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**Federal Aviation
Administration**

Aviation Safety
Charleston WV, FSDO

Charleston, WV

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Subject: ERA25LA015, FAA Inspector Aircraft Accident Investigation Statement

Initial travel to accident scene, acting as FAA IIC, on October 15, 2024. Accident located at 149 Hamilton LN Rowlesburg, WV 26425. Airport identified as Cheat River Island Airport (56WV). The airport is turf/grass consisting of 2000 x 50 ft. runways 13 and 31. Arrived on scene at 1230 EDT. Met by, and escorted to the scene by, airport owner.

Inspection at scene revealed runway excursion, at approximately mid-field on the left-hand side of Runway 31, where the aircraft came to rest amongst trees and brush with the nose overhanging an embankment, in a precarious position. The aircraft was identified as N79HY, an Aviat A-1B (Husky), serial number 2289. Aircraft accident time was reported to be 1800 EDT local on October 11, 2024. Specific Latitude and Longitude coordinates unavailable. There were no discernable marks on the runway due to the grass and numerous aircraft landings and take-offs during this period.

The aircraft had substantial damage to right wing that resulted from impact with a large tree. No injuries were reported. Flight control continuity, as best as could be determined due to aircraft damage and limited access to the cockpit, appeared to be intact and functioning properly. No engine related inspections conducted due to aircraft location and no suspicion of engine performance related to the accident. Traditional 4-point accident photos were taken except for a direct nose photo due to inaccessibility. No other anomalies were observed during the investigation.

An aircraft record, obtained from the pilot after the initial on-scene investigation, for an annual inspection and airworthiness directives (AD's) compliance, as required by 14 CFR 91.417, dated 24 May 2024, aircraft total airframe time 882.1, was reviewed with no issues noted. A copy of this record was provided to NTSB.

There were two potential witnesses identified. The fly-in event "Air Boss" and a pilot following the accident aircraft on landing. These individuals were interviewed by NTSB subsequent to the initial on-scene investigation and were not interviewed, nor any statements provided to, the FAA.

Concerns following pilot NTSB interview stating unexplained aircraft pulling to the left after landing and subsequent closer look at airport owner provided photos of tailwheel assembly

resulted in a second scene visit on October 31, 2024, arrival at 1015 EDT. An additional FAA Inspector from my office accompanied me to the scene. We met with, and was escorted by, the airport owner. The aircraft had been moved from the accident resting place to the adjacent runway mowed area the day before by an aircraft recovery crew, as authorized by the NTSB IIC.

The aircraft cockpit was accessed by one FAA inspector while the other inspector witnessed flight control movement, including rudder and subsequent rudder horn feedback to the tailwheel assembly. Aircraft brakes were applied, one wheel at a time, with the aircraft rotated laterally to confirm proper brake operation. A detailed inspection of the brakes, rudder and tail wheel assembly was conducted utilizing Aviat Aircraft Inc. Model A-1B Instructions for Continued Airworthiness document number 70192-004, revision D dated 05 October 2005, as provided by Aviat Quality Assurance Manager (QAM). No anomalies were identified. It was also noted there was a post-production Alaskan Bushwheel ABI- 3200B tailwheel assembly Supplemental Type Certificate (STC) SA01233SE installed. A review of FAA records indicates the STC was installed on July 23, 2020. This assembly was inspected per the STC installation instructions ABI3200B-II 011306 document, provided by Aviat QAM. The installation of the tailwheel STC appears to be in compliance with the installation requirements with proper left and right steering springs installed and tensioned.

An additional observation noted during the inspection revealed the tailwheel leaf spring center attached point was not centered, displaced slightly to the right side of the attach bracket, as looking forward. There were no fresh slippage markings which would most likely indicate the spring bracket position may have been in this position since installation. It was later verified that leaf spring removal or replacement was not part of STC SA01233SE. The result of the spring slightly off center to the right results in the appearance of the entire tailwheel assembly being somewhat displaced to the right. However, the tailwheel can be directionally centered with the rudder with equal tailwheel left and right steering spring tension. Consultation with Aviat indicates the original equipment manufacturer (OEM) leaf spring may have been replaced with an ABI leaf spring while retaining the OEM bracket. Aviat's conclusion is the result of the off-center leaf spring on taxi operations would probably be negligible. It does not appear to be a factor in this accident since it appears to have been in this position for an extended period.

A FAA interview was conducted with the pilot on November 14, 2024. He did not offer any new information or reasons for what contributed to the accident other than what was previously stated in his NTSB interview on October 23, 2024. The pilot was unaware of any tailwheel leaf spring changes since the time that he had acquired the aircraft. He verified there were no maintenance record entries in the aircraft logbook indicating leaf spring replacement. He also stated that he hadn't noticed any tendencies for the aircraft to "pull to the left" during landings during any previous flights.

Hobbs hour meter reading was 803.9, as observed during second on-scene visit. Engine tachometer reading was not recorded since it was electronic and power was off.

Airman information, as requested by NTSB, from FAA SPAS database, has been provided to the NTSB.

Accident photos and FAA IIC statement provided to NTSB IIC.

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