National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# GAA17CA466	**08/02/2017 1315 CDT**	**Regis# N128LA**	**Uvalde, TX**	**Apt: Garner Field UVA**
Acft Mk/Mdl AB SPORTINE AVIACIJA LAK 17-A		**Acft SN 151**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Prelim** **Prob Caus: Pending**
			Fatal 0 **Ser Inj 0**	**Flt Conducted Under: FAR 091**
Opr Name: MILLER, KEITH R.		**Opr dba:**		**Aircraft Fire: NONE**

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Accident Rpt# GAA17CA004	**10/02/2016 1830 EDT**	**Regis# N53AW**	**Fort Valley, GA**	**Apt: Cameron Field GA81**
Acft Mk/Mdl AIRBORNE WINDSPORTS PTY LTD EDGE		**Acft SN XT-912-0182**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Factual Prob Caus: Pending**
Eng Mk/Mdl ROTAX 912UL		**Acft TT 913**	**Fatal 0 Ser Inj 1**	**Flt Conducted Under: FAR 091**
Opr Name: WOODRIFF LEE		**Opr dba:**		**Aircraft Fire: NONE**
				AW Cert: LTSP

Summary

According to the flight instructor in the weight-shift-control aircraft, he made two low approaches and two go-arounds to runway 36. He reported that, during the third approach, he crossed the runway threshold and "rounded up" and that the left wing "flew up, and the right wing dropped precipitously, as if it stalled." The aircraft swiftly yawed to the right and descended rapidly, and the pilot stated that he responded with a full control deflection. He added that the deflection leveled the aircraft just before impact with the turf and that the aircraft heading was about 35ø to 50ø right of the runway heading. The aircraft sustained substantial damage to both wings and the airframe.

A Federal Aviation Administration (FAA) Aviation Safety Inspector examined the aircraft wreckage and was unable to locate the right overcenter washout strut spilt ring. The split ring connects the washout strut and the leading edge of the right wing spar, which allows the pilot to manipulate the aircraft's directional control. In postimpact photographs of the left side overcenter washout strut split ring, it appears to be partially attached, and the right side split ring was not located in the wreckage.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The failure of the aircraft's right overcenter washout strut split ring, which resulted in the pilot's inability to maintain lateral control of the aircraft and subsequent ground impact.

Events

1. Approach-VFR pattern final - Aerodynamic stall/spin
2. Approach-VFR pattern final - Attempted remediation/recovery
3. Approach-VFR pattern final - Collision with terr/obj (non-CFIT)

Findings - Cause/Factor

1. Aircraft-Aircraft structures-Wing structure-Attach fittings (on wing)-Failure - C
2. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Lateral/bank control-Not attained/maintained - C

Narrative

According to the flight instructor in the weight shift control aircraft, he made two low approaches and two go-arounds to runway 36. He reported that during the third approach, he crossed the runway threshold, "rounded up" and the left wing "flew up, and the right wing dropped precipitously, as if it stalled." The aircraft swiftly yawed to the right, descended rapidly and the pilot avowed that he responded with a full control deflection. He added that the deflection leveled the aircraft just before impact with the turf, and the aircraft heading was about 35ø to 50??ø right of the runway heading. The aircraft sustained substantial damage to both wings and the airframe.

A Federal Aviation Administration (FAA), Aviation Safety Inspector examined the aircraft wreckage and was unable to locate the right side over-center washout strut spilt ring. The split ring connects the washout strut and the leading edge of the right wing spar, which allows the pilot to manipulate the aircraft's directional control. Post-impact photographs of the left side over-center washout strut split ring appears to be partially attached, and the right side split ring was not located in the wreckage.

Accident Rpt# GAA17CA292 05/20/2017 1730 MST	**Regis# N168AT**	**Casa Grande, AZ**	**Apt: Casa Grande Muni CGZ**
Acft Mk/Mdl AIRTIME AIRCRAFT INC CYGNET-NO	**Acft SN 00107**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Factual Prob Caus: Pending**
Eng Mk/Mdl ROTAX 912	**Acft TT 35**	**Fatal 0 Ser Inj 0**	**Flt Conducted Under: FAR 091**
Opr Name: DENTON, WALTER G.	**Opr dba:**		**Aircraft Fire: NONE**
			AW Cert: LTSP

Summary

The flight instructor in the amphibious, float-equipped, weight-shift-controlled trike reported that he was demonstrating multiple touch-and-go landings for the student pilot, who was in the front seat of the tandem-seat trike. He added that, during the final approach, the wind was "light and variable," and the landing was "smooth and stable." He further added that, as power was applied to takeoff, a "gust of wind and dust came in from our left and got under the wing." Subsequently, the trike veered off the runway to the right and rolled over.

The wing and fuselage sustained substantial damage.

The flight instructor reported that there were no preaccident mechanical malfunctions or failures with the trike that would have precluded normal operation.

An automated weather observation station at the accident airport recorded that, about the time of the accident, the wind was from 330ø at 9 knots. The flight instructor reported the takeoff was from runway 5.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The flight instructor's failure to maintain directional control during takeoff in gusting crosswind conditions.

Events

1. Takeoff - Other weather encounter
2. Takeoff - Loss of control on ground
3. Takeoff - Runway excursion
4. Takeoff - Collision with terr/obj (non-CFIT)
5. Takeoff - Nose over/nose down

Findings - Cause/Factor

1. Personnel issues-Task performance-Use of equip/info-Aircraft control-Instructor/check pilot - C
2. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Directional control-Not attained/maintained - C
3. Environmental issues-Conditions/weather/phenomena-Wind-Crosswind-Effect on operation
4. Environmental issues-Conditions/weather/phenomena-Wind-Gusts-Effect on operation

Narrative

The flight instructor in the amphibious float-equipped weight-shift controlled trike reported that, he was demonstrating multiple touch-and-go landings for the student pilot, who was in the front seat of the tandem seat trike. He added that during the final approach, wind was "light and variable" and the landing was "smooth and stable." He further added that as power was applied to takeoff, a "gust of wind and dust came in from our left and got under the wing." Subsequently, the trike veered off the runway to the right and rolled over.

The wing and fuselage sustained substantial damage.

The flight instructor reported that there were no preaccident mechanical malfunctions or failures with the trike that would have precluded normal operation.

An automated weather observation station, at the accident airport, about the time of the accident, recorded wind 330ø at 9 knots. The flight instructor reported the takeoff was on runway 5.

Accident Rpt# ERA16LA120 02/28/2016 1337 EST	**Regis# N187SF**	**Atlanta, GA**	**Apt: Dekalb-peachtree PDK**	
Acft Mk/Mdl CZECH AIRCRAFT WORKS SPOL SRO	**Acft SN 08SC190**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Factual**	**Prob Caus: Pending**
Eng Mk/Mdl ROTAX 912ULS	**Acft TT 1935**	**Fatal 0 Ser Inj 0**	**Flt Conducted Under: FAR 091**	
Opr Name: ASMAN SANFORD JAY	**Opr dba:**		**Aircraft Fire: NONE**	
			AW Cert: LTSP	

Events

1. Takeoff - Loss of engine power (total)

Narrative

On February 28, 2016, at 1337 eastern standard time, N187SF, Czech Aircraft Works SPOL SRO - SportsCruiser, made a forced landing after a total loss of engine power while on takeoff from DeKalb-Peachtree Airport (PDK), Atlanta, Georgia. The airplane sustained substantial damage, but the private pilot/owner was not injured. Visual meteorological conditions existed at the time of the accident and no flight plan was filed for the flight that was being conducted as a 14 Code of Federal Regulations Part 91 personal flight. The flight was originating at the time of the accident.

The pilot stated that this was his first flight of the day. He conducted a thorough preflight inspection of the airplane before he started the engine. He then let the engine warm up to normal operating temperature before taxing to the runway. The pilot said he performed an engine run-up and everything was normal. Both fuel tanks were full with about 15 gallons of auto-gas, and the fuel selector was on the left tank. The fuel pump was "on." During the takeoff from runway 21R, the engine lost power. He switched fuel tanks, but the engine did not re-start. The pilot declared an emergency and attempted to land on runway 3R, but landed about 300 ft southeast of the runway on grass. The landing gear collapsed on landing and the airplane slid and spun 180ø before it came to rest.

The airplane was equipped with a Dynon Skyview display. Engine performance data downloaded from the unit revealed an interruption in fuel flow to the engine during the short flight, about 12.5 minutes after the data recording began, and about 2 minutes before the data recording ceased.

A postaccident examination of the airplane and engine revealed the fuselage, both wings, the firewall, and an engine mount were substantially damaged. The Rotax 912 ULS engine remained attached to the airframe and two of the three propeller blades were broken off at the hub. Both carburetors were displaced from their respective sockets and the gascolator bowl was shifted from its mounting bracket. The float bowls were removed from each carburetor and inspected. A small amount of fuel was observed in each bowl along with a small amount of contamination that was consistent with a small particle of fuel line. No mechanical anomalies were noted with either carburetor and the float bowls were re-installed on the engine. The spark plugs were removed from the engine and a continuity and compression check were completed via manual rotation of the propeller. No mechanical issues were noted. The engine was then prepped to be test run, which involved cutting the remaining propeller blade and removing the fuel pump inlet line from the firewall and placing it in a fuel container with fresh fuel. The engine was started and run to 5,700 RPM (5,800 RPM was max). Fuel pressure was 5.8 PSI, which is in the normal pressure range. The engine ran continuously for several minutes without hesitation. No mechanical deficiencies were observed with the engine that would have precluded normal operation at the time of impact.

Examination of the airplane's fuel system revealed that the airplane did not have a mandatory fuel return line installed as per the Rotax 912ULS installation instructions. The fuel return line was made mandatory via an amendment to the installation manual on August 1, 2012. The manual stated on page 3, section 73-00-00, subsection 1.1) Description of system - Return Line, "NOTE: The return line prevents malfunctions caused by the formation of vapor lock." Additionally, page 6, Section 73-00-00, subsection 1.3 of the manual stated, "Requirements of the fuel system - Fuel return line, NOTICE: The installation of a fuel return line is mandatory. If the fuel distributor piece with regulator from Rotax is not available, the fuel pressure must be regulated by a restriction in the fuel return line, which ensures that the fuel pressure is under all operation condition within the operating limits specified by Rotax." No fuel return line or restrictor regulator was installed on this airplane as per the Rotax installation instructions.

The accident engine was manufactured in January 2012 and was not the original engine installed on the airplane. A review of maintenance logs revealed the engine was installed on the accident airplane by a repair station in December 2013. The pilot/owner purchased the airplane with the new Rotax 912ULS engine already installed in 2014. He was unaware that the mandatory fuel return line was not installed.

The Airframe Maintenance Manual (AMM) depicted the airplane's fuel system design layout with a fuel return line installed. However, the accident airplane was manufactured in 2008 and based on the information provided by the airframe manufacturer, no Czech SportCruiser airplane manufactured prior to 2010 had a fuel return line installed. The fuel line was only made mandatory by the engine manufacturer, Rotax, if their Rotax 912ULS engine was installed after August 1, 2012. The airframe manufacturer made the fuel return line standard in September 2010 as the design modification no. S - K - 0084 and a change to the AMM

Revision 6, for the SportCruiser in January 2011. According to the airframe manufacturer, 94 airplanes were manufactured for the US market without a fuel return line. Prior to the design modification, there were no reports of any engine problems or shutdowns.

The pilot held a private pilot certificate for airplane single-engine land and instrument airplane. His last FAA third-class medical was issued on July 24, 2014. The pilot reported a total of 1,117 flight hours, of which, 56 hours were in the same make/model as the accident airplane.

At 1255, the weather reported at the airport was visibility 10 miles, wind 210ø at 10 knots gusting to 20 knots, and clear skies.

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: Factual Prob Caus: Pending**
Eng Mk/Mdl ROTAX 912	**Acft TT 183**	**Fatal 2 Ser Inj 0**	**Flt Conducted Under: FAR 091**
Opr Name: ICON AIRCRAFT INC	**Opr dba:**		**Aircraft Fire: NONE**

Summary

The commercial pilot departed in the light sport, amphibious airplane during daytime visual meteorological conditions to perform a new employee familiarization flight with the passenger, who the company had recently hired. A witness, who was in a boat on a lake, reported seeing the accident airplane flying about 30 to 50 ft over the water at what appeared to be between 30 to 40 mph. The witness added that, as the airplane passed by his position and entered a nearby cove, which was surrounded by rising terrain on either side and at its end, he heard the engine "rev up and accelerate hard" as the airplane approached the right side of the canyon "in what appeared to be an effort to climb out of" the canyon. Subsequently, the airplane climbed to about 100 ft above the water and entered a left turn as it began to descend before it flew beyond the witness's field of view. The witness stated that he heard the sound of impact shortly after losing sight of the airplane.

Review of recorded data from two separate recording devices installed in the airplane revealed that, about 15 minutes after departure, the airplane started a descent from 3,700 ft GPS altitude. About 7 minutes later, it had descended to 450 ft GPS altitude and turned to a northerly heading, staying over the water between the shorelines. About 46 seconds later, at a GPS altitude of 450 ft and 54 knots indicated airspeed (KIAS), the airplane entered the cove. About 20 seconds later, engine power was increased, and the airplane began to climb while it turned slightly right before initiating a left turn. The airplane reached a maximum GPS altitude of 506 ft before it began to descend. Shortly after, the airplane impacted terrain at a GPS altitude of 470 ft and 66 KIAS. Postaccident examination of the airframe and engine revealed no evidence of any preexisting mechanical malfunctions that would have precluded normal operation.

It is likely that the pilot mistakenly thought the canyon that he entered was a different canyon that led to the larger, open portion of the lake. Additionally, it is likely that, once the pilot realized there was no exit from the canyon, he attempted to perform a 180ø left turn to exit in the direction from which he entered. Based upon performance information outlined in the Pilot's Operating Handbook for the accident airplane, the airplane's altitude above the water's surface and its indicated airspeed, and the ridge line elevations in the area adjacent to the accident site, the airplane would have not been able to climb out of the rising terrain that surrounded the area, which led to his failure to maintain clearance from terrain.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's failure to maintain clearance from terrain while maneuvering at a low altitude. Contributing to the accident was the pilot's mistaken entry into a canyon surrounded by steep rising terrain while at a low altitude for reasons that could not be determined.

Events

1. Maneuvering-low-alt flying - Abrupt maneuver
2. Maneuvering-low-alt flying - Collision with terr/obj (non-CFIT)

Findings - Cause/Factor

1. Personnel issues-Action/decision-Info processing/decision-Decision making/judgment-Pilot - C
2. Personnel issues-Task performance-Use of equip/info-Use of equip/system-Pilot - C
3. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Altitude-Not attained/maintained - C
4. Environmental issues-Physical environment-Terrain-Mountainous/hilly terrain-Ability to respond/compensate
5. Personnel issues-Action/decision-Action-Incorrect action selection-Pilot - F
6. Personnel issues-Psychological-Perception/orientation/illusion-Geographic disorient (lost)-Pilot - F

Narrative

HISTORY OF FLIGHT

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 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 the company had recently hired. A witness, who was in a boat on Lake Berryessa near the entrance to Little Portuguese Canyon, reported seeing the airplane flying about 30 to 50 ft above the lake at what appeared to be between 30 to 40 mph. The witness stated that the engine was running smoothly and that the airplane was level. The airplane passed by his position flying in a northerly direction and entered Little Portuguese Canyon. The witness reported hearing the engine "rev up and accelerate hard" as the airplane approached the right side of the canyon "in what appeared to be an effort to climb out of" the canyon. Subsequently, the airplane climbed to about 100 ft above ground level and then entered a left turn as it began to quickly descend. The witness stated that it appeared that the pilot attempted to make a "U-turn in the air" just before the airplane flew beyond his field of view. The witness stated that he heard the sound of impact shortly after losing sight of the airplane.

A second witness, who was located inside a house boat parked in a cove adjacent to the accident site, reported that she saw an airplane fly by her position at a low altitude in a northerly direction and did not see it return. The witness added that neither her nor anyone in her group heard the airplane impact the ground.

The airplane was equipped with a flight data monitoring device that captured data from the flight data computer. In addition, the airplane was equipped with an engine control unit that captured the most recent hour of data from the engine. The recovered data showed that the engine was started at 0839:34, and that, at 0852:00, the airplane departed runway 2 at VCB and then initiated a left turn to a northerly heading. The airplane reached a maximum GPS altitude of about 3,700 ft at 0900:00 and began to descend shortly thereafter. At 0905:25, the airplane turned to the west, crossed the shore of Lake Berryessa near the Monticello Dam, and continued to descend. By 0906:44, the airplane descended to 450 ft GPS altitude and turned to a northerly heading while it remained over the water between the shorelines. At 0907:30, the airplane entered Little Portuguese Canyon at 450 ft GPS altitude and 54 KIAS. At 0907:50, engine power was increased, and the airplane began to climb while it turned slightly east and then initiated a left turn to the west. The airplane reached a maximum altitude of 506 ft GPS altitude at 0908:03 before it began to descend. The airplane struck terrain at 0908:06 at 470 ft GPS altitude and 66 KIAS. Throughout the entire span of the recorded data, all engine parameters were within the normal operating range. For further information regarding the downloaded data, see the Other Devices Factual Report in the public docket for this accident.

Lake Berryessa is a reservoir that is about 23 miles long and 3 miles wide. The southern area of the lake features various coves and canyons, which are mostly surrounded by areas of steep rising terrain. In addition, there is only one entrance to the larger area of the lake from the southern area of the lake. The areas of rising terrain that surrounded Little Portuguese Canyon varied between 780 and 1,420 ft msl. The accident site was located about 0.35 nautical mile (nm) from the tops of 1,200-ft-high ridges to the west, 0.36 nm from the 1,050-ft-high ridges to the east, and 1.34 nm from the 1,200-ft-high ridges to the north. In addition, Little Portuguese Canyon narrowed in width from about 700 ft at the opening to about 300 ft near the accident site and 240 ft near the farthest northern area of the canyon.

PERSONNEL INFORMATION

The pilot held a commercial pilot certificate with airplane single-engine and multiengine land and sea, rotorcraft helicopter, glider, and instrument airplane ratings. The pilot was issued a Federal Aviation Administration (FAA) second-class airman medical certificate on November 25, 2016, with the limitation that he "must wear corrective lenses." At the time of his most recent medical application, the pilot reported that he had accumulated 4,600 hours total flight time, 14 hours of which were in the previous 6 months.

Review of the pilot's logbook and company flight records revealed that the pilot had accumulated a total of 4,506 hours of flight time, 595 hours of which were in the accident make/model airplane. The pilot had logged 23 hours of flight time in the 90 days before the accident. The pilot's most recent flight review was completed on April 23, 2016.

The passenger did not hold any pilot or medical certificates.

AIRCRAFT INFORMATION

The two-seat, high-wing, retractable gear, amphibious light sport airplane, serial number 00007, was manufactured in 2016. It was powered by a 100-horsepower Rotax 912IS Sport engine and was equipped with a Sensenitch three-blade propeller. In addition, the airplane was equipped with a ballistic recovery parachute. Review of the airframe and engine maintenance logbook records revealed that the most recent 100-hour inspection was completed on May 5, 2017, at a Hobbs time of 94.8 hours. At the time of the accident, the engine and airframe had accumulated 182.7 hours since new.

The accident make/model airplane's Pilot's Operating Handbook, Section 2.2, "Airspeed Limitations," noted that the published clean configuration stall speed (Vs) was 45 knots indicated airspeed (KIAS) at idle power, maximum takeoff weight, and flaps not extended. The published landing configuration stall speed (Vso) was 39 KIAS at idle power, maximum takeoff weight, and flaps extended to 30ø.

Section 5.1, "Summary of Performance Specifications," stated that the best angle of climb speed (Vx) with flaps retracted was 54 KIAS and that the best rate of climb speed (Vy) was 58 KIAS. Section 5.4.1 stated that, at maximum gross weight, the stall speeds for flaps retracted, 0ø, 30ø, 45ø, and 60ø angle of bank were 45, 48, 54, and 64 KIAS, respectively. Section 5.8, "Rate of Climb," stated that the published climb rate at maximum gross weight, flaps retracted, full throttle, airspeed of 58 KIAS, and 60ø outside air temperature would be 629 ft per minute (fpm) at sea level and 592 fpm at 1,000 ft mean sea level (msl).

METEOROLOGICAL INFORMATION

At 0853, a recorded weather observation at VCB, located about 13 miles southeast of the accident site, revealed that the wind was from 030ø at 5 knots, visibility 10 statute miles, clear sky, temperature 64øF, dew point 52øF, and an altimeter setting of 29.95 inches of mercury.

WRECKAGE AND IMPACT INFORMATION

Examination of the accident site revealed that the airplane impacted terrain on an approximate 194ø heading and came to rest upright in the northern area of Little Portuguese Canyon on Lake Berryessa at an elevation of about 440 ft msl. 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. A large area of freshly disturbed dirt was observed immediately in front of the right wing. No damage was observed to the surrounding vegetation and trees immediately in front of the right wing or behind (upslope) of the wreckage.

Examination of the fuselage revealed that the fuselage structure, engine nacelle, and wing center section were crushed downward and displaced laterally to the left. The canopy structure was displaced from the airplane and located adjacent to the wreckage. The forward portion of the cockpit area exhibited significant impact damage with most of the instrument panel separated. The empennage structure was separated from the airframe just forward of the vertical stabilizer; however, it remained attached via control cables. The ballistic parachute handle was partially extended, and the pin was removed. The parachute and rocket were intact and not deployed.

The wreckage was recovered to a secure location for further examination; both wings and empennage were removed to facilitate transport of the wreckage.

The roof structure of the fuselage, which included the wing mounts, was crushed downward and slightly rotated right about 10ø and was shifted laterally to the left. The engine remained attached to the fuselage structure. The right sea wing exhibited impact damage and was fractured throughout. The left sea wing exhibited impact damage, was partially separated from the fuselage, and was displaced upward. One of the propeller blades was embedded in the left sea wing. Both main landing gears appeared to be in the "up" position. Both wing lock mechanisms were in the "locked" position.

Rudder control continuity was established from the rudder pedals aft to the area of the separated portion of the empennage. Aileron control continuity was established from the left and right control sticks to the wing root bell crank (cables continuous). The right side aileron bell crank was pulled away from its mount with the cables still attached, consistent with impact damage. Elevator control continuity was established from the control sticks to the separated portion of the empennage.

The right wing leading edge to the wing root remained attached to the wing structure. The wing structure aft of the aileron bell crank at the wing root was separated, extending aft at a 45ø angle to about 18 inches outboard of the wing root. The separated portion of the wing structure remained attached to the fuselage. The leading edge exhibited impact damage throughout its span. The flap remained attached via the center and outboard mount. The aileron remained attached via the inboard mount. Flight control continuity to the aileron was established from the wing root bellcrank to the aileron.

The left wing was fractured in half from the leading edge (at the flap/aileron junction) extending outboard at an approximate 45ø angle outboard to the trailing edge. The aileron was separated into two pieces. The inboard section remained attached to the inboard mount. The outboard portion of the aileron was separated just outboard of the inboard mount and separated from the middle and outboard mounts. Flight control continuity was established from the wing root aileron bellcrank to the aileron.

The rudder and elevator remained attached to their respective mounts. Flight control continuity of the rudder and elevator was established from the area of separation. Both left and right elevator tips were in the "locked" position.

The engine remained intact and attached to the airframe. The crankshaft was partially rotated by the propeller; however, rotation was limited due to one propeller blade being embedded in the left sea wing. The embedded propeller blade exhibited chordwise striations on the front and aft sides of the blade tip.

MEDICAL AND PATHOLOGICAL INFORMATION

According to the Napa County Coroner's autopsy report, the pilot's cause of death was "multiple blunt impact injuries," and the manner of death was "accident."

The FAA's Bioaeronautical Sciences Research Laboratory conducted toxicology tests on specimens from the pilot. The results were negative for all tests performed.

Accident Rpt# GAA17CA319 06/02/2017 1510 CDT	**Regis# N600US**	**Chapman, KS**	**Apt: Prairie Cottage 8KS8**	
Acft Mk/Mdl MAGNAGHI AERONAUTICA SPA SKY	**Acft SN LSA026**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Factual**	**Prob Caus: Pending**
Eng Mk/Mdl ROTAX 912 ULS2-01	**Acft TT 41**	**Fatal 0 Ser Inj 0**	**Flt Conducted Under: FAR 091**	
Opr Name: US AERO LLC.	**Opr dba:**		**Aircraft Fire: NONE**	
			AW Cert: LTSP	

Events

2. Initial climb - Loss of control in flight

Narrative

The pilot reported that, during takeoff from a private turf airstrip, about 50 ft. above ground, the airplane encountered a gust of wind that "quickly" lifted the left wing and pushed the airplane to the right. He added that he attempted to level the wings, but he "did not have enough aileron." Subsequently, the airplane impacted terrain in a nose low, right wing down attitude.

The fuselage and both wings sustained substantial damage.

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

The pilot reported that the temperature was 85?, the sky was clear, and the wind was from 200ø at 5 knots, and not gusting. He took off on runway 23.

An automated weather observation station, about 14 nautical miles from the accident airport, recorded wind from 170ø at 9 knots, gusting to 20 knots.

Accident Rpt# ERA17CA236	**07/08/2017 1130 EDT**	**Regis# N796SR**	**Lake Ashby, FL**	**Apt: N/a**	
Acft Mk/Mdl PROGRESSIVE AERODYNE INC SEAREY		**Acft SN 1060**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Factual**	**Prob Caus: Pending**
Eng Mk/Mdl ROTAX 914UL		**Acft TT 20**	**Fatal 0**	**Ser Inj 1**	**Flt Conducted Under: FAR 091**
Opr Name: CHRISTOPHER A CARLSON		**Opr dba:**			**Aircraft Fire: NONE**
					AW Cert: LTSP

Summary

The pilot of the special light sport, amphibious airplane stated that he had planned a local personal sightseeing flight, which included departing from an airport, landing on a lake about 20 miles away, then returning to the departure airport. During the approach to landing on the lake, the pilot left the landing gear in the extended position, which was the wrong position for a water landing. Once the airplane touched down on water, it decelerated quickly, nosed over, and then came to rest inverted. The pilot added that there were no preimpact mechanical malfunctions with the airplane that would have precluded normal operation. When the airplane was recovered from the lake, damage was observed on both wings and the fuselage. The landing gear were observed in the extended position, and the landing gear selector was also in the landing gear extended position.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's incorrect configuration of the landing gear for a water landing in an amphibious airplane, which resulted in a nose-over.

Events

1. Landing - Landing gear not configured
2. Landing - Nose over/nose down
3. Landing - Collision with terr/obj (non-CFIT)

Findings - Cause/Factor

1. Aircraft-Aircraft systems-Landing gear system-Gear extension and retract sys-Incorrect use/operation - C
2. Personnel issues-Action/decision-Action-Incorrect action selection-Pilot - C

Narrative

The pilot of the special light sport amphibian airplane stated that he had planned a local personal sightseeing flight, which included departing from an airport, landing on a lake about 20 miles away, then returning to the departure airport. During the approach to landing on the lake, the pilot left the landing gear in the extended position, which was the wrong position for a water landing. Once the airplane touched down on water, it decelerated quickly, nosed over and came to rest inverted. The pilot added that there were no preimpact mechanical malfunctions with the airplane. When the airplane was recovered from the lake, substantial damage was observed on both wings and the fuselage. The landing gear was observed in the extended position and the landing gear selector was also in the landing gear extended position.

Accident Rpt# GAA17CA340	**06/14/2017 1300 PDT**	**Regis# N4206N**	**Reno, NV**	**Apt: Air Sailing NV23**
Acft Mk/Mdl SPORTINE AVIACIJA LAK 12-NO SERIES		**Acft SN 682**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Factual Prob Caus: Pending**
		Acft TT 553	**Fatal 0 Ser Inj 0**	**Flt Conducted Under: FAR 091**
Opr Name: EDWARD E. WINCHESTER		**Opr dba:**		**Aircraft Fire: NONE**
				AW Cert: SPE

Summary

The glider pilot reported that, during an aerotow takeoff and after becoming distracted by something in the cockpit, he looked back outside and noticed that he was about 100 ft higher than the tow airplane. He added that he attempted to correct, "but the tow hook released on its own." The pilot turned the glider to the left, the left wing impacted the ground, and the glider came to rest in some brush.

The glider sustained substantial damage to the fuselage.

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

The Federal Aviation Administration's Glider Flying Handbook, FAA-H-8083-13A, "Normal Assisted Takeoff" section, stated, in part:

One of the most dangerous occurrences during aerotow is allowing the glider to fly high above and losing sight of the towplane. The tension on the towline caused by the glider pulls the towplane tail up, lowering its nose. If the glider continues to rise, pulling the towplane tail higher, the tow pilot may not be able to raise the nose. Ultimately, the tow pilot may run out of up elevator authority.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The glider pilot's failure to maintain proper pitch during an aerotow takeoff.

Events

1. Takeoff - Miscellaneous/other
2. Initial climb - Altitude deviation
3. Initial climb - Loss of control in flight
4. Initial climb - Attempted remediation/recovery
5. Initial climb - Glider tow event
6. Initial climb - Collision with terr/obj (non-CFIT)

Findings - Cause/Factor

1. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Pitch control-Not attained/maintained - C
2. Personnel issues-Task performance-Use of equip/info-Aircraft control-Pilot - C
3. Personnel issues-Psychological-Attention/monitoring-Task monitoring/vigilance-Pilot
4. Environmental issues-Physical environment-Object/animal/substance-(general)-Contributed to outcome

Narrative

The glider pilot reported that during an aerotow takeoff, after becoming distracted by something in the cockpit, he looked back outside and noticed he was about 100 ft. higher than the tow airplane. He added that he attempted to correct, "but the tow hook released on its own". The pilot turned to the left, the left wing impacted the ground, the glider came to rest in some brush.

The glider sustained substantial damage to the fuselage.

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

The Federal Aviation Administration's Glider Flying Handbook, FAA-H-8083-13A, "Normal Assisted Takeoff" section, stated in part:

One of the most dangerous occurrences during aerotow is allowing the glider to fly high above and losing sight of the towplane. The tension on the towline caused by the glider pulls the towplane tail up, lowering its nose. If the glider continues to rise, pulling the towplane tail higher, the tow pilot may not be able to raise the nose. Ultimately, the tow pilot may run out of up elevator authority.

Accident Rpt# ERA17CA008	**10/07/2016 1343 EDT**	**Regis# N100UK**	**Ashwood, VA**	**Apt: Ingalls Field HSP**
Acft Mk/Mdl ALGIMANTAS JONUSAS RV-10		**Acft SN 41224**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Factual Prob Caus: Pending**
Eng Mk/Mdl LYCOMING IO-540-D4A5		**Acft TT 199**	**Fatal 0 Ser Inj 2**	**Flt Conducted Under: FAR 091**
Opr Name: PAUL FURLOW		**Opr dba:**		**Aircraft Fire: NONE**
				AW Cert: SPE

Events

2. Enroute - VFR encounter with IMC

Narrative

The non-instrument rated private pilot obtained weather information from an online flight planning website. Prior to departure he also telephoned his destination airport and "determined the weather was all OK." He then took off and climbed to 5,500 feet above mean sea level for the cruise portion of his flight. He advised that he also checked and monitored weather while enroute, but the "fog and clouds came down really thick," so he decided to divert to the nearest airport. While flying towards his diversion airport, the visibility deteriorated and a "TERRAIN ALERT" warning illuminated on his GPS display. He attempted to pull up twice, but impacted trees and terrain on the side of a mountain. The pilot and passenger were seriously injured during the impact and the airplane was substantially damaged. The pilot reported that there were no preimpact mechanical failures or malfunctions of the airframe or engine that would have precluded normal operation.Review of weather observations indicated an extensive area of low clouds, and a large area of marginal visual flight rules (MVFR) conditions existed over the pilot's planned route. Low instrument flight rules (IFR) conditions prevailed at the diversion airport and in the vicinity of the accident site, with visibility less than 1/4-mile in heavy rain and overcast ceilings at 100 ft. The MVFR to IFR weather conditions had been forecast, and AIRMETs warning of IFR and mountain obscuration conditions had been issued.

Accident Rpt# CEN16FA344 09/02/2016 1000 CDT	**Regis# N676DT**	**Viborg, SD**	**Apt: Marv Skie-lincoln County Y14**
Acft Mk/Mdl AVES DOUGLAS JAMES RV 6	**Acft SN 22759**	**Acft Dmg: DESTROYED**	**Rpt Status: Factual Prob Caus: Pending**
Eng Mk/Mdl LYCOMING O-360-A1A	**Acft TT 390**	**Fatal 2 Ser Inj 0**	**Flt Conducted Under: FAR 091**
Opr Name: BUCHOLZ ALLEN L	**Opr dba:**		**Aircraft Fire: GRD**

Summary

The commercial pilot and the passenger, his 14-year-old granddaughter who wanted to become a pilot, were making a local flight in the airplane. No radar or GPS track information was found for the flight. A witness heard the airplane's engine "sputtering" before the airplane impacted the ground in a cornfield. A postimpact fire consumed the engine cowling, cockpit, fuselage, and the forward portion of the empennage. Damage to the airplane, the crop, and marks on the ground indicated that the airplane impacted in a slightly nose-low and left-wing-low attitude with no forward airspeed, consistent with a relatively flat spin. The propeller remained attached to the engine and was embedded in the soil and positioned horizontally. The propeller blades were slightly bent aft and did not exhibit any leading-edge damage, consistent with minimal, if any, power being produced by the engine during impact. No mechanical malfunctions or anomalies were found with the engine or airframe that would have precluded normal operation. However, the examination was limited by the extensive postcrash fire damage. The circumstances of the accident are consistent with the airplane exceeding its critical angle of attack, resulting in an aerodynamic stall and subsequent flat spin into terrain. Given the witness report of a "sputtering" engine and the propeller signatures consistent with the engine not producing power at impact, it is likely that the engine lost power before impact. However, it could not be determined whether the engine lost power before the loss of control or whether the pilot intentionally reduced power during the descent.

The14-year-old passenger was seated in the left seat, and the pilot was seated in the right seat. Although the family reported that the flight was not instructional, it is possible that the pilot allowed the passenger to manipulate the flight controls. Regardless of which occupant was manipulating the flight controls, the pilot was the only certificated pilot on board and was responsible for the safety of the flight.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's failure to maintain airplane control, which resulted in the airplane exceeding its critical angle of attack, an aerodynamic stall, and subsequent flat spin into terrain.

Events

1. Unknown - Loss of control in flight
2. Unknown - Aerodynamic stall/spin

Findings - Cause/Factor

1. Personnel issues-Task performance-Use of equip/info-Aircraft control-Pilot - C
2. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Angle of attack-Not attained/maintained - C
3. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Airspeed-Not attained/maintained - C

Narrative

HISTORY OF FLIGHT

On September 2, 2016, about 1000 central daylight time, an experimental, amateur-built RV-6 airplane, N676DT, impacted a cornfield following a loss of control near Viborg, South Dakota. The commercial pilot and the passenger were fatally injured, and the airplane was destroyed. 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. Visual meteorological conditions prevailed, and no flight plan had been filed. The local flight departed from Marv Skie-Lincoln County Airport (Y14), Tea, South Dakota, about 0900.

Family members reported that the passenger was the pilot's 14-year-old granddaughter, who aspired to become a pilot, and that it was very common for them to take local flights on the weekends. They added that the purpose of the flight was personal and not instructional.

A witness reported hearing an engine "sputtering," followed by a loud "thud," and then he observed a fireball. The witness did not see the airplane in flight.

PERSONNEL INFORMATION

AIRCRAFT INFORMATION

The airplane was built from a kit by a previous owner, and it was configured for two occupants with side-by-side seating. The airplane received a special

airworthiness certificate with an experimental designation on September 11, 1996.

The investigation was unable to determine when the airplane had been fueled last.

METEOROLOGICAL INFORMATION

There were no active AIRMETs or SIGMETs near the accident location. Also, there were no PIREPS applicable to the accident area.

WRECKAGE AND IMPACT INFORMATION

The accident site was located in a mature cornfield about 10 nautical miles west of Viborg and 27 nautical miles southwest of Y14. The airplane came to rest on top of the corn stalks, some of which remained unbroken near the empennage. The wreckage exhibited no lateral or forward displacement. Outside of the wreckage area there was no airplane debris and no noticeable damage to the crop. According to first responders, the passenger was seated in the left seat and her 4-point seatbelt remained fastened. The pilot was seated in the right seat and his 4-point seatbelt remained fastened.

The engine cowling, cockpit, fuselage, and forward portion of the empennage were consumed by a postimpact fire (figure 1).

The wing roots and bottom side of the fuselage were thermally damaged. The wing tank fuel caps were found in place and secure.

The left wing tip fairing separated from the wing and was found near the forward left side of the wreckage. The left wing exhibited rearward and upward impact crushing signatures (figure 2). Impact marks were found under the left wing tip. The left flap was partially underneath the left wing and remained attached at the connection points. The left aileron remained partially attached to the wing; the inboard connection remained attached while the outboard connection was impact separated. The left fuel tank was breached.

The right wing sustained leading edge damage and rearward crushing near the inboard section. The right flap was retracted and mostly undamaged. The right aileron was found in a neutral position, remained attached, and was mostly undamaged.

The aileron control tubes remained attached to the aileron surfaces and were continuous inboard to the fuselage where they were both consumed by fire.

The elevator control tube remained attached to the elevator surface and extended about 4 ft into the rear fuselage where it was thermally damaged and partially consumed by fire. The forward portion of the elevator control tube remained attached to its connection at the control stick. The elevator trim tab was slightly down from the neutral position. The rudder control cables remained attached to each side of the rudder. The rudder control cables were continuous to the forward ball swage in the cockpit area, and the right ball swage was covered with melted aluminum. The rudder pedals were found in the forward cockpit near the firewall and sustained thermal damage and impact damage.

The throttle and mixture control knobs were near the full forward position. The cockpit instrumentation was mostly consumed by fire. The ignition was positioned to "BOTH." The fuel selector was set to the right fuel tank position.

The two-bladed metal propeller remained attached to crankshaft flange. The propeller was embedded in the soil and positioned horizontally (figure 3). The propeller blades were slightly bent aft and did not exhibit any leading edge damage.

The engine remained attached to the engine mounts and sustained thermal damage primarily near the rear, which encompassed the engine accessories. The top spark plug electrodes, which were all automotive style plugs, were free of damage and exhibited coloration consistent with normal operation. The empennage and exhaust manifold did not contain any visible oil residue. Engine mechanical continuity was established from the vacuum pump drive to the

propeller flange. When the crankshaft was rotated via the accessory drive gear, thumb compression and suction were obtained at each cylinder. The valve rockers were undamaged and exhibited movement consistent with normal operation. The magneto drive gear in the accessory section and fuel pump plunger actuated when the accessory drive gear was rotated. The engine driven fuel pump was thermally damaged. The carburetor remained secure on its mounting pad with the mixture and throttle controls secure at their respective connections. The carburetor throttle control was near the full open position, and the mixture was near the full rich position. The carburetor fuel inlet screen was free of contaminants. The carburetor air inlet was free of obstruction. The carburetor was removed and opened for examination, which revealed that the float bowl remained free of contamination and the plastic floats were thermally damaged. The left and right electronic ignition components were thermally damaged. The ignition harness was mostly consumed by fire; however, it appeared to have been connected at each spark plug. The vacuum pump remained secure to its mounting pad, and the plastic coupler was thermally damaged. The engine oil suction screen was free of contaminants.

The postaccident examination of the engine and airframe did not reveal any mechanical malfunctions or anomalies that would have precluded normal operation. The postimpact fire prevented a complete examination of the airplane.

MEDICAL AND PATHOLOGICAL INFORMATION

The Sanford Health Pathology Clinic, Sioux Falls, South Dakota, completed an autopsy on the pilot, and the cause of death was multiple blunt force injuries. The Federal Aviation Administration's (FAA) Bioaeronautical Sciences Research Laboratory conducted toxicology testing, which revealed verapamil and norverapamil in the blood and liver.

Verapamil is a prescription drug used in the treatment of hypertension, angina, and arrhythmias. Norverapamil is a metabolite of verapamil.

The Sanford Health Pathology Clinic also completed an autopsy on the passenger, and the cause of death was blunt force injury. The FAA's Bioaeronautical Sciences Research Laboratory conducted toxicology testing, which was negative for carbon monoxide in the blood.

ADDITIONAL INFORMATION

A review of FAA radar data for the accident area did not reveal any radar returns that correlated to the flight. Also, there were no air traffic control communications found from the airplane.

An undamaged Appareo Stratus PRX V2 was found near the wreckage. The unit was downloaded by the NTSB Recorders Laboratory and did not reveal any data from the accident flight.

The pilot's iPad was found by the family, and the ForeFlight application revealed 37 previous flight track logs. The track logs were from November 29, 2014 to July 26, 2016.

Accident Rpt# ERA16LA153 04/02/2016 1530 EDT	**Regis# N349E**	**South Harrison, NJ**	**Apt: N/a**	
Acft Mk/Mdl BUTTERHOF ANTHONY J GINNY B-NO	**Acft SN 001**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Factual**	**Prob Caus: Pending**
Eng Mk/Mdl CONTINENTAL O-200		**Fatal 0 Ser Inj 0**	**Flt Conducted Under: FAR 091**	
Opr Name: BUTTERHOF ANTHONY J	**Opr dba:**		**Aircraft Fire: NONE**	
			AW Cert: SPE	

Events

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

Narrative

On April 2, 2016, about 1530 eastern daylight time, an experimental amateur-built Ginny B, N349E, was substantially damaged during a forced landing in South Harrison Township, New Jersey. The pilot sustained minor injuries. Visual meteorological conditions prevailed, and no flight plan had been filed for the local flight from Alloway Airfield (NJ02), Alloway, New Jersey. The personal flight was conducted under the provisions of 14 Code of Federal Regulations Part 91.

According to the pilot, who also held an airframe and powerplant (A&P) certificate, the flight was the first since he overhauled and installed a Continental O-200 engine. The pilot took off about 1500, and headed north from the airport. About 30 minutes later, the engine experienced a sudden and complete loss of power, and the pilot could not get it restarted. The pilot then completed a forced landing to a grassy field, where the airplane nosed over. The airplane's wing spar, vertical stabilizer, and right wing struts were substantially damaged.

The pilot and another A&P rated mechanic subsequently performed a conditional inspection on the airplane, where they found that fuel had leaked from the gascolater between the glass cup and the metal frame. They also noted that the bale clamp was not safety-wired, which allowed it to loosen and relax the seal between the gascolator glass cup and its metal frame.

Accident Rpt# CEN17LA293 07/31/2017 835 CDT	**Regis# N204BC**	**Potosi, MO**	**Apt: Washginton County Airport 8WC**
Acft Mk/Mdl CHAPMAN T-BIRD II	**Acft SN 10119**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Prelim Prob Caus: Pending**
		Fatal 0 Ser Inj 1	**Flt Conducted Under: FAR 091**
Opr Name:	**Opr dba:**		**Aircraft Fire: NONE**
			AW Cert: SPE

Events

1. Takeoff - Loss of control in flight

Narrative

On July 31, 2017, at 0835 central daylight time, an amateur built Chapman T-Bird II, N204BC, collided with the terrain shortly after takeoff from the Washington County Airport (8WC), Potosi, Missouri. The private pilot was seriously injured. The airplane was substantially damaged. The airplane was registered to and operated by a private individual as a 14 Code of Federal Regulations Part 91 personal flight. Visual flight rules conditions existed near the accident site at the time of the accident, and a flight plan had not been filed. The local flight was departing at the time of the accident.

A witness reported the takeoff and initial climb looked normal. The airplane then entered what looked like a right crosswind turn, which was the normal procedure after takeoff on runway 02. He stated the wing "dropped" in the turn and the airplane continued a descending turn until it disappeared behind the terrain. The witness, who had flown the accident airplane, stated that the airplane had a tendency to "drop a wing" in turns and that you had to be quick to recover.

Accident Rpt# WPR17LA153 **07/14/2017 1330 PDT** **Regis# N559JC** **Spokane, WA** **Apt: Felts Field SFF**

Acft Mk/Mdl CLARK JAMES T VANS RV8-UNDESIGNAT **Acft SN 80268** **Acft Dmg: SUBSTANTIAL** **Rpt Status: Prelim** **Prob Caus: Pending**

Fatal 0 **Ser Inj 0** **Flt Conducted Under: FAR 091**

Opr Name: JONATHAN LIARD **Opr dba:** **Aircraft Fire: NONE**

AW Cert: SPE

Events

1. Initial climb - Loss of engine power (total)

Narrative

On July 14, 2017, at 1330 Pacific daylight time, an experimental amateur-built Clark Vans RV-8 airplane, N559JC, sustained substantial damage following a loss of engine power and subsequent off-airport forced landing from Felts Field Airport (FSS), Spokane, Washington. The pilot, the sole occupant, received minor injuries. The pilot/owner operated the airplane as a 14 Code of Federal Regulations Part 91 local personal flight. Visual meteorological conditions prevailed and no flight plan had been filed.

The pilot reported that the engine started to surge after takeoff and he turned back to the airport. During the turn back, the engine lost power and he observed black smoke coming from the engine compartment. The pilot made a forced landing to an open field that resulted in substantial damage to the airplane.

The wreckage was transported to a secure facility for further examination.

Accident Rpt# GAA17CA467 07/30/2017 1815 CDT	**Regis# N616JJ**	**Lawrenceburg, TN**	**Apt: Lawrenceburg-lawrence County 2M2**
Acft Mk/Mdl JAMES D RIGGS RV-10-NO SERIES	**Acft SN 40853**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Prelim Prob Caus: Pending**
		Fatal 0 Ser Inj 0	**Flt Conducted Under: FAR 091**
Opr Name: RIGGS, JAMES D.	**Opr dba:**		**Aircraft Fire: NONE**

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Accident Rpt# CEN17LA302	**08/03/2017 1000 CDT**	**Regis# N571UJ**	**Mantone, IN**	**Apt: Mantone C92**
Acft Mk/Mdl JAMES F HAKE MTO SPORT-NO SERIES		**Acft SN M01269**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Prelim** **Prob Caus: Pending**
			Fatal 0 **Ser Inj 1**	**Flt Conducted Under: FAR 091**
Opr Name: JAMES F. HAKE		**Opr dba:**		**Aircraft Fire: NONE**
				AW Cert: SPX

Events

1. Landing-flare/touchdown - Roll over

Narrative

On August 3, 2017, about 0917 central daylight time, a Hake MTO Sport gyroplane, N571UJ, sustained minor damage when it tipped over on landing at Mantone Airport (C92), Mantone, Indiana. Visual meteorological conditions prevailed at the time of the accident. The personal flight was being conducted under the provisions of Title 14 Code of Federal Regulations Part 91 without a flight plan. The pilot sustained a serious injury. The local flight originated at an undetermined time.

Witnesses reported the pilot flared too high and landed hard on runway 36. The gyroplane bounced and tipped over. The pilot later told a Federal Aviation Administration FAA) inspector that he had applied right rudder on landing. The rudder pedals remain connected to the steerable nose gear. When the nose wheel touched down, the side load caused the gyrocopter to tip onto its side and the rotor and propeller both struck the ground. The pilot said the accident was due to pilot error and that there were no mechanical or weather issues.

Accident Rpt# GAA17CA324 05/28/2017 1500 EDT	**Regis# N272SS**	**Boca Raton, FL**	**Apt: Boca Raton BCT**	
Acft Mk/Mdl JESS LLC JUST AIRCRAFT SUPERS	**Acft SN JA274-09-12**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Factual**	**Prob Caus: Pending**
Eng Mk/Mdl ROTAX 912ULS	**Acft TT 685**	**Fatal 0 Ser Inj 0**	**Flt Conducted Under: FAR 091**	
Opr Name: NEW BOCA LEASING LLC	**Opr dba:**		**Aircraft Fire: NONE**	
			AW Cert: SPE	

Summary

The pilot of a tailwheel-equipped airplane reported that, during the landing roll, the airplane veered to the left. He added that he applied brakes, but the airplane continued to the left. Subsequently, the airplane ground looped to the left, the right main landing gear collapsed, and the right wing impacted the ground.
The airplane sustained substantial damage to the right wing.
The pilot reported that the winds were light and variable.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's failure to maintain directional control during the landing roll.

Events

1. Landing-landing roll - Loss of control on ground
2. Landing-landing roll - Collision with terr/obj (non-CFIT)

Findings - Cause/Factor

1. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Directional control-Not attained/maintained - C
2. Personnel issues-Task performance-Use of equip/info-Aircraft control-Pilot - C

Narrative

The pilot of a tailwheel-equipped airplane reported that during the landing roll, the airplane veered to the left. He added that he applied brakes, but the airplane continued to the left. Subsequently, the airplane ground looped to the left, the right main landing gear collapsed, and the right wing impacted the ground.

The airplane sustained substantial damage to the right wing.

The pilot reported that the winds were light and variable.

Accident Rpt# ERA17LA258 07/22/2017 1730 EDT	**Regis# N651JL**	**Aiken, SC**	**Apt: Aiken Muni AIK**	
Acft Mk/Mdl KUBASSEK DAVID ZENITH 601-XL	**Acft SN 4613**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Prelim**	**Prob Caus: Pending**
Eng Mk/Mdl LYCOMING O-235		**Fatal 0 Ser Inj 0**	**Flt Conducted Under: FAR 091**	
Opr Name: ROY PLACKIS	**Opr dba:**		**Aircraft Fire: NONE**	
			AW Cert: SPE	

Events

1. Landing - Landing gear collapse

Narrative

On July 22, 2017, about 1730 eastern daylight time, an experimental, amateur-built Zenith 601XL, N651JL, was substantially damaged during landing at Aiken Municipal Airport (AIK), Aiken, South Carolina. The commercial pilot was not injured. The personal flight was conducted under the provisions of 14 Code of Federal Regulations Part 91. Visual meteorological conditions prevailed and no flight plan was filed for the flight that departed Hendersonville Airport (0A7), Hendersonville, North Carolina.

In a statement provided to a Federal Aviation Administration (FAA) inspector, the pilot reported that after touchdown the airplane began "shaking violently." He pulled back on the yoke, which resulted in a tail strike, the nose gear collapsed when it contacted the ground the second time.

Examination of the airplane by the FAA inspector revealed substantial damage to the firewall, leading edge of the left wing, and nose gear. The inspector stated the airplane touched down approximately 800 ft from the threshold of runway 25. About 65 ft from the runway there were tire marks in the grass from the two main wheels and divots from the nose gear fairing.

The two-seat, low wing, tricycle landing gear-equipped airplane, was powered by a Lycoming O-235, 116-horsepower engine.

The pilot held a commercial pilot certificate with ratings for airplane single-engine land, airplane single-engine sea, airplane multiengine land, and instrument airplane. He also possessed an airframe and powerplant mechanic certificate.

The 1815 weather at AIK included wind from 180ø at 6 knots; visibility 10 statute miles; temperature 32ø C; dew point 23ø C; and altimeter setting 29.98 inches of mercury.

The airplane was recovered and retained for further examination.

Accident Rpt# GAA17CA316	**06/02/2017 1400 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: Factual Prob Caus: Pending**
Eng Mk/Mdl LYCOMING IO-360-A1-B6		**Acft TT 97**	**Fatal 0 Ser Inj 0**	**Flt Conducted Under: FAR 091**
Opr Name: WALTER S. MALINOWSKI		**Opr dba:**		**Aircraft Fire: NONE**
				AW Cert: SPE

Events

1. Landing - Loss of control on ground

Narrative

The pilot reported that during the landing, as the main gear touched down, a gust of wind "carried" the airplane off the right side of the runway. He added that when the nose gear touched down, it sunk into the soft ground and the airplane "flipped over on its back".

The airplane sustained substantial damage to its canopy and empennage.

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

The pilot reported the weather at the accident site, about the time of the accident as, wind from 330ø at 12 knots, gusting to about 20 knots. The pilot landed on runway 06.

An automated weather observation system about 14 nautical miles from the accident site reported that, about the time of the accident, wind from 310ø at 8 knots, gusting to 16 knots.

Accident Rpt# GAA17CA451	**07/28/2017 1215 CDT**	**Regis# N410BP**	**Oshkosh, WI**	**Apt: Wittman Rgnl OSH**	
Acft Mk/Mdl MARK GOLDBERG BEARHAWK		**Acft SN**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Prelim**	**Prob Caus: Pending**
			Fatal 0 **Ser Inj 0**	**Flt Conducted Under: FAR 091**	
Opr Name: MICHAEL NELLIS		**Opr dba:**		**Aircraft Fire: NONE**	

Accident Rpt# CEN17FA297	**07/31/2017 2030 CDT**	**Regis# N22HW**	**Topeka, KS**	**Apt: Philip Billard Municipal Airpo TOP**
Acft Mk/Mdl PIPER PA30		**Acft SN 30-791**	**Acft Dmg: DESTROYED**	**Rpt Status: Prelim Prob Caus: Pending**
			Fatal 2 Ser Inj 0	**Flt Conducted Under: FAR 103**
Opr Name: INDIVIDUAL		**Opr dba:**		**Aircraft Fire: NONE**
				AW Cert: STN

Events

1. Approach-VFR pattern base - Loss of control in flight

Narrative

On July 31, 2017, about 2030, a Piper PA-30, N22HW, impacted terrain at Philip Billard Municipal Airport (TOP), Topeka, Kansas. The student pilot and the flight instructor sustained fatal injuries and the airplane was destroyed by impact forces. The airplane was operated by a private individual who was the the registered owner of the airplane, under the provisions of 14 Code of Federal Regulations Part 91 as in instructional flight that was not operating on a flight plan. Visual meteorological conditions prevailed at the time of the accident. The flight originated from TOP.

The student pilot had been receiving flight instruction from the flight instructor toward the addition of a multi-engine land airplane rating onto his private pilot certificate, which had a single engine landing and instrument rating. The accident flight was a practice multi-engine check ride for the student pilot's examination that was scheduled the following day.

A witness stated that the flight had used runway 18 for takeoff and landing prior to the accident takeoff, which was from runway 18. The witness stated that as the airplane passed the airport terminal building, it was very low in altitude and not climbing very fast. The airplane turned east and into the left-hand airport traffic pattern. The witness did not see the airplane impact the terrain.

The airplane wreckage was located between runway 13 and taxiway B, near the approach end of runway 13. The tail-to-nose heading of the wreckage was about 125 degrees. The airplane's wing flaps and landing gear were retracted. The airplane exhibited damage consistent with a low-speed impact in a left wing-low and shallow pitch attitude.

Post-accident examination of the airplane revealed no mechanical anomalies that would have precluded normal operation.

Accident Rpt# GAA17CA458A 07/28/2017 1300 PDT	**Regis# N16MR**	**Spokane, WA**	**Apt: SKA**	
Acft Mk/Mdl RANDALL MARVIN L VANS RV	**Acft SN 811-3**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Prelim**	**Prob Caus: Pending**
		Fatal 0 Ser Inj 0	**Flt Conducted Under: FAR 091**	
Opr Name: VANGUARD SQUADRON INC	**Opr dba:**		**Aircraft Fire: NONE**	

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Accident Rpt# CEN16LA316	**08/09/2016 1500 CDT**	**Regis# N6214C**	**Winterset, IA**	**Apt: Winterset Muni 3Y3**	
Acft Mk/Mdl SCHABACKER KONRAD J ACRO SPORT		**Acft SN KJS 1993**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Factual**	**Prob Caus: Pending**
Eng Mk/Mdl LYCOMING O-360-A1D		**Acft TT 89**	**Fatal 0**	**Ser Inj 0**	**Flt Conducted Under: FAR 091**
Opr Name: LEO SMITH		**Opr dba:**			**Aircraft Fire: NONE**

Events

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

Narrative

On August 9, 2016, at 1600 central daylight time, an amateur-built Schabacker Konrad J Acro Sport II, N6214C, collided with two parked airplanes following a loss of control while landing at the Winterset Municipal Airport (3Y3), Winterset, Iowa. Neither the airline transport pilot (ATP) pilot nor the airplane owner/pilot rated-passenger were injured. The airplane was substantially damaged. The aircraft was registered to the pilot-rated passenger and it was being operated under the provisions of 14 Code of Federal Regulations Part 91 as a personal flight. Visual meteorological conditions prevailed for the flight, which was not operated on a flight plan. The flight originated from the Mason City Municipal Airport (MCW), Mason City, Iowa, at 1340.

The airplane owner had recently purchased the airplane and had the pilot fly the airplane because the airplane owner did not hold an endorsement to fly tailwheel equipped airplanes. The pilot had a total flight time of 2.5 hours in the accident airplane.

The pilot reported they overflew the airport, checked the windsock, and noted the wind was calm so they decided to land on runway 32. Shortly into the landing roll, the airplane began to veer to the left. The pilot straightened the airplane and added engine power to initiate an aborted landing. The airplane once again veered to the left and traveled down an embankment before it collided with two unoccupied parked airplanes on the ramp which were: N601FA, an Aerostar 601P, and N31EG, a Piper PA-23-250.

The pilot reported the local wind was calm at the time of the landing. The winds recorded at Des Moines International Airport, Des Moines, Iowa, located about 22 miles northeast of 3Y3, were from 150 degrees at 6 knots.

A postaccident examination of the landing gear and brakes was conducted by a Federal Aviation Administration inspector. The inspector reported that he did not find any anomalies that would have prevented the pilot's ability to maintain directional control of the airplane. In addition, the pilot reported that there was no mechanical failure/malfunction of the airplane.

Accident Rpt# CEN17LA295 07/30/2017 1900 EDT	**Regis# N896JC**	**Loudenville, OH**	**Apt: N/a**
Acft Mk/Mdl STEELE ACRO SPORT II	**Acft SN 689**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Prelim Prob Caus: Pending**
Eng Mk/Mdl LYCOMING O-360-A3A		**Fatal 0 Ser Inj 0**	**Flt Conducted Under: FAR 091**
Opr Name: PILOT	**Opr dba:**		**Aircraft Fire: NONE**
			AW Cert: SPE

Events

1. Enroute - Loss of engine power (partial)

Narrative

On July 30, 2017, about 1900 eastern daylight time, an experimental amateur-built Steele Acro Sport II biplane, N896JC, nosed over during a forced landing following a partial loss of engine power near Loudenville, Ohio. The pilot and passenger received minor injuries. The airplane sustained substantial wing damage during the nose over. 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 in the area of the accident site about the time of the accident, and the flight was not operated on a flight plan. The flight originated from the Smith Field Airport (SMD), near Fort Wayne, Indiana, and was destined for the Holmes County Airport, near Millersburg, Ohio.

According to operations personnel at SMD, the airplane had landed there and self-serve fueling had been conducted at 1543. The airplane was serviced with 15.8 gallons of fuel.

At 1852, the recorded weather at the Mansfield Lahm Regional Airport, near Mansfield, Ohio, was: Wind 340ø at 8 kts; visibility 10 statute miles; sky condition clear; temperature 26ø C; dew point 14ø C; altimeter 30.17 inches of mercury.

Accident Rpt# GAA17CA299 05/21/2017 1230 AKD	**Regis# N484WT**	**Talkeetna, AK**	**Apt: Talkeetna TKA**	
Acft Mk/Mdl THOMAS E HUDZINSKI BACKCOUNTRY	**Acft SN BC31411007**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Factual**	**Prob Caus: Pending**
Eng Mk/Mdl AEROSPORT POWER IO-375	**Acft TT 460**	**Fatal 0 Ser Inj 0**	**Flt Conducted Under: FAR 091**	
Opr Name: THOMAS E. HUDZINSKI	**Opr dba:**		**Aircraft Fire: NONE**	
			AW Cert: SPE	

Summary

The pilot reported that, while participating in a slow flight competition, he was over the target area for the radar speed check about 30 ft above the ground, at 17 mph ground speed, when the left wing stalled. He added that he did not have sufficient altitude to recover. Subsequently, the airplane impacted the ground.
The airplane sustained substantial damage to both wings.
The pilot reported that there were no preaccident mechanical failures or malfunctions 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 pilot's failure to maintain a proper airspeed and his exceedance of the airplane's critical angle of attack, which resulted in an aerodynamic stall.

Events

1. Maneuvering-low-alt flying - Loss of control in flight
2. Maneuvering-low-alt flying - Aerodynamic stall/spin
3. Maneuvering-low-alt flying - Collision with terr/obj (non-CFIT)

Findings - Cause/Factor

1. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Angle of attack-Capability exceeded - C
2. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Airspeed-Not attained/maintained - C
3. Personnel issues-Task performance-Use of equip/info-Aircraft control-Pilot - C
4. Environmental issues-Task environment-Pressures/demands-(general)-Effect on personnel

Narrative

The pilot reported that, while participating in a slow flight competition, he was over the target area for the radar speed check about 30ft. above the ground, at 17 mph ground speed, when the left wing stalled. He added, that he did not have sufficient altitude to recover. Subsequently, the airplane impacted the ground.

The airplane sustained substantial damage to both wings.

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

Accident Rpt# GAA17CA358 06/19/2017 1823 PDT	**Regis# N234VA**	**Eugene, OR**	**Apt: Mahlon Sweet Field EUG**
Acft Mk/Mdl VANS AIRCRAFT INC RV-12-NO SERIES	**Acft SN S12008**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Factual Prob Caus: Pending**
Eng Mk/Mdl ROTAX 912ULS	**Acft TT 1051**	**Fatal 0 Ser Inj 0**	**Flt Conducted Under: FAR 091**
Opr Name: LANE COMMUNITY COLLEGE	**Opr dba:**		**Aircraft Fire: NONE**
			AW Cert: LTSP

Events

1. Takeoff - Loss of control on ground

Narrative

According to the flight school director, the student pilot was conducting stop-and-go landings during a solo flight. He added that the student pilot reported that during takeoff, the airplane began to "fishtail," the student pilot reduced power, but the airplane continued to the left, exited the runway, and impacted a taxiway sign.

The airplane sustained substantial damage to the fuselage.

The flight school director reported that, according to the student pilot there were no preaccident mechanical failures or malfunctions with the airplane that would have precluded normal operation.

Accident Rpt# GAA17CA458B 07/28/2017 1300 PDT	**Regis# N6GT**	**Spokane, WA**	**Apt: SKA**	
Acft Mk/Mdl WILTS GAYLE T RV-3A-NO SERIES	**Acft SN 811-1**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Prelim**	**Prob Caus: Pending**
		Fatal 0 Ser Inj 0	**Flt Conducted Under: FAR 091**	
Opr Name: VANGUARD SQUADRON INC	**Opr dba:**		**Aircraft Fire: NONE**	

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Accident Rpt# CEN17FA288	**07/27/2017 400 CDT**	**Regis# N701XL**	**Laddonia, MO**	**Apt: N/a**
Acft Mk/Mdl ZENITH CH701SP		**Acft SN 7-4618**	**Acft Dmg: DESTROYED**	**Rpt Status: Prelim** **Prob Caus: Pending**
Eng Mk/Mdl ROTAX 912ULS			**Fatal 2** **Ser Inj 0**	**Flt Conducted Under: FAR 091**
Opr Name: BOBBY R. FAULKNER		**Opr dba:**		**Aircraft Fire: NONE**
				AW Cert: SPX

Events

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

Narrative

On July 27, 2017, about 0415 central daylight time, a Zenith CH 701SP, N701XP, piloted by a non-instrument rated sport pilot, was destroyed when the it impacted terrain approximately 6.5 miles north of Laddonia, and 16.5 miles northeast of Mexico, Missouri. Instrument meteorological conditions prevailed at the time of the accident. The personal flight was being conducted under the provisions of Title 14 Code of Federal Regulations Part 91 without a flight plan. The pilot and passenger on board the airplane were fatally injured. The cross-country flight originated from Mexico Municipal Airport (KMYJ), Mexico, Missouri, about 0400, and was en route to Oshkosh (OSH), Wisconsin.

According to the airport manager, the airplane arrived late in the day on July 26. The pilot said he wanted to get an early start the next morning because he wanted to arrive at OSH when the control tower opened at 0700. The manager said he believed the pilot and his wife camped that evening next to the airplane. When the manager arrived at the airport the next morning, the airplane was gone. The airplane was later reported missing and an ALNOT (Alert Notice) was issued that evening. The wreckage was located early the next morning.

The on-scene investigation revealed the airplane struck the ground in a right wing low, nose down attitude as evidenced by green position light fragments at the beginning of the ground scar, followed by the impact crater. A crushed right wing and relatively intact left wing were located further down the debris path, followed by the fuselage and engine. The debris path was aligned on a heading back towards Mexico. There is no record that the pilot obtained a weather briefing or filed a flight plan.

Accident Rpt# GAA17CA301 04/30/2017 1510 PDT	**Regis# N89SR**	**Napa, CA**	**Apt: N/a**	
Acft Mk/Mdl ZWICKER MURRAY R GLASTAR-NO	**Acft SN 5492**	**Acft Dmg: SUBSTANTIAL**	**Rpt Status: Factual**	**Prob Caus: Pending**
Eng Mk/Mdl LYCOMING O-360 SERIES		**Fatal 0 Ser Inj 0**	**Flt Conducted Under: FAR 091**	
Opr Name: BORHAUG, JAN E.	**Opr dba:**		**Aircraft Fire: NONE**	
			AW Cert: SPE	

Summary

The pilot of the amphibious float-equipped airplane reported that, after the owner had completed multiple touch-and-go water landings, he chose to take the flight controls and perform a few water landings himself. He added that his first touch-and-go water landing "went very well." However, during the second touch-and-go water landing, the touchdown was smooth, but as he added power to "begin the climb away," the airplane veered right and nosed over into the water. He added that the right float may have struck a submerged object during the landing.

The right wing lift strut sustained substantial damage.

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

According to a Federal Aviation Administration (FAA) Aviation Safety Inspector who inspected the accident airplane postaccident, the forward first third section of the right float was bent upward and had "scratching and scoring" marks on the bottom side of the float. He added that he did not observe any rust or corrosion on either float.

A review of the FAA airman certification database revealed that neither pilot held an airplane single-engine sea rating.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The amphibious float-equipped airplane's encounter with a submerged object during a water landing, which resulted in a nose-over.

Events

1. Landing-landing roll - Collision with terr/obj (non-CFIT)
2. Landing-landing roll - Landing gear collapse
3. Landing-landing roll - Nose over/nose down

Findings - Cause/Factor

1. Environmental issues-Physical environment-Object/animal/substance-Hidden/submerged object-Effect on equipment - C
2. Personnel issues-Experience/knowledge-Experience/qualifications-Qualification/certification-Pilot
3. Personnel issues-Experience/knowledge-Experience/qualifications-Qualification/certification-Copilot

Narrative

The pilot of the amphibious float-equipped airplane reported that, after the owner had completed multiple touch-and-go water landings, he elected to take the flight controls and perform a few water landings himself. He added that his first touch-and-go water landing "went very well." However, during the second touch-and-go water landing, the touchdown was smooth, but as he added power to "begin the climb away", the airplane veered right and nosed over into the water. He added that, the right float may have struck a submerged object during the landing.

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