

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# GAA17CA190	03/11/2017 1345 PST	Regis# N56FD	Minden, NV	Apt: Minden-tahoe MEV
Acft Mk/Mdl DAVIS FRANK R XENOS		Acft SN XNS-019	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl JABIRU 3300A		Acft TT 74	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: FRANK R. DAVIS		Opr dba:		Aircraft Fire: NONE
				AW Cert: SPE

Summary

The pilot of the tailwheel-equipped airplane reported that, during touchdown, the airplane "weathervaned to the left and full right rudder could not keep it on the runway." Subsequently, the main landing gear dug into the soft mud, and the airplane nosed over.

The airplane sustained substantial damage to the empennage.

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

The automated weather observation system located on the accident airport reported that, about the time of the accident, the wind was variable at 6 knots. The pilot landed on runway 34.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's failure to maintain directional control in variable wind conditions.

Events

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

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
3. Environmental issues-Physical environment-Runway/land/takeoff/taxi surface-Soft surface-Effect on equipment
4. Environmental issues-Conditions/weather/phenomena-Wind-Variable wind-Effect on operation

Narrative

The pilot of the tailwheel-equipped airplane reported that, during touchdown the airplane "weathervaned to the left and full right rudder could not keep it on the runway". Subsequently, the main landing gear dug into the soft mud and the airplane nosed over.

The airplane sustained substantial damage to the empennage.

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

The automated weather observation system located on the accident airport reported that, about the time of the accident, the wind was variable at 6 knots. The pilot landed on runway 34.

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Accident Rpt# GAA17CA397 07/07/2017 1515 EDT Regis# N253BC Ahoskie, NC Apt: N/a
Acraft Mk/Mdl RAINBOW SKY REACH (PTY) LTD Acft SN CH143B Acft Dmg: SUBSTANTIAL Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl ROTAX 912ULS Acft TT 169 Fatal 0 Ser Inj 0 Flt Conducted Under: FAR 091
Opr Name: OVERWATCH TOOLS LLC. Opr dba: Aircraft Fire: NONE
AW Cert: LTSP

Summary

The pilot of the float-equipped airplane reported that he overflew the river where he planned to land about 1,000 ft above the water. He observed "negligible surface clues" indicating wind direction and recalled that a nearby "ATIS" reported the wind as "light" and from the southwest, so he decided to land to the south. He added that, following a normal landing touchdown, as the airplane was slowing, a "sudden moderate to severe gust of wind came from the right to left." He added that he "inputted right stick to counter" the wind gust and applied power to "go-around," but the airplane nosed over forward and to the left. The fuselage, empennage, 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.

An automated weather observation station 14 nautical miles (nm) southwest from the accident site reported, about the time of the accident, wind from 340ø at 3 knots. The departure airport about 30 nm northeast reported, about the time the pilot departed, wind from 300ø at 4 knots. The pilot reported that the wind was from the southwest, gusting to 10 to 15 knots. He added that the landing direction was to the south.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's failure to maintain proper lateral/bank control during the landing in gusting wind conditions, which resulted in a nose-over into water.

Events

1. Landing-landing roll - Other weather encounter
2. Landing-landing roll - Loss of control on ground
3. Landing-landing roll - Nose over/nose down

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-Lateral/bank control-Not attained/maintained - C
3. Environmental issues-Conditions/weather/phenomena-Wind-Gusts-Effect on operation

Narrative

The pilot of the float-equipped airplane reported that, he overflew the river where he planned to land about 1,000 ft. above the water. He observed "negligible surface clues" indicating wind direction and recalled that a nearby "ATIS" reported the wind as "light" and from the southwest, so he decided to land to the south. He added that, following a normal landing touchdown, as the airplane was slowing, a "sudden moderate to severe gust of wind came from the right to left." He added that, he "inputted right stick to counter" the wind gust and applied power to "go-around," but the airplane nosed over forward and to the left.

The fuselage, empennage, 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.

An automated weather observation station, about the time of the accident, 14 nautical miles (NM) southwest from the accident site, reported wind from 340ø at 3 knots. The departure airport, about 30 NM northeast, near the time the pilot departed, reported wind from 300ø at 4 knots. The pilot reported the wind from the southwest, gusting 10 to 15 knots. He added that the landing direction was to the south.

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Accident Rpt# GAA17CA557	09/26/2017 1250 EDT	Regis# N184SJ	Orange, MA	Apt: Orange Muni ORE
Acft Mk/Mdl BELLET JAMES J VANS RV		Acft SN 81645	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl LYCOMING IO-360			Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: BELLET, JAMES J.		Opr dba:		Aircraft Fire: NONE
				AW Cert: SPE

Events

1. Prior to flight - Miscellaneous/other

Narrative

The Federal Aviation Administration (FAA) Aviation Safety Inspector reported that, during a telephone conversation, the pilot reported that during the climb he noticed the engine cylinder heat temperature gauge exceed 500ø F. The pilot added that, he immediately turned back to the departure airport, and while in the downwind for the landing runway, the engine lost power. The pilot further added that, the airplane immediately lost altitude, cleared a tree line in the path to the runway, but impacted the terrain hard in a base to final flight path near the runway threshold. He added that when he exited the airplane, he observed an engine cowl plug installed on the right side of the engine cowl and removed it.

The right wing and fuselage sustained substantial damage.

The FAA inspector reported that he traveled to the accident, and while on-site, he observed the left cowl plug melted onto the engine cylinders. He added that the right cowl plug was found on the ground near the airplane.

The pilot did not report that there were any preaccident mechanical malfunctions or failures with the airplane that would have precluded normal operation.

The pilot failed to submit the NTSB Form 6120.1 Pilot/ Operator Aircraft Accident/ Incident Report.

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Accident Rpt# ERA17LA335	09/25/2017 1740 EDT	Regis# N926KB	Odessa, FL	Apt: N/a
Acft Mk/Mdl BRAD J BATES MOSQUITO XE 285-NO S	Acft SN MXE 1306A17B	Acft Dmg: SUBSTANTIAL	Rpt Status: Prelim	Prob Caus: Pending
Eng Mk/Mdl SUZUKI INNTEC 800	Acft TT 20	Fatal 0 Ser Inj 0	Fit Conducted Under: FAR 091	
Opr Name: BATES BRAD J	Opr dba:	Aircraft Fire: NONE		AW Cert: SPE

Events

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

Narrative

On September 25, 2017, about 1740 eastern daylight time, an experimental amateur-built, Mosquito XE 285 helicopter, N926KB, was substantially damaged when it impacted a residence in Odessa, Florida, during an autorotation. The private pilot sustained minor injuries. Visual meteorological conditions prevailed, and no flight plan was filed for the local personal flight conducted under the provisions of 14 Code of Federal Regulations Part 91.

According to the pilot, he had departed from his residence in Odessa, Florida about 1645 for a local flight. He flew around the local area at an altitude of 800 to 1,000 ft above mean sea level, for about 45 minutes. During this time, there was no indication of any type of mechanical problem with the helicopter or engine. The pilot was returning to where he had departed from, and the helicopter was in a slow descent, when he noticed a substantial loss of engine and rotor rpm. He then tried to increase power with no response, so he immediately entered an autorotation and started looking for a place to land. He aimed for an open area, but "fell short" and the helicopter impacted the roof of a residence.

Examination of the accident site and wreckage by a Federal Aviation Administration (FAA) inspector revealed that the helicopter struck the back side of the roof perpendicular to the roof's peak. It came to rest on its left side with the cockpit on the forward side of the roof's peak, and the tailboom (still attached, but bent) on the back side of the roof's peak. The left landing gear skid had penetrated the roof into the attic and two other holes were also present in the roof, which corresponded to the location of the tips of both main rotor blades.

Both main rotor blades remained attached to the rotor head, and the tail rotor remained attached to the tail boom. The drivetrain and flight controls were intact; however, there was no indication of main rotor rotation at impact either on the main rotor blades or the roof surface.

According to FAA airman records and pilot records, the pilot held a private pilot certificate with a rating for helicopters. His most recent FAA third-class medical certificate was issued on January 28, 2016. He reported that he had accrued 79.8 total hours of flight experience, 18.1 of which was in the accident helicopter make and model.

According to FAA airworthiness and helicopter maintenance records, the helicopter's special airworthiness certificate was issued on April 20, 2017. Its most recent condition inspection was completed on that same date. At the time of the accident, the helicopter and engine had accrued about 20 total hours of operation.

The wreckage was retained for further examination.

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Accident Rpt# GAA17CA567	09/06/2017 1330 EDT	Regis# N1214J	Dunkirk, NY	Apt: Chautauqua County/dunkirk DKK
Acft Mk/Mdl CHANCEY GERRY M RV-12-NO SERIES	Acft SN 120054	Acft Dmg: SUBSTANTIAL	Fatal 0	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl ROTAX		Ser Inj 0		Fit Conducted Under: FAR 091
Opr Name: EMMERLING, FRANCIS	Opr dba:			Aircraft Fire: NONE
				AW Cert: SPE

Events

2. Initial climb - Loss of control in flight

Narrative

During a telephone conversation with the NTSB investigator-in-charge, the pilot reported that, immediately after takeoff, the airplane encountered a gust of wind and the right wing dipped. Subsequently, the airplane drifted to the right and the right wing impacted terrain and a taxiway sign. He added that he "lost control during takeoff."

The right wing and fuselage sustained substantial damage.

The pilot did not report that there were any preaccident mechanical malfunctions or failures with the airplane that would have precluded normal operation.

An automated weather observation station at the airport, about the time of the accident, reported wind from 270ø at 10 knots. The pilot reported the takeoff was on runway 33.

The pilot failed to submit the NTSB Form 6120.1 Pilot/ Operator Aircraft Accident/ Incident Report.

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Accident Rpt# GAA17CA484	08/10/2017 1200 EDT	Regis# N211BP	Ocean City, NJ	Apt: Ocean City Muni 26N
Acft Mk/Mdl CONSTRUCCIONES AERONAUTICAS SA	Acft SN E-3B-172	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual	Prob Caus: Pending
Eng Mk/Mdl LYCOMING IO-360-A2B	Acft TT 2908	Fatal 0	Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: ARTHUR MANFREDI - HANGAR 13 LLC	Opr dba:	Aircraft Fire: NONE		AW Cert: SPE

Summary

The pilot of the tailwheel-equipped biplane reported that, during the landing roll, the biplane started to veer right. He attempted to regain control, but the biplane continued to veer right and ground looped. Subsequently, the bottom of the left wing impacted the ground, and the left main landing gear collapsed.

The biplane sustained substantial damage to the left wing.

The pilot reported that there were no preaccident mechanical failures or malfunctions with the biplane 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 directional control during the landing roll.

Events

1. Landing - Loss of control on ground
2. Landing - Dragged wing/rotor/float/other

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 the tailwheel-equipped biplane reported that, during the landing roll, the biplane started to veer right. He attempted to regain control, but the biplane continued to veer right and ground looped. Subsequently, the bottom of the left wing impacted the ground and the left main gear collapsed.

The biplane sustained substantial damage to the left wing

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

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Accident Rpt# GAA17CA518	09/02/2017 1500	Regis# N429NC	Afton, WY	Apt: Afton Muni AFO
Acft Mk/Mdl CROFT ROBERT C KITFOX SUPER		Acft SN KA10123166	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl ROTEC R2800 MKII		Acft TT 176	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: RODERICK, JAMES J.		Opr dba:		Aircraft Fire: NONE
				AW Cert: SPE

Events

2. Approach-VFR go-around - Loss of control in flight

Narrative

The pilot of the tailwheel-equipped airplane reported that, during landing, the airplane bounced, so he applied power for a go around. He added that the airplane "immediately banked left sharply". He attempted to recover by using rudder and aileron inputs, but the airplane impacted terrain.

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.

A review of recorded data from the automated weather observation station located on the airport reported that, about 5 minutes before the accident, the wind was calm. The airplane was landing on runway 34.

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Accident Rpt# WPR15LA170 05/29/2015 1100 Regis# N747N Hurricane, UT Apt: General Dick Stout Field 1L8
Acraft Mk/Mdl DUENAS PULSAR III Acft SN 573 Acft Dmg: SUBSTANTIAL Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl AEROMAXX BB420 H Acft TT 10 Fatal 0 Ser Inj 1 Flt Conducted Under: FAR 091
Opr Name: CARLOS DUENAS Opr dba: Aircraft Fire: NONE
AW Cert: SPE

Summary

The private pilot of the experimental, amateur-built airplane reported that the purpose of the flight was to evaluate the effect of airstream cooling on the engine oil temperature once the airplane reached level flight. He stated that departure, climb, and level-off were uneventful; however, while maneuvering, the oil temperature began to increase. A descent did not mitigate the increase in oil temperature, and the engine subsequently experienced a total loss of power. The pilot attempted to restart the engine; when it did not respond, he began a right turn toward the departure runway. The airplane touched down short of the runway and collided with a fence. The pilot sustained a serious head injury and did not recall anything after the turn toward the airport. The experimental engine was not made available for examination after the accident, and the reason for the elevated oil temperature and subsequent loss of engine power was not determined.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: An elevated oil temperature and subsequent total loss of engine power for reasons that could not be determined based on the available information.

Events

1. Maneuvering - Loss of engine power (total)
2. Emergency descent - Loss of engine power (total)
3. Landing-flare/touchdown - Off-field or emergency landing

Findings - Cause/Factor

1. Not determined-Not determined-(general)-(general)-Unknown/Not determined - C
2. Aircraft-Aircraft power plant-Eng oil sys (airframe furnish)-Temperature-Not specified

Narrative

HISTORY OF FLIGHT

On May 29, 2015, about 1100 mountain daylight time, an experimental amateur-built Pulsar III, N747N, collided with corral fences during an emergency off airport forced landing at Hurricane, Utah. The private pilot sustained serious injuries; the airplane sustained substantial damage. The pilot/owner was operating the airplane under the provisions of 14 Code of Federal Regulations (CFR) Part 91. The local personal flight departed General Dick Stout Field (1L8) in Hurricane about 1000. Visual meteorological conditions prevailed, and no flight plan had been filed.

The pilot reported that the purpose of the flight was to evaluate the effect of airstream cooling on the engine oil temperature once the airplane reached level flight. The plan was to circle above the airport while climbing to the desired altitude, establish level flight, observe the oil temperature, and land. After takeoff, climb performance and oil temperature were normal. At 5,100 ft msl (airport elevation was 3,347 ft), the pilot began to circle the airport. After three circles, he noticed that the oil temperature was about 220° F, and he began a shallow descent to help cool the engine.

About 4,500 ft, the oil temperature was about 230° F, and the engine shut off. He turned on the auxiliary fuel pump, and attempted to restart the engine. When it did not respond, he began a right turn towards runway 19 at 1L8. The airplane touched down short of the runway, and collided with the corral fences. The pilot sustained a serious head injury, and did not recall anything after the turn toward the airport.

One witness stated that he had observed the takeoff, and watched the airplane complete two climbing turns. He heard a radio transmission from someone asking the pilot if everything was alright. The pilot replied no, he was "dead sticking," which meant to the witness that the engine was not running. The witness observed the airplane was about 1/2 mile from the airport, and the propeller was not turning. He lost sight of the airplane just prior to touchdown.

AIRCRAFT INFORMATION

The engine was an experimental Aeromaxx BB420 H, serial number 11U, rated at 118 hp. Aeromaxx used their own remanufactured and restored Corvair parts to build Corvair engines for homebuilt, experimental aircraft.

The experimental engine was not available for an exam.

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Accident Rpt# GAA17CA407	07/12/2017 730 MDT	Regis# N116GD	Los Lunas, NM	Apt: Mid Valley Airpark E98
Acft Mk/Mdl GERALD DONOVAN RANS S-16		Acft SN 0101027	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl TELEDYNE CONTINENTAL MOTORS	Acft TT 2	Fatal 0	Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: GERALD DONOVAN	Opr dba:			Aircraft Fire: NONE
				AW Cert: SPE

Summary

The pilot of the experimental amateur-built airplane reported that he was performing a "test flight" and had previously accumulated about 2 hours of total flight time with the airplane. He added that, during the takeoff roll, the airplane veered to the left, and he responded by applying right rudder and aft pitch to rotate the airplane. He added that, as the airplane lifted off the runway, the airplane continued to the left and impacted weeds and a ditch.

The elevator, wings, and right aileron sustained substantial damage.

The pilot reported that there were 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 pilot's failure to maintain directional control during takeoff.

Events

1. Takeoff - Loss of control on ground
2. Takeoff - Runway excursion
3. Takeoff - Collision with terr/obj (non-CFIT)

Findings - Cause/Factor

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

Narrative

The pilot of the experimental amateur-built airplane reported that he was performing a "test flight" and had accumulated about 2 hours of total flight time previously with the airplane. He added that, during the takeoff roll the airplane veered to the left and he responded by applying right rudder and aft pitch to rotate the airplane. He added that, as the airplane lifted off the runway, the airplane continued to the left and impacted weeds and a ditch.

The elevator, wings, and right aileron sustained substantial damage.

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

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Accident Rpt# CEN16LA202	05/29/2016 1100	Regis# N95R	Carlsbad, NM	Apt: Cavern City Air Terminal CNM
Acft Mk/Mdl HARRY OAS PITTS S1C		Acft SN OAS-1	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl LYCOMING O-320		Acft TT 935	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: ALEXANDER S NAVARRE		Opr dba:		Aircraft Fire: NONE
				AW Cert: SPE

Events

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

Narrative

On May 29, 2016, about 1100 mountain daylight time, an experimental, amateur-built Harry Oas Pitts S1C airplane, N95R, was substantially damaged when it nosed over following a runway excursion during landing on runway 14L (4,616 feet by 150 feet, asphalt) at the Cavern City Air Terminal (CNM), Carlsbad, New Mexico. The pilot was not injured. The airplane was registered to and operated by private individuals 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 Big Spring McMahon-Wrinkle Airport (BPG), Big Spring, Texas, at about 0935.

The pilot reported that the prevailing wind was from 160 degrees at 8 knots while on approach to runway 14L at CNM. The approach and touchdown were without incident; however, as the airplane slowed, a "slight" left turn developed. Right rudder and brake inputs were not effective. The left turn continued until the airplane departed the runway pavement. The right wing subsequently struck the ground and the airplane nosed over.

Examination of the runway environment revealed a skid mark beginning left of the centerline and gradually curving toward the left side of the pavement. The mark appeared to have been associated with the left main landing gear tire. There did not appear to be any skid marks associated with the right main landing gear tire.

A postaccident examination was conducted by a local mechanic on behalf of the NTSB. Flight control continuity was confirmed and each control surface exhibited freedom of movement. The brake system was intact and operational. No flat spots were observed on either tire. The mechanic noted that the brakes seemed to be "touchy," adding that a small amount of pedal travel was required to actuate the brakes. In addition, the firewall exhibited a scrape mark and depression consistent with contact from the right rudder/brake pedal linkage. However, movement of the right pedal did not appear to be restricted.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# GAA17CA576 08/30/2017 1440 EDT Regis# N6GH Montgomery, NY Apt: Orange County MGJ
Acft Mk/Mdl HUNTER GEORGE RV 6-UNDESIGNAT Acft SN AIRLANE III Acft Dmg: SUBSTANTIAL Rpt Status: Prelim Prob Caus: Pending
Fatal 0 Ser Inj 0 Flt Conducted Under: FAR 091
Opr Name: HUNTER GEORGE Opr dba: Aircraft Fire: NONE

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# GAA17CA467 07/30/2017 1700 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: Factual Prob Caus: Pending
Eng Mk/Mdl LYCOMING IO-540 Acft TT 70 Fatal 0 Ser Inj 1 Flt Conducted Under: FAR 091
Opr Name: RIGGS, JAMES D. Opr dba: Aircraft Fire: NONE
AW Cert: SPE

Summary

The pilot reported that, during the landing flare, the airplane encountered wind shear and landed hard. He added that, during the bounce, he applied power to go around, but the airplane yawed to the left "severely." The pilot added right rudder and reduced power to abort the takeoff in an attempt to land back on the runway. The airplane was "about 6 ft. [above ground level]" and continued left, and the left wing impacted a ditch. Subsequently, the propeller struck the ground, the airplane rotated 180°, and the airplane came to rest.

The airplane sustained substantial damage to the fuselage and both wings.

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

There were no nearby National Weather Service reporting stations. An online commercial weather service provider reported that a nearby station reported, about the time of the accident, wind from 315° at 1.6 mph, gusting to 3.4 mph. The pilot reported sky clear, visibility 10+, temperature 74°F, and altimeter setting 29.90 inches of mercury, and he observed the wind direction from 270° at a light-and-variable speed, gusting to 7 knots. The airplane landed on runway 35.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's improper landing flare and failure to maintain yaw control during a go-around in gusting wind conditions.

Events

1. Landing - Hard landing
2. Landing - Attempted remediation/recovery
3. Landing - Collision with terr/obj (non-CFIT)

Findings - Cause/Factor

1. Personnel issues-Task performance-Use of equip/info-Aircraft control-Pilot - C
2. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Yaw control-Not attained/maintained - C
3. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Landing flare-Not attained/maintained - C
4. Environmental issues-Conditions/weather/phenomena-Wind-Windshear-Effect on operation
5. Environmental issues-Conditions/weather/phenomena-Wind-Gusts-Effect on operation
6. Environmental issues-Physical environment-Object/animal/substance-(general)-Contributed to outcome

Narrative

The pilot reported that, during the landing flare, the airplane encountered windshear and landed hard. He added that during the bounce, he applied power to go around, but the airplane yawed to the left "severely". The pilot added right rudder and reduced power to abort the takeoff in an attempt to land back on the runway. The airplane "about 6 ft. [above ground level]" continued left and the left wing impacted a ditch. Subsequently, the propeller struck the ground, the airplane rotated 180°, and the airplane came to rest.

The airplane sustained substantial damage to the fuselage and both wings.

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

There were no nearby National Weather Service reporting stations. An online commercial weather service provider reported that a nearby station, about the time of the accident, reported wind from 315° @ 1.6 mph, gusting 3.4 mph. The pilot reported sky clear, visibility 10+, temperature 74?, altimeter 29.90, and he observed the wind direction from 270° at a light and variable speed, gusting to 7 knots. The airplane landed on runway 35.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# CEN17LA302	08/03/2017 1000 CDT	Regis# N571UJ	Mentone, IN	Apt: Mentone C92
Acft Mk/Mdl JAMES F HAKE MTO SPORT-NO SERIES	Acft SN M01269	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual	Prob Caus: Pending
Eng Mk/Mdl ROTAX 912 ULS	Acft TT 185	Fatal 0	Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: JAMES F. HAKE	Opr dba:			Aircraft Fire: NONE

Summary

The sport pilot of the gyroplane stated that, upon touchdown, he should have raised the aircraft's nose to reduce airspeed; however, he allowed the nosewheel to contact the runway. He subsequently applied right rudder to maintain runway alignment. Since the nosewheel and rudder were interconnected (the nosewheel did not pivot on a caster), the application of rudder resulted in the gyroplane tipping over on its side, and both the rotor and propeller blades struck the ground. The pilot stated that there were no mechanical malfunctions or anomalies that would have precluded normal operation of the gyroplane.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's failure to maintain a proper touchdown attitude, which resulted in a loss of directional control during the landing roll.

Events

1. Landing-flare/touchdown - Roll over

Findings - Cause/Factor

1. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Landing flare-Not attained/maintained - C
2. Personnel issues-Action/decision-Action-Incorrect action performance-Pilot - C

Narrative

On August 3, 2017, about 0917 central daylight time, a Hake MTO Sport gyroplane, N571UJ, was substantially damaged when it tipped over on landing at Mentone Airport (C92), Mentone, 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 minor injuries. The local flight originated about 0930.

According to the pilot's accident report, when he touched down on the main landing gear, he applied "moderate" right rudder to maintain runway alignment and to avoid slipping. He stated he should have raised the nose to reduce airspeed, but instead he lowered the nose and struck the runway. The pilot explained that on this particular gyroplane, the nose wheel and rudder are interconnected; that is, the nose wheel does not pivot on a caster. When the gyroplane touched down, it "jerked" abruptly to the right and tipped over. The pilot concluded, "This accident was the result of pilot error. There was no malfunction [of the gyroplane, flight controls, or engine]."

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# GAA17CA451 07/28/2017 1030 CDT Regis# N410BP Oshkosh, WI Apt: Wittman Rgnl OSH
Acft Mk/Mdl MARK GOLDBERG BEARHAWK Acft SN Acft Dmg: SUBSTANTIAL Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl LYCOMING O-360 Fatal 0 Ser Inj 0 Flt Conducted Under: FAR 091
Opr Name: MICHAEL NELLIS Opr dba: Aircraft Fire: NONE
AW Cert: SPE

Summary

The pilot of the tailwheel-equipped airplane reported that, during the landing roll in crosswind conditions, when "transitioning from rudder to braking, the tail started rapidly swinging to the left due to wind." He added that "rudder correction was ineffective," and he applied wheel brakes, but the airplane continued in the ground loop clockwise, the left main landing gear collapsed, and the left wing impacted the runway.

The left wing sustained substantial damage.

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

An automated weather observation station at the accident airport reported, about the time of the accident, wind from 040ø at 8 knots. The pilot reported that, while on short final, the air traffic tower controller announced, "wind 050 at 12." The pilot added that the landing was on runway 36.

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 in crosswind conditions, which resulted in a ground loop.

Events

1. Landing-landing roll - Other weather encounter
2. Landing-landing roll - Loss of control on ground
3. Landing-landing roll - Landing gear collapse
4. Landing-landing roll - Abnormal runway contact

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-Directional control-Not attained/maintained - C
3. Environmental issues-Conditions/weather/phenomena-Wind-Crosswind-Effect on operation

Narrative

The pilot of the tailwheel-equipped airplane reported that, during the landing roll in crosswind conditions, when "transitioning from rudder to braking the tail started rapidly swinging to the left due to wind." He added that "rudder correction was ineffective" and he applied wheel brakes, but the airplane continued in the ground loop clockwise, the left main landing gear collapsed, and the left wing impacted the runway.

The left wing sustained substantial damage.

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

An automated weather observation station, about the time of the accident, at the accident airport, reported wind from 040ø at 8 knots. The pilot reported that while on short final the air traffic tower controller announced, "wind 050 at 12." The pilot added that the landing was on runway 36.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# GAA17CA444	07/27/2017 1100 PDT	Regis# N302DM	Priest River, ID	Apt: N/a
Acft Mk/Mdl MCINTOSH DONALD W KITFOX SERIES	Acft SN S70407064	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual	Prob Caus: Pending
Eng Mk/Mdl JABIRU 3300A	Acft TT 678	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091	
Opr Name: MCINTOSH, DONALD W.	Opr dba:		Aircraft Fire: NONE	
			AW Cert: SPE	

Summary

The pilot of the float-equipped airplane reported that, during a water landing, "immediately upon touchdown, the tail came up to the right and the plane veered left." He added that he applied "hard left aileron," but the right wing tip impacted the water, and the airplane spun to a stop.

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.

An automated weather observation station 14 nautical miles northeast from the accident site reported, about the time of the accident, wind from 170ø at 6 knots. The pilot reported the wind was variable at 5 knots, gusting to 11 knots. He added that the landing direction was to the southeast.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's failure to maintain lateral/bank control during the landing in variable gusting wind conditions.

Events

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

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-Lateral/bank control-Not attained/maintained - C
3. Environmental issues-Conditions/weather/phenomena-Wind-Gusts-Effect on operation
4. Environmental issues-Conditions/weather/phenomena-Wind-Variable wind-Effect on operation

Narrative

The pilot of the float-equipped airplane reported that, during a water landing, "immediately upon touchdown, the tail came up to the right and the plane veered left." He added that he applied "hard left aileron," but the right wing tip impacted the water and the airplane spun to a stop.

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.

An automated weather observation station, about the time of the accident, 14 nautical miles northeast from the accident site, reported wind from 170ø at 6 knots. The pilot reported the wind was variable at 5 knots, gusting to 11 knots. He added that the landing direction was to the southeast.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# WPR18LA021	10/30/2017 1416 PDT	Regis# N88MV	Selma, CA	Apt: N/a
Acft Mk/Mdl METCALFE ROBERT B VANS RV		Acft SN 24874	Acft Dmg: SUBSTANTIAL	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl LYCOMING O-360-A3A		Acft TT 1422	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: LOCKARD JOHN D II		Opr dba:		Aircraft Fire: NONE
				AW Cert: SPE

Events

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

Narrative

On October 30, 2017, about 1416 Pacific daylight time, a Vans Aircraft experimental, amateur built RV-6, N88MV, was substantially damaged during a forced off-airport landing near Selma, California. The private pilot/owner was uninjured. The personal flight was conducted under the provisions of Title 14 Code of Federal Regulations Part 91. Visual meteorological conditions prevailed.

According to the pilot, he departed Fresno Chandler Executive Airport (FCH), Fresno, California for a local flight. He proceeded west to climb above the Fresno Yosemite International Airport (FAT), Fresno, California and verified his transponder operation with Fresno Approach. He then headed towards the west/southwest. About 15 to 20 minutes later, the pilot began a descent to get below the FAT Class C airspace, and return to FCH. At about 4,000 ft, the pilot noticed that the airplane batteries, located in the cockpit near his right foot, were getting hot. The pilot switched the engine monitor display to check the electrical system values, and saw that the indicated voltage was 15.5 volts, and that the indicated current was just above 30 amperes. At that point, the engine suddenly lost all power, but continued to windmill.

The pilot made some abbreviated and unsuccessful attempts to restore power, but then turned his attention to landing the airplane. He determined that the nearest airport was Selma Airport (0Q4), Selma, California which was about 10 miles away, and he began a gliding descent towards that airport. He communicated his situation and plans to a Fresno Approach controller. When the airplane altitude was about 1,000 ft, the pilot determined that he would not be able to reach 0Q4, and selected a road as his intended off-airport landing site. At that time, the only traffic on that road was an oncoming truck, but as the pilot continued the descent, he became uncertain whether the airplane would have sufficient altitude to clear the truck. The pilot then offset his flight path to the side of the road, in order to ensure that he would clear the truck. The truck passed the airplane, and the pilot then turned left and underflew some powerlines in an attempt to line up with, and land on, the road. That effort was unsuccessful, and the airplane touched down in a vineyard on the other side of the road. The aircraft flipped over about its nose, and came to rest inverted. The pilot escaped the airplane by breaking the canopy. Although there was fuel leaking from the airplane, there was no fire. Federal Aviation Administration (FAA) inspectors examined the airplane at the site. The airplane was recovered and transported to a secure facility for further examination.

According to FAA records, the airplane was constructed in 2000 by another individual, and that individual sold it to the accident pilot in February 2013. At the time of the pilot's purchase, the airplane was equipped with a Lycoming O-360 series engine, and a Hartzell 2-blade constant speed propeller. According to the pilot, the airplane and engine had each accumulated a total time (TT) in service of 1,422 hours, and the engine had never been overhauled.

The pilot reported that about 5 weeks before the accident, he mostly completed installation of new, EFII-brand fully electronic ignition and fuel injection systems. He also installed two EARTHX-brand lithium-ion batteries as part of the modifications. Subsequent to that, the pilot ran the engine and systems multiple times in order to configure and test the new installations. Prior to the accident flight, he had put about 1.5 to 2 hours of ground run time on the engine, and had conducted two uneventful test flights of about 30 minutes each. In particular, the pilot noted that during those ground and flight runs, the system voltage was about 14 volts, and the system current was about 7 amperes. The accident flight was the third flight with the new systems, and the engine power failure occurred about 25 minutes into that flight.

The pilot held commercial, airline transport, and flight instructor certificates, and airplane single- and multi-engine land and instrument ratings. He reported a total flight experience of 2,700 hours, including 300 hours in the accident airplane make and model. His most recent flight review was completed October 2017, and his most recent FAA first-class medical certificate was also issued in October 2017.

The 1415 automated weather observation at FCH, located about 10 miles north of the accident location, included calm winds, visibility 9 miles, clear skies, temperature 23 degrees C, dew point 12 degrees C, and an altimeter setting of 29.77 inches of mercury.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# GAA17CA417	07/16/2017	850 CDT	Regis# N714H	Brenham, TX	Apt: Brenham Muni 11R
Acft Mk/Mdl PERNER/PITTS S1S-NO SERIES			Acft SN 15P	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl LYCOMING IO-360				Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: RONALD ROWARS			Opr dba:		Aircraft Fire: NONE
					AW Cert: SPE

Summary

The pilot of the tailwheel-equipped airplane reported that, during touchdown, the airplane bounced, and he applied power to go around. He added that the "yaw factor" affected the go-around, and the left wing struck the runway, followed by the propeller, which resulted in the airplane cartwheeling off the runway to the left. The airplane stopped between hangars about 375 ft from the runway.

The left and right 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.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's failure to maintain lateral/bank and yaw control during a go-around.

Events

1. Landing - Abnormal runway contact
2. Approach-VFR go-around - Loss of control in flight
3. Approach-VFR go-around - Abnormal runway contact
4. Approach-VFR go-around - Collision with terr/obj (non-CFIT)

Findings - Cause/Factor

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

Narrative

The pilot of the tailwheel-equipped airplane reported that, during touchdown the airplane bounced and he applied power to go-around. He added that, the "yaw factor" affected the go-around and the left wing struck the runway, followed by the propeller, which resulted in the airplane cartwheeling off the runway to the left. The airplane stopped between hangars about 375 ft. from the runway.

The left and right 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.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# CEN18LA027	11/05/2017 1150 CST	Regis# N618ER	St Mary's, KS	Apt: N/a
Acft Mk/Mdl RIGGS KENNETH W T BIRD II-NO SERIES	Acft SN 90062000	Acft Dmg: SUBSTANTIAL	Fatal 0	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl ROTAX		Ser Inj 2	Flt Conducted Under: FAR 091	
Opr Name: BILL LINN	Opr dba:	Aircraft Fire: NONE		AW Cert: SPE

Events

1. Enroute - Part(s) separation from AC
-

Narrative

On November 5, 2017, about 1150 central standard time, a T-Bird II airplane, N618ER, conducted a forced landing near St. Marys, Kansas. The pilot and passenger received serious injuries and the airplane was substantially damaged during the accident. The airplane was registered to and operated by a private individual under the provisions of 14 Code of Federal Regulations Part 91 as a personal flight. Visual meteorological conditions prevailed at the time.

The responding Federal Aviation Administration (FAA) inspector reported that the pilot and passenger had departed from a private airstrip. The pilot reported to the inspector, that during cruise flight, they heard a "pop", and the engine lost power. He attempted a forced landing; however, the airplane impacted terrain hard. An initial examination of the airplane found substantial damage to the fuselage, and a propeller blade had separated from the engine in-flight.

The airplane was retained for further examination.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# GAA17CA424 07/18/2017 1330 PDT Regis# N702KF Owyhee, OR Apt: Owyhee Reservoir State 28U
Acft Mk/Mdl SALERNO KENNETH G JR KITFOX Acft SN S60102-049 Acft Dmg: SUBSTANTIAL Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl ROTAX 914 Fatal 0 Ser Inj 0 Flt Conducted Under: FAR 091
Opr Name: SALERNO, KENNETH G JR. Opr dba: Aircraft Fire: NONE
AW Cert: SPE

Summary

The pilot of the tailwheel-equipped airplane reported that, during the takeoff roll on a rough, dirt airstrip, the airplane encountered a "hump" and bounced prematurely. He added that, when the airplane touched back down, one of the tires hit a "rut," and the airplane veered left toward a tall sage brush. He further added that he "didn't correct direction properly" and attempted to rotate the airplane "early" to clear the sage brush, but the airplane's main landing gear impacted the sage brush, which resulted in a nose-over.

The fuselage and left wing sustained substantial damage.

The pilot reported that there were 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 pilot's failure to maintain directional control during takeoff from a rough, dirt airstrip.

Events

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

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-Directional control-Not attained/maintained - C
3. Environmental issues-Physical environment-Runway/land/takeoff/taxi surface-(general)-Effect on operation
4. Environmental issues-Physical environment-Object/animal/substance-(general)-Contributed to outcome

Narrative

The pilot of the tailwheel-equipped airplane reported that, during the takeoff roll on a rough, dirt airstrip, the airplane encountered a "hump" and bounced into the air prematurely. He added that, when the airplane touched back down, one of the tires hit a "rut" and the airplane veered left toward a tall sage brush. He further added that he "didn't correct direction properly" and attempted to rotate the airplane "early" to clear the sage brush, but the airplane's main landing gear impacted the sage brush, which resulted in a nose over.

The fuselage and left wing sustained substantial damage.

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

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# CEN17CA345	09/09/2017 845 MDT	Regis# N70RV	Ramah, NM	Apt: Mystic Bluffs NM56
Acft Mk/Mdl SHINER RV-4		Acft SN 2139	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl LYCOMING O-320-D1A		Acft TT 1264	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: PILOT		Opr dba:		Aircraft Fire: NONE
				AW Cert: SPE

Summary

The pilot reported that the sun was in his eyes as he was landing his low-wing airplane. He said that there were 3-ft-high berms in the area where the airplane touched down and that the runway was about 30 ft wide. The left wing struck the berm and the weeds. The propeller then impacted the berm, followed by the right wing and tailwheel. The right wing sustained substantial damage. The pilot reported that there were no mechanical malfunctions of the airplane.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's failure to maintain clearance from berms during landing in sun glare conditions.

Events

1. Landing-landing roll - Collision during takeoff/land

Findings - Cause/Factor

1. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Altitude-Not attained/maintained - C
2. Personnel issues-Psychological-Attention/monitoring-Monitoring environment-Pilot - C
3. Environmental issues-Conditions/weather/phenomena-Light condition-Glare-Effect on personnel - C
4. Environmental issues-Physical environment-Object/animal/substance-(general)-Effect on operation

Narrative

The pilot reported that he was landing his low wing airplane. The pilot stated that the sun was in his eyes when he was landing the airplane. He said that the berms were 3 ft high in the area where the airplane touched down and the runway was about 30 ft wide. The left wing struck the berm and the weeds. The airplane's propeller then impacted the berm followed by the right wing and tailwheel. The right wing sustained substantial damage during the impact with the berm. The pilot reported that there were no airplane mechanical malfunctions.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# GAA17CA480	07/28/2017 1217 EDT	Regis# N9214	Poughkeepsie, NY	Apt: Hudson Valley Rgnl POU
Acft Mk/Mdl THOMAS J HANKAMP VAN'S AIRCRAFT	Acft SN 538	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual	Prob Caus: Pending
Eng Mk/Mdl SUBARU EJ25	Acft TT 8	Fatal 0	Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: THOMAS J. HANKAMP	Opr dba:	Aircraft Fire: NONE	AW Cert: SPE	

Summary

The pilot of the tailwheel-equipped airplane reported that, during a "taxi test" in crosswind conditions, he overcorrected, and the airplane ground looped. Subsequently, the airplane exited the runway to the right and came to rest nose down.

The airplane sustained substantial damage to the firewall.

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

The automated weather observation system on the accident airport reported that, about the time of the accident, the wind was from 320ø at 5 knots. The pilot was departing from runway 06.

The Federal Aviation Administration (FAA) inspector reported that, throughout many conversations with the pilot, the initial statement was that the pilot lost control during takeoff and did have intent for flight. The FAA inspector verified this after talking with the local tower, who had cleared the airplane for takeoff.

Cause Narrative

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

Events

1. Takeoff - Loss of control on ground
2. Takeoff - Attempted remediation/recovery
3. Takeoff - Runway excursion
4. Takeoff - Nose over/nose down

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 the tailwheel-equipped airplane reported that, during a "taxi test" in crosswind conditions, he over corrected and ground looped. Subsequently, the airplane exited the runway to the right and came to rest nose down.

The airplane sustained substantial damage to the firewall.

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

The automated weather observation system on the accident airport reported that, about the time of the accident, the wind was from 320ø at 5 knots. The pilot was departing on runway 06.

The Federal Aviation Administration Inspector reported that, throughout many conversations with the pilot, the initial statement was that the pilot lost control during takeoff and did have intent for flight. The FAA Inspector verified this after talking with the local tower, who had cleared the airplane for takeoff.

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# CEN17LA092 01/30/2017 1000 CST Regis# N1971C Jennings, LA Apt: Jennings 3R7
Acft Mk/Mdl ZENITH CH750 STOL Acft SN 75-10246 Acft Dmg: SUBSTANTIAL Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl LYCOMING O-320-A2B Acft TT 10 Fatal 0 Ser Inj 0 Flt Conducted Under: FAR 091
Opr Name: CHRIS M. BRAMMER, JR. Opr dba: Aircraft Fire: NONE

Summary

The private pilot had recently completed building the airplane and had flown it about 10 hours. He reported that, during that time, the airplane had experienced fuel flow issues; specifically, fuel was not flowing evenly from the wing tanks. Fuel was supplied to the engine from both tanks via gravity; the tanks were not individually selectable. To remedy the uneven fuel flows, the airplane kit manufacturer suggested that the pilot add snorkels to each vented fuel tank cap. The pilot did so; however, this did not correct the uneven fuel flow. The pilot tried several combinations before closing the vented caps completely and using only snorkels, which was the configuration of the fuel system on the day of the accident.

The pilot departed on the accident flight with 7 gallons of fuel in one tank and 8 gallons in the other. He flew for about one hour, and, while returning to the airport, he noted that the left fuel tank gauge was reading low and that the right fuel tank gauge was reading high. The engine subsequently experienced a total loss of power and the pilot performed an emergency landing in a field short of the runway.

Although the loss of engine power is consistent with fuel starvation, it could not be determined why the fuel in the right tank failed to supply the engine; nor could the underlying reason for the uneven fuel flow be determined based on the information available.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: A failure of the right fuel tank to supply fuel to the engine for reasons that could not be determined, which resulted in a total loss of engine power due to fuel starvation.

Events

1. Approach-VFR pattern final - Loss of engine power (total)
2. Emergency descent - Off-field or emergency landing
3. Landing-landing roll - Nose over/nose down

Findings - Cause/Factor

1. Aircraft-Aircraft systems-Fuel system-Fuel distribution-Failure - C
2. Aircraft-Fluids/misc hardware-Fluids-Fuel-Related operating info - C

Narrative

On January 30, 2017, about 1000 central standard time, the pilot of a Zenith CH750 STOL, N1971C, made a forced landing in a field 3 miles east of Jennings, Louisiana, after the engine lost power. The pilot, the sole occupant on board, received minor injuries. The airplane was substantially damaged. The airplane was registered to and operated by the pilot under the provisions of 14 Code of Federal Regulations (CFR) Part 91 as a personal flight. Visual meteorological conditions (VMC) prevailed at the time of the accident, and no flight plan had been filed. The local flight originated from Jennings, Louisiana, Airport (3R7) about 0900.

The pilot had recently completed building the airplane and had logged about 10 hours. He was having fuel flow issues; specifically, fuel was not flowing evenly from the wing tanks. The Zenith CH750 is a high wing airplane and the fuel tanks, each holding 15 gallons, are in each wing. Fuel is gravity-fed to the carburetor and engine. Early tests showed a fuel flow of 2.5 gallons per minute via gravity feed, and 1.5 gallons per minute with the auxiliary fuel pump on. The vented fuel caps were plumbed together with a T-fitting above and behind the pilot seats. Fuel flowed down to an ON/OFF selector valve before travelling to a gascolator, an in-line fuel filter, an auxiliary fuel pump, and the carburetor. Sitting on the ramp, the fuel level in each tank evened out to within ~gallon of each other within minutes.

Because of the uneven fuel flows, Zenith - the airplane kit manufacturer -- suggested that the pilot add snorkels to each vented cap. The pilot did so and the next test flight revealed fuel was being pushed out of one tank and draining from the opposite tank. The pilot tried several combinations before closing the vented caps completely and using only snorkels.

On the morning of the accident, the pilot departed 3R7 with 7 gallons of fuel in one tank and 8 gallons in the other. He flew for about one hour, performing several full power climbs as per the Phase 1 certification protocol. Returning to the airport, he noted the left fuel tank gauge was reading low and the right fuel tank gauge was reading high. Zenith had told him that once the fuel level in one tank reached 1 to 2 gallons, the other tank would continue to supply fuel. He was aligned with the runway and on a 3-mile final approach and 1,800 when the engine lost power. Realizing he could not glide to the airport and was approaching a fence line with trees and a power line, he elected to make a forced landing in a field. When the airplane touched down, the nose gear dug into

the soft ground and the airplane nosed over. The pilot said, "The cause of the crash. . .was fuel starvation due to the left tank running empty and the right tank not flowing to the engine."