



# ILLINOIS STATE POLICE

## FIELD REPORT

Field Report Number: **F01-18-00009**  
TraCS Report Number: **18-38331001380**  
CAD Number: **011800000492**

|                                                                                      |                                     |                                    |                                  |                                                      |                                              |  |
|--------------------------------------------------------------------------------------|-------------------------------------|------------------------------------|----------------------------------|------------------------------------------------------|----------------------------------------------|--|
| Type of Report(s): <b>Other</b>                                                      |                                     |                                    |                                  |                                                      | Supplemental<br><input type="checkbox"/>     |  |
| ORI Number<br><b>IL0989900</b>                                                       | How Notified<br><b>Other Agency</b> | Incident Date<br><b>01/20/2018</b> | Incident Time<br><b>12:33 PM</b> | Initial Notification Date<br><b>01/20/2018</b>       | Initial Notification Time<br><b>12:33 PM</b> |  |
| Location Description<br><b>OFF ROADWAY NETWORK AT: LAT 41.90 AND LON -89.42</b>      |                                     |                                    | X Coordinate<br><b>299217.15</b> | Y Coordinate<br><b>4641607.87</b>                    |                                              |  |
| County in which Incident Occurred<br><b>LEE</b>                                      |                                     | Township<br><b>DIXON TWP</b>       |                                  | Location Type<br><b>LAKE/WATERWAY</b>                |                                              |  |
| Associated Reports :<br>1.)<br>2.)<br>3.)<br>4.)                                     |                                     | Agency Name                        |                                  | Reference Type<br>Reference Number                   |                                              |  |
| Brief Description of Report<br><b>AIRCRAFT ACCIDENT</b>                              |                                     |                                    |                                  |                                                      |                                              |  |
| Use of Force?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                     | What Type(s) of Force were Used?   |                                  |                                                      |                                              |  |
| <b>PERSON 1</b>                                                                      |                                     |                                    |                                  |                                                      |                                              |  |
| Type of Person<br><b>DRIVER</b>                                                      |                                     |                                    |                                  |                                                      | Caution<br><b>No</b>                         |  |
| Last Name<br><b>MANSKE</b>                                                           |                                     | First Name<br><b>DAVID</b>         |                                  | Middle Name<br><b>R</b>                              | Suffix                                       |  |
| Alias(es)                                                                            |                                     |                                    | Business/Organization            |                                                      |                                              |  |
| DOB Known?<br><b>YES</b>                                                             | Date of Birth<br>[REDACTED]         | Age<br><b>50</b>                   | Gender<br><b>MALE</b>            | Race<br>[REDACTED]                                   | Ethnicity<br>[REDACTED]                      |  |
| Skin Tone<br>[REDACTED]                                                              | Height<br>[REDACTED]                | Weight<br>[REDACTED]               | Hair Color<br>[REDACTED]         | Eye Color<br>[REDACTED]                              | Build<br>[REDACTED]                          |  |
| Marital Status                                                                       |                                     |                                    |                                  |                                                      |                                              |  |
| Scars/Marks/Tattoos (select up to 10)                                                |                                     |                                    |                                  |                                                      |                                              |  |
| Address<br>[REDACTED]                                                                |                                     |                                    | City<br><b>MACHESNEY PARK</b>    |                                                      | State<br><b>IL</b>                           |  |
| Zip Code<br><b>61115</b>                                                             |                                     |                                    |                                  |                                                      |                                              |  |
| Place of Birth<br><b>US - UNITED STATES</b>                                          |                                     | Resident Status<br><b>RESIDENT</b> |                                  | Other Contact Information                            |                                              |  |
| Home/Cell Phone #<br>[REDACTED]                                                      |                                     | SSN<br>[REDACTED]                  |                                  | Drivers License Number<br>[REDACTED]                 |                                              |  |
| License State<br><b>IL</b>                                                           |                                     |                                    |                                  |                                                      |                                              |  |
| ISP ticket #                                                                         |                                     | FBI #<br><b>999556AB9</b>          | BOI/SID #<br><b>IL0989911</b>    |                                                      | LEADS #                                      |  |
| NCIC #                                                                               |                                     |                                    |                                  |                                                      |                                              |  |
| Employer or School                                                                   |                                     |                                    | Occupation                       |                                                      |                                              |  |
| Address                                                                              |                                     | City                               |                                  | State                                                | Zip Code                                     |  |
| Work Phone #                                                                         |                                     |                                    |                                  |                                                      |                                              |  |
| Type of Injury (up to 5)<br><b>APPARENT BROKEN BONES</b>                             |                                     |                                    |                                  | Address where treatment given<br><b>KSB HOSPITAL</b> |                                              |  |
| <b>PERSON 2</b>                                                                      |                                     |                                    |                                  |                                                      |                                              |  |
| Type of Person<br><b>PASSENGER</b>                                                   |                                     |                                    |                                  |                                                      | Caution<br><b>No</b>                         |  |
| Last Name<br><b>NADOWSKI</b>                                                         |                                     | First Name<br><b>JAMIE</b>         |                                  | Middle Name<br><b>K</b>                              | Suffix                                       |  |
| Alias(es)                                                                            |                                     |                                    | Business/Organization            |                                                      |                                              |  |
| DOB Known?<br><b>YES</b>                                                             | Date of Birth<br>[REDACTED]         | Age<br><b>60</b>                   | Gender<br><b>FEMALE</b>          | Race<br>[REDACTED]                                   | Ethnicity<br>[REDACTED]                      |  |

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| Skin Tone                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       | Height     | Weight             | Hair Color             | Eye Color                          | Build         | Marital Status |
| Scars/Marks/Tattoos (select up to 10)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |       |            |                    |                        |                                    |               |                |
| Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |       |            |                    | City                   | State                              | Zip Code      |                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |       |            |                    | MACHESNEY PARK         | IL                                 | 61115         |                |
| Place of Birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |       |            | Resident Status    |                        | Other Contact Information          |               |                |
| US - UNITED STATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |       |            | RESIDENT           |                        |                                    |               |                |
| Home/Cell Phone #                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |       | SSN        |                    | Drivers License Number |                                    | License State |                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |       |            |                    |                        |                                    | IL            |                |
| ISP ticket #                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | FBI # | BOI/SID #  |                    | LEADS #                |                                    | NCIC #        |                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |       |            |                    |                        |                                    |               |                |
| Employer or School                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |       |            |                    | Occupation             |                                    |               |                |
| Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |       |            |                    | City                   | State                              | Zip Code      | Work Phone #   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |       |            |                    |                        |                                    |               |                |
| Type of Injury (up to 5)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |       |            |                    |                        | Address where treatment given      |               |                |
| APPARENT BROKEN BONES, OTHER MAJOR INJURY, POSSIBLE INTERNAL INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |       |            |                    |                        | KSB AND ROCKFORD MEMORIAL HOSPITAL |               |                |
| <b>VEHICLE 1</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |       |            |                    |                        |                                    |               |                |
| Vehicle Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Make  | Model      |                    |                        | Style                              |               |                |
| License Plate #                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |       | State      | License Plate Year | Color(s)               |                                    |               |                |
| VIN #                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |       | Impounded? | Impound Location   |                        |                                    |               | Towed?<br>YES  |
| Owner Last Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |       | First Name |                    | Middle Name            |                                    | Suffix        |                |
| MANSKE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |       | DAVID      |                    | R                      |                                    |               |                |
| Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |       |            |                    |                        |                                    | State         |                |
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| City                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       | Zip Code   | Phone Number       |                        | Vehicle Tied to Person(s)          |               |                |
| MACHESNEY PARK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |       | 61115      |                    |                        | 001                                |               |                |
| <b>NARRATIVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |       |            |                    |                        |                                    |               |                |
| <p>The purpose of this report is to document an aircraft accident that occurred on January 20, 2018 at approximately 12:33 P.M.</p> <p>On January 20, 2018 at approximately 12:33 P.M., Lee County received a 911 call stating an airplane had crashed into the Rock River near Wisconsin Street in Grand Detour. Lee County Deputies arrived on scene and located the aircraft on the iced over Rock River, west of Broad Street between two islands in the River. Fire and Ems were able to reach the plane and located two subjects, a male and a female. Both subjects were transported to KSB Hospital in Dixon with the initial report of non life-threatening injuries.</p> <p>The male subject, learned to be the Pilot and owner of the aircraft, was identified as David R. Manske [REDACTED] utilizing his Illinois driver's license. The female passenger identified herself as Jamie K. Nadowski [REDACTED] later confirmed utilizing SOS imaging. I, Trooper Courtney Frye [REDACTED] interviewed both subjects at the Hospital. Nadowski was being treated for non-life threatening injuries at the time of the interview. Nadowski stated she did not remember anything prior to the crash. Nadowski advised she remembered Manske advised her they were on the ice but she did not remember anything else. Nadowski was unable to remember what airport the aircraft left from. Nadowski stated she believed they were heading to the airport in Poplar Grove before the accident occurred. Nadowski advised she was the passenger and Manske was the pilot of the aircraft.</p> <p>Nadowski's injuries became life-threatening when the hospital discovered internal bleeding. Nadowski was transported to Rockford Memorial Hospital for further treatment. Nadowski is currently in stable condition and being monitored in the ICU.</p> <p>I attempted to interview Manske but he refused to answer any questions without a lawyer present. While at the hospital, I spoke with Krista Niezwaag (Physician Assistant handling Manske's case). Niezwaag advised upon Manske's arrival, he stated to her the aircraft got wrapped in wires, cartwheeled twice in the air and crashed nose down into the ice, coming to rest in the up-right position. Niezwaag also stated Manske refused all medical tests she requested other than x-rays. Manske was treated for a few broken bones and a chin laceration and then checked himself out of the hospital against the medical staff's recommendations.</p> <p>Nate Heller [REDACTED] is a possible witnesses to the aircraft accident. I have been unable to make contact with Heller at this time but was advised Heller had witnessed the accident and advised a Jim Ross to call 911. Jim Ross [REDACTED] is the subject who contacted 911 and advised of the aircraft accident. Kelly Snyder [REDACTED] and Sue Vanooster [REDACTED] are witnesses of the aircraft flying prior to the accident.</p> |       |            |                    |                        |                                    |               |                |

| OFFICER                                                    |                                  |                                                                                   |                           |                          |
|------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------------------------|---------------------------|--------------------------|
| Officer Name<br><b>C CHIGAROS</b>                          |                                  | Officer ID<br>[REDACTED]                                                          | Assisting Officer Name(s) |                          |
| Assisting Officer ID(s)                                    |                                  |                                                                                   |                           |                          |
| Date report completed<br><b>02/13/2018</b>                 | Accept Date<br><b>02/13/2018</b> | Supervisor<br><b>T LAYNE</b>                                                      |                           | Officer ID<br>[REDACTED] |
| Video Taken:<br>No                                         | Video Number:                    | Evidence Seizure:                                                                 | Photos:<br><b>YES</b>     |                          |
| Case Status<br><b>REFERRED TO RESPONSIBLE JURISDICTION</b> |                                  | Copies To:<br><b>NTSA CHIEF DAVID BOWLING; [REDACTED] INVESTIGATOR [REDACTED]</b> |                           |                          |
| Investigating Officer (Signature)                          |                                  |                                                                                   |                           |                          |