAR 091
Opr Name: IRLAND V. BROWN Opr dba: Aircraft Fire: GRD
AW Cert: SPE

Summary

The pilot reported that he attempted to land on his private airstrip but that he "landed long" due to "gusty crosswind conditions." Upon touchdown, a wind gust lifted the right wing, which resulted in the right wheel lifting off the ground. He added that he then performed a go-around, and that, due to the "high angle of attack" while attempting to clear trees and power lines, he did not have visibility out of his front windscreen. Subsequently, the airplane struck a tree and two power lines. The airplane descended, impacted the ground, and was consumed by a fire started by the severed power lines.

The airplane sustained substantial damage to both wings, fuselage, and empennage.

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

The automated weather observation system located about 7 nautical miles from the accident site, about the time of the accident, reported wind from 190° at 14 knots, gusting to 19 knots. The pilot landed to the southwest.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's unstabilized approach and failure to attain the proper touchdown point while attempting to land in gusting crosswind conditions, which resulted in an attempted go-around and collision with trees and power lines.

Events

1. Landing - Landing area overshoot
2. Landing - Loss of control on ground
3. Landing-aborted after touchdown - Abrupt maneuver
4. Landing-aborted after touchdown - Collision with terr/obj (non-CFIT)

Findings - Cause/Factor

1. Personnel issues-Task performance-Use of equip/info-Aircraft control-Pilot - C
2. Personnel issues-Action/decision-Info processing/decision-Decision making/judgment-Pilot - C
3. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Descend/approach/glide path-Not attained/maintained - C
4. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Crosswind correction-Not attained/maintained - F
5. Environmental issues-Physical environment-Object/animal/substance-Wire-Contributed to outcome
6. Environmental issues-Physical environment-Object/animal/substance-Tree(s)-Contributed to outcome
7. Environmental issues-Conditions/weather/phenomena-Wind-Crosswind-Effect on operation
8. Environmental issues-Conditions/weather/phenomena-Wind-Gusts-Effect on operation

Narrative

According to the Federal Aviation Administration (FAA), the pilot reported that he attempted to land on his private airstrip, but "landed long" due to "gusty crosswind conditions". Upon touchdown, a gust of wind lifted the right wing, which resulted in the right wheel lifting off the ground. He then performed a go-around, and reported that due to the "high angle of attack" while attempting to clear trees and power lines, he did not have visibility out of his front windscreen. Subsequently, the airplane struck a tree and two power lines. The airplane descended impacting the ground, and was consumed by a fire started by the severed powerlines.

The airplane sustained substantial damage to both wings, fuselage and empennage.

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

The automated weather observation system about 7 nautical miles from the accident site, about the time of the accident, reported the wind at 190° at 14 knots, gusting to 19 knots. The pilot landed to the southwest.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# GAA17CA316 06/02/2017 1431 EDT Regis# N102CM Canaan Valley, WV Apt: Windwood Fly-in Resort WV62
Acft Mk/Mdl MALINOWSKI WALTER S RV8-A Acft SN 81015 Acft Dmg: SUBSTANTIAL Rpt Status: Prelim Prob Caus: Pending
Fatal 0 Ser Inj 0 Flt Conducted Under: FAR 091
Opr Name: WALTER S. MALINOWSKI Opr dba: Aircraft Fire: NONE

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# CEN17LA208	06/03/2017 1435 CDT	Regis# N956ML	New Berlin, TX	Apt: Heritage Airpark TE86
Acft Mk/Mdl MICHAEL S. LOGAN KITFOX-SERIES 5	Acft SN S9407-0038	Acft Dmg: DESTROYED	Fatal 1	Rpt Status: Prelim Prob Caus: Pending
		Ser Inj 0	Fit Conducted Under: FAR 091	
Opr Name: MICHAEL S. LOGAN	Opr dba:		Aircraft Fire: GRD	
			AW Cert: SPX	

Events

1. Initial climb - Loss of control in flight
-

Narrative

On June 3, 2017, about 1435 central daylight time, a SkyStar Kitfox Series 5 amateur-built airplane, N956ML, impacted terrain at Heritage Airpark (TE86), New Berlin, Texas. The private pilot, the sole person on board was fatally injured, and the airplane was destroyed. The flight was being operated as a 14 Code of Federal Regulations Part 91 personal flight, and no flight plan had been filed. Day visual meteorological conditions existed near the accident site about the time of the accident. The local flight originated from TE86, about 1400.

According to Federal Aviation Administration (FAA) inspectors, the pilot's wife said her husband was going to practice touch-and-go landings. There were no witnesses to the accident. The inspectors said all of the wreckage was within a 15-foot radius of the point of impact, and there were ground signatures consistent with the airplane spinning on impact. There was fire after impact that consumed much of the airplane. Flight control continuity was established.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# ANC16LA059	08/12/2016 1800 AKD	Regis# N625EX	Wasilla, AK	Apt: Todds Strip Airport 5AK5
Acft Mk/Mdl WIGHT CARBON CUB CCK-1865		Acft SN 0093	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl AEROSPORT CC-340		Acft TT 96	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: PILOT		Opr dba:		Aircraft Fire: NONE
				AW Cert: SPE

Events

1. Landing-flare/touchdown - Loss of control on ground
2. Landing-flare/touchdown - Loss of control on ground

Narrative

On August 12, 2016, about 1800 Alaska daylight time, a tundra tire-equipped, amateur-built, experimental, Wight (Cub Crafters) Carbon Cub CCK-1865 airplane, N625EX, sustained substantial damage while landing on runway 7 at Todds Strip Airport, a private airstrip situated near Wasilla, Alaska. The airline transport pilot and one passenger onboard were uninjured. The airplane was registered to, and operated by, the pilot under the provisions of 14 Code of Federal Regulations Part 91 as a personal flight that was not operating on a flight plan. Visual meteorological conditions prevailed at the time of the accident for the flight that originated from Summit Airport, Summit, Alaska, about 1630, and was destined to Todds Strip Airport.

The pilot reported that his flight to the Todds Strip Airport, a 1,500-foot-long by 60-foot-wide turf and gravel-covered airstrip was uneventful. He added that while landing, during touchdown in a wheel landing configuration, the airplane veered sharply to the left as the tailwheel touched down. The pilot said he applied a "full deflection" of the right rudder and right brake controls in an attempt to correct the veer, but the airplane continued to veer left. The right wing and right horizontal stabilizer subsequently struck the ground, sustaining substantial damage.

After the airplane stopped, the pilot unsuccessfully attempted to turn the airplane to the right using rudder, brake, and engine power. The pilot stated that he was unable to straighten the tail wheel with the rudder control inputs because the tail wheel was bent. The pilot reported that the airplane had a total time in service of 96 hours. The airplane tailwheel spring had been replaced with a coil spring assembly that was not part of the original airplane kit manufacturer's assembly, which was a leaf spring. The coil spring was an Alaskan Bushwheels T3 Heavy Duty tailwheel suspension system with a reported total time in service of 30 hours.

Alaskan Bushwheels T3 Heavy Duty tailwheel suspension system underwent a post-accident metallurgical examination by the National Transportation Safety Board Materials Laboratory. The examination revealed that the underside of the flange used to mount the suspension to the airframe exhibited compression deformation under the faying surfaces of the bolt head washer.

Cracks were observed in weld deposits and at the edge of the bolt hole for mounting the tail wheel. The crack fracture surfaces exhibited orange and dark red corrosion product. The dark red coloration of the corrosion deposits suggested that these cracks were pre-existing to the accident. After removal of the corrosion product, the fracture surfaces were examined with a 5X to 50X stereo-zoom microscope. The fractographic features were consistent with overstress fracture.

The crack emanating from the edge of the bolt hole was examined. After removal of superficial orange-colored corrosion product, the fracture surface of the bolt hole crack was examined with a 5X to 50X stereo-zoom microscope. The fracture initiated and propagated due to fatigue before transitioning to overstress.

The edges of the main side plates of the suspension assembly exhibited deformation and impact wear scars. The location of the scars on the side plates is consistent with contact with the airplane's tail wheel steering arms.

The pivot bracket exhibited permanent deformation and edge cracking in the region of the welded-in-place bushing as indicated in the close views. A through-thickness crack on the right side was opened for examination of the fracture surface. After removal of orange-colored corrosion product, the fracture surface of the crack was examined with a 5X to 50X stereo-zoom microscope. The fractographic features were consistent with overstress fracture.

A weld along the radiused bend in the pivot bracket exhibited a partial thickness crack in the base metal adjacent to the toe of the weld.

The suspension assembly exhibited general twisting deformation, primarily as the result of deformation in the pivot bracket.