Aviation Investigation Final Report

Location:	LaFayette, Georgia	**Accident Number:**	ERA25FA151
Date & Time:	March 20, 2025, 14:30 Local	**Registration:**	N969SS
Aircraft:	CIRRUS DESIGN CORP SR22	**Aircraft Damage:**	Destroyed
Defining Event:	Aerodynamic stall/spin	**Injuries:**	2 Fatal
Flight Conducted Under:	Part 91: General aviation - Instructional		

Analysis

The reported purpose of the flight was because the pilot receiving instruction and his flight instructor both had a free day to go flying. The flight logbook of the pilot receiving instruction showed that he had been receiving instruction toward his commercial pilot certificate from the flight instructor. After picking up the flight instructor the pilot took off and completed two circuits in the airport traffic pattern. Both landing approaches during these circuits were consistent with a power-off 180° accuracy approach and landing. The third circuit was consistent with the previous two approaches. During the third approach, as the airplane neared the ground, data recovered from avionics onboard the airplane showed that the airplane's pitch began to increase while the airplane was in a steep left bank. Simultaneously, the airspeed began to decrease below the stall speed listed in the airplane Pilot's Operating Handbook (POH). The airplane then suddenly rolled right, and the pitch decreased. The airplane impacted the ground before the runway threshold in the displaced threshold area and was heavily damaged by postimpact fire. Postaccident examination of the wreckage found no evidence of any preimpact mechanical malfunctions or failures with the airframe or engine that would have precluded normal operation.

The power-off 180° accuracy approach and landing was a maneuver that was required to be demonstrated in order to obtain a commercial pilot certificate. This maneuver involved reducing engine power to idle while on the downwind leg of the traffic pattern and attempting to land on or just beyond a preselected point on the runway. Performance of this maneuver required the pilot to assess the risks associated with wind, airplane performance, and low-altitude maneuvering, to include stalls or spins. One of the common errors associated with this maneuver was a pilot's attempt to "stretch" a glide during an undershot approach. Given the airplane's observed pitch, bank, and airspeed during the final moments of the accident flight, it

is likely that, during the power-off 180° accuracy approach and landing maneuver attempt, the pilot receiving instruction misjudged the landing, which resulted in an undershot approach. He then likely attempted to stretch the glide, which resulted in the airplane exceeding the critical angle of attack and entering an aerodynamic stall/spin at an altitude too low to successfully recover. Additionally, the flight instructor should have been able to recognize the airplane's attitude and airspeed as the airplane approached the low altitude aerodynamic stall and been able to intervene in sufficient time to prevent it.

Although there was no clear evidence that the pilot receiving instruction was impaired by effects of diabetes or its treatment at the time of the accident, the pilot receiving instruction had also used prescription medications, including clomiphene and chloroquine, that were not reported at his last aviation medical examination, and that, while not typically impairing, could have had adverse side effects. In addition, the pilot receiving instruction had cardiovascular conditions, including moderate coronary artery disease, high blood pressure, and diabetes, that were associated with increased risk of an impairing or incapacitating cardiovascular event, such as arrythmia, heart attack, or stroke. Although there is no autopsy evidence that such an event occurred, such an event cannot be excluded by autopsy evidence alone.

The flight instructor's abnormally elevated carboxyhemoglobin level can be attributed to effects of the postimpact fire. In-flight carbon monoxide poisoning was unlikely given the fact that the pilot receiving instruction did not have elevated carboxyhemoglobin.

Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be:

The pilot's exceedance of the airplane's critical angle of attack while landing and the flight instructor's inadequate remedial action, which resulted in an aerodynamic stall/spin at an altitude too low for recovery.

Findings

Personnel issues	Aircraft control - Pilot
Aircraft	Angle of attack - Not attained/maintained
Personnel issues	Lack of action - Instructor/check pilot

Factual Information

History of Flight

Approach-VFR pattern final	Aerodynamic stall/spin (Defining event)
Uncontrolled descent	Collision with terr/obj (non-CFIT)

On March 20, 2025, at 1430 eastern daylight time, a Cirrus SR22, N969SS, was destroyed when it was involved in an accident near LaFayette, Georgia. The pilot receiving instruction and the flight instructor were fatally injured. The airplane was operated as a Title 14 *Code of Federal Regulations* Part 91 instructional flight.

According to data recovered from the onboard avionics, the pilot receiving instruction departed Richard B. Russell Regional Airport—J.H. Towers Field (RMG), Rome, Georgia, where the airplane was based, at 1335. The airplane arrived at Barwick Lafayette Airport (9A5), LaFayette, Georgia, at 1353, where the pilot receiving instruction picked up the flight instructor.

The data show that the airplane took off from runway 20 at 9A5 at 1419 and completed two circuits in the traffic pattern. The landing approaches observed from the data were consistent with power-off 180° accuracy approaches and landings. During the third circuit in the traffic pattern the data showed that at 1429:59 the engine speed began to reduce from 2,660 rpm and the airplane's altitude was about 1,700 ft mean sea level (msl). The airplane began a continuous left turning descent and the final rpm data point, at 1430:51, showed a engine speed of 1,670 rpm and an altitude of 892 ft msl. The airplane continued the left turning descent, and at 1430:53 the left bank began to increase, reaching a maximum of 48° at 1430:56. The pitch also began to increase at 1430:55 to a maximum of 27.1° at 1430:57, with an indicated airspeed of 72 kts and altitude of 859 ft msl. The pitch then began to drop to near level, and the airplane began to bank to the right with the last data point, at 1430:58, showing a 1.5° pitch up, 74.2° right bank, indicated airspeed of 69 kts, and an altitude of 857 ft msl (or about 80 ft agl).

A witness reported seeing the airplane as it approached the airport. He reported that when he saw the airplane the nose was up. Another witness reported seeing the airplane bank "sharply" while approaching the airport and that the "nose was a little higher than the tail." He reported that, just before the airplane dropped below a stand of trees, the wings "seemed to dip sharply back in the other direction" and, immediately after that, there was a large explosion and fireball.

Flight instructor Information

Certificate:	Commercial; Flight instructor	**Age:**	48,Male
Airplane Rating(s):	Single-engine land; Multi-engine land	**Seat Occupied:**	Right
Other Aircraft Rating(s):	None	**Restraint Used:**	4-point
Instrument Rating(s):	Airplane	**Second Pilot Present:**	Yes
Instructor Rating(s):	Airplane single-engine	**Toxicology Performed:**	Yes
Medical Certification:	Class 1 Without waivers/limitations	**Last FAA Medical Exam:**	December 10, 2024
Occupational Pilot:	Yes	**Last Flight Review or Equivalent:**	
Flight Time:	(Estimated) 1645 hours (Total, all aircraft)		

Pilot Information

Certificate:	Private	**Age:**	52,Male
Airplane Rating(s):	Single-engine land	**Seat Occupied:**	Left
Other Aircraft Rating(s):	None	**Restraint Used:**	4-point
Instrument Rating(s):	Airplane	**Second Pilot Present:**	Yes
Instructor Rating(s):	None	**Toxicology Performed:**	Yes
Medical Certification:	Class 2 With waivers/limitations	**Last FAA Medical Exam:**	July 17, 2024
Occupational Pilot:	No	**Last Flight Review or Equivalent:**	June 9, 2023
Flight Time:	379.3 hours (Total, all aircraft), 310.6 hours (Total, this make and model), 333.4 hours (Pilot In Command, all aircraft), 16.5 hours (Last 90 days, all aircraft), 8.5 hours (Last 30 days, all aircraft), 0 hours (Last 24 hours, all aircraft)		

The pilot receiving instruction was seated in the front left seat of the airplane. A review his logbook showed that he had been receiving instruction toward his commercial pilot certificate. The logbook showed he had a total time of 379.3 hours with 310.6 hours in the make and model of the accident airplane. The logbook also showed that the flight instructor had previously provided instruction to the pilot receiving instruction during his instrument training. A family friend of the pilot receiving instruction reported that the purpose of the flight was for the two to fly together because they both had the day free. He continued that the pilot receiving instruction would “not miss an opportunity to hone his skillset.”

The flight instructor was seated in the right front seat of the airplane. A review of FAA airman records showed he originally received his flight instructor certificate in January 2020. At his most recent medical examination on December 10, 2024, he reported his civil flight experience as 1,645 total hours, with 20 hours flown in the previous 6 months. A review of the flight instructor’s electronic logbook showed a total time of 382.0 hours from May 16, 2019, to March 1, 2024. There were no electronic logbook entries from March 1, 2024, to the date of the

accident. It showed a total of 358.1 hours of instruction given and 23.9 hours in the make and model of the accident airplane. No other pilot logbooks for the flight instructor were found.

Based on the available information the flight instructor's recent flight experience could not be determined. The flight instructor was hired by a fractional corporate business jet operator as a first officer in October 2024; however, he resigned in December 2024, before satisfactorily completing their training program.

Aircraft and Owner/Operator Information

Aircraft Make:	CIRRUS DESIGN CORP	**Registration:**	N969SS
Model/Series:	SR22	**Aircraft Category:**	Airplane
Year of Manufacture:	2006	**Amateur Built:**	
Airworthiness Certificate:	Normal	**Serial Number:**	2157
Landing Gear Type:	Tricycle	**Seats:**	4
Date/Type of Last Inspection:	October 1, 2024 Annual	**Certified Max Gross Wt.:**	3400 lbs
Time Since Last Inspection:		**Engines:**	1 Reciprocating
Airframe Total Time:	3054.5 Hrs as of last inspection	**Engine Manufacturer:**	Continental Aerospace Technologies
ELT:	C126 installed, not activated	**Engine Model/Series:**	IO-550-N
Registered Owner:	On file	**Rated Power:**	310 Horsepower
Operator:	On file	**Operating Certificate(s) Held:**	None

Fueling records from RMG showed the airplane was last fueled with 54.2 gallons of 100LL aviation fuel on the day of the accident at 1321. The fueler who fueled the airplane reported that he had filled both of the airplane's wing fuel tanks fully. Fueling records from 9A5 showed that no fuel was purchased between the time the accident airplane arrived and the time it departed.

The data recovered from the onboard avionics contained basic flight and engine parameters. The recording rates of the parameters varied, from engine data being recorded every 4 seconds to GPS data being recorded at 4 samples per second. According to the Cirrus SR22 POH the stall speed with 50% flaps ranged from 78 kts to 80 kts indicated airspeed (depending on the airplane's center of gravity) when in a 45° bank.

Meteorological Information and Flight Plan

Conditions at Accident Site:	Visual (VMC)	**Condition of Light:**	Day
Observation Facility, Elevation:	9A5,776 ft msl	**Distance from Accident Site:**	0.25 Nautical Miles
Observation Time:	14:35 Local	**Direction from Accident Site:**	20°
Lowest Cloud Condition:	Scattered / 4300 ft AGL	**Visibility**	10 miles
Lowest Ceiling:		**Visibility (RVR):**	
Wind Speed/Gusts:	10 knots / None	**Turbulence Type Forecast/Actual:**	None / None
Wind Direction:	330°	**Turbulence Severity Forecast/Actual:**	N/A / N/A
Altimeter Setting:	29.97 inches Hg	**Temperature/Dew Point:**	8°C / -1°C
Precipitation and Obscuration:	No Obscuration; No Precipitation		
Departure Point:	LaFayette, GA	**Type of Flight Plan Filed:**	None
Destination:		**Type of Clearance:**	None
Departure Time:		**Type of Airspace:**	Class G

The airport had an Automated Weather Observation System (AWOS-3) installed that typically issued observations every 20 minutes. At 1415 the issued observation reported the wind from 260° at 7 knots. Based on the runway in use during the accident flight, this would result in a 6.1-knot crosswind from the right and a 3.5-knot headwind. At 1435 the issued observation reported the wind from 330° at 10 knots. Based on the runway being used, this would result in a 7.7-knot crosswind from the right and a 6.4-knot tailwind.

Airport Information

Airport:	BARWICK LAFAYETTE 9A5	**Runway Surface Type:**	Asphalt
Airport Elevation:	776 ft msl	**Runway Surface Condition:**	Dry
Runway Used:	20	**IFR Approach:**	None
Runway Length/Width:	4999 ft / 75 ft	**VFR Approach/Landing:**	Traffic pattern

Wreckage and Impact Information

Crew Injuries:	2 Fatal	**Aircraft Damage:**	Destroyed
Passenger Injuries:	N/A	**Aircraft Fire:**	On-ground
Ground Injuries:	N/A	**Aircraft Explosion:**	On-ground
Total Injuries:	2 Fatal	**Latitude, Longitude:**	34.692361,-85.2889

The airplane came to rest about 25 ft into the grass off the right side of runway 20 at 9A5, about 20 ft past the runway threshold. The wreckage was located at an altitude of 776 ft msl, on a magnetic heading of about 340°, and was inverted. There was extensive thermal damage to the airplane. An initial impact mark and scraping to the runway were located about 175 ft before the final resting location of the airplane. Multiple pieces of the right wing structure were found strewn along the debris path. Propeller strike marks were observed on the runway pavement consistent with the accident airplane's wreckage path. Measurements of these strike marks were taken. Based on the number of propeller blades, last recorded ground speed from the onboard avionics, and distance between strike marks an estimated engine speed of 2,659 rpm was calculated.

The fuselage, empennage, both wings, and most of the cockpit were consumed by postimpact fire. Flight control continuity for all major control surfaces was established from the area of the flight control surfaces to the cockpit. The flap actuator jackscrew and shaft were found in the wreckage with about 3 inches of the jackscrew exposed. This would equate to a flap extension of 50%. The gascolator remained attached to the firewall. It was removed for examination and was found to be free of debris.

The Cirrus Aircraft Parachute System (CAPS) rocket ignited during the postimpact fire. The CAPS parachute was found in the wreckage still packed and exhibited thermal damage. The CAPS parachute risers were consumed by fire. Part of a strap found in the middle of the runway was still folded with the red break thread used to keep it folded unbroken. Lanyards were found with no collar, broom strawed, and shackled together. The strap cover was partially intact and found about 125 ft from the wreckage.

The engine exhibited thermal and impact damage. The crankshaft was rotated by hand using a tool inserted into an accessory drive pad. Crankshaft, camshaft, and valvetrain continuity were confirmed through multiple rotations of the crankshaft. Valves for cylinder Nos. 1, 2, 3, 4, and 6 moved freely. The No. 5 cylinder exhibited impact damage. The airplane was equipped with one standard magneto and one electronic magneto, both of which remained secure to the engine. The standard magneto was removed from the engine and its input drive was rotated by hand. The impulse coupling snapped, and spark was observed from all towers. All 6 top sparkplugs were removed and examined; they all exhibited normal wear when compared to the Champion Aerospace Aviation Check-A-Plug chart. The oil filter was removed and cut open and no contamination was noted in the filter pleats.

The fuel pump remained attached to the engine with the throttle control installed correctly. The pump was removed and there was fuel present. The driveshaft remained intact, and the pump turned freely by hand. The mixture control was found to be installed correctly on the throttle body/fuel control manifold and the valve operated as expected. The fuel manifold was installed correctly, and all lines were tight. Fuel was present inside the valve and a minimal amount of debris was noted in the fuel screen. The fuel injector nozzles were installed correctly and when removed for examination were found normal and clear.

The four-blade propeller remained attached to the crankshaft flange and was impact-separated from the engine. All four blades remained secure in the propeller hub. The propeller governor remained attached to the engine and the control arm remained attached to the governor. The governor oil gasket screen was free of debris.

Medical and Pathological Information

The Georgia Bureau of Investigation, Department of Forensic Sciences, Office of the Medical Examiner ruled the cause of death for the pilot receiving instruction and the flight instructor as thermal injuries and their manner of death as accident.

The autopsy of the pilot receiving instruction identified coronary artery disease, with plaque causing 60% narrowing of the left anterior descending coronary artery, 50% narrowing of the left circumflex coronary artery, and 30% narrowing of the right coronary artery. The remainder of the autopsy, including visual examination of the heart, did not identify other significant natural disease. Extensive thermal injury was present, without airway soot. The FAA Forensic Sciences Laboratory performed toxicological testing of postmortem specimens from the pilot receiving instruction. Clomiphene, chloroquine, tadalafil, metformin, lisinopril, and atorvastatin were found in heart blood and urine. Glucose was measured at 19 mg/dL in vitreous fluid and was not detected in urine. Carboxyhemoglobin was reported as not detected in heart blood.

Clomiphene is a prescription medication that can be used in the treatment of low testosterone. It is not typically impairing but may sometimes have adverse side effects including blurry vision or seeing spots or flashes. The FAA allows Aviation Medical Examiners to issue medical certification to pilots who use clomiphene for low testosterone, subject to certain specific requirements, including a 14-day initial ground trial and confirmation of no visual side effects. Chloroquine is a prescription medication that can be used for malaria prophylaxis and treatment. It also may be used to treat conditions including lupus and rheumatoid arthritis. Additionally, chloroquine has been prescribed for prevention or treatment of the COVID-19

virus, but has not been proven to be effective for such use. Although chloroquine does not typically have direct impairing effects, it may have adverse side effects including retinopathy and heart rhythm problems. FAA medical certification of pilots on chloroquine depends on the underlying condition and effects of treatment.

Tadalafil is a prescription medication commonly used to treat erectile dysfunction, as a sexual enhancement aid, and to treat symptoms of an enlarged prostate. Tadalafil is not typically impairing, although the FAA states that pilots who use it on an as-needed basis should wait 24 hours after use before flying, to monitor for side effects.

Metformin is a prescription oral medication commonly used for blood sugar control in diabetes and prediabetes. Metformin is not typically impairing, and may be acceptable for FAA pilot medical certification if the underlying condition is determined to be acceptable.

Lisinopril is a prescription medication commonly used to treat high blood pressure. Lisinopril is not generally considered impairing. Atorvastatin is a prescription medication commonly used to control cholesterol and reduce cardiovascular risk. Atorvastatin is not generally considered impairing.

According to the flight instructor's autopsy report, a portable co-oximetry screening test measured carboxyhemoglobin at 15.6%, and Georgia Bureau of Investigation testing of heart blood measured carboxyhemoglobin at 20%, plus or minus 5%. The FAA Forensic Sciences Laboratory performed toxicological testing of postmortem specimens from the flight instructor. Carboxyhemoglobin was measured at 19% in heart blood. Carboxyhemoglobin is formed when carbon monoxide binds to hemoglobin in blood, diminishing the blood’s ability to deliver oxygen to body tissues. Carbon monoxide is an odorless, tasteless, colorless, nonirritating gas that can be produced during hydrocarbon combustion. Carbon monoxide poisoning usually occurs by inhalation of smoke or exhaust fumes. Nonsmokers normally have carboxyhemoglobin levels of less than 1-3%, while heavy smokers may have levels as high as 10-15%.

Additional Information

The Airplane Flying Handbook (FAA-H-8083-3C) Chapter 9 describes the Power-Off 180° Accuracy Approach and Landing, stating the following:

> "The 180° power-off approach is executed by gliding with idle power from a given point on a downwind leg to a preselected landing spot. It is an extension of the principles involved in the 90° power-off approach just described. The objective is to further develop judgment in estimating distances and glide ratios, in that the airplane is flown without power from a higher altitude and through a 90° turn to reach the base-leg position at a proper altitude for executing the 90° approach.
>
> The 180° power-off approach requires more planning and judgment than the 90° power-off approach. In the execution of 180° power-off approaches, the airplane is flown on a downwind heading parallel to the landing runway. The altitude from which this type of approach is started varies with the type of airplane, but should usually not exceed 1,000 feet above the ground, except with large airplanes. Greater accuracy in judgment and maneuvering is required at higher altitudes.
>
> When abreast of or opposite the desired landing spot, the throttle is closed and altitude maintained while decelerating to the manufacturer's recommended glide speed or 1.4 VSO. The point at which the throttle is closed is the downwind key position.
>
> The turn from the downwind leg to the base leg is a uniform turn with a medium or slightly steeper bank. The degree of bank and amount of this initial turn depend upon the glide angle of the airplane and the velocity and direction of the wind. Again, the base leg is positioned as needed for the altitude or wind condition. Position the base leg to conserve or dissipate altitude so as to reach the desired landing spot.
>
> The turn onto the base leg is made at an altitude high enough and close enough to permit the airplane to glide to what would normally be the base key position in a 90° power-off approach. Initial flaps may be extended prior to the base key position if needed.
>
> Although the base key position is important, it should not be overemphasized nor considered as a fixed point on the ground. Many inexperienced pilots may gain a conception of it as a particular landmark, such as a tree, crossroad, or other visual reference, to be reached at a certain altitude. This misconception leaves the pilot at a total loss any time such objects are not present. Both altitude and geographical location should be varied as much as is practical to eliminate any such misconceptions. After reaching the base key position, the approach and landing are the same as in the 90° power-off approach.
>
> Common errors in the performance of power-off accuracy approaches are:
>
> 1. Downwind leg is too far from the runway/landing area.
> 2. Overextension of downwind leg resulting from a tailwind.

3. Inadequate compensation for wind drift on base leg.

4. Skidding turns in an effort to increase gliding distance.

5. Failure to lower landing gear in retractable gear airplanes.

6. Attempting to “stretch” the glide during an undershoot.

7. Premature flap extension/landing gear extension.

8. Use of throttle to increase the glide instead of merely clearing the engine.

9. Forcing the airplane onto the runway in order to avoid overshooting the designated landing spot.

The commercial pilot for airplane category airman certification standard (FAA-S-ACS-7B) Area of Operation IV. Takeoffs, Landings, and Go-Arounds; Task M. Power-Off 180° Accuracy Approach and Landing described the maneuver objective, risk management, and skills. It stated that the performance of this maneuver required the pilot to identify, assess, and mitigate the risks associated with wind, airplane performance, and low-altitude maneuvering, to include stalls or spins.

Preventing Similar Accidents

Prevent Aerodynamic Stalls at Low Altitude (SA-019)

The Problem

While maneuvering an airplane at low altitude in visual meteorological conditions, many pilots fail to avoid conditions that lead to an aerodynamic stall, recognize the warning signs of a stall onset, and apply appropriate recovery techniques. Many stall accidents result when a pilot is momentarily distracted from the primary task of flying, such as while maneuvering in the airport traffic pattern, during an emergency, or when fixating on ground objects.

What can you do?

- Be honest with yourself about your knowledge of stalls and your preparedness to recognize and handle a stall situation in your airplane. Seek training to ensure that you fully understand the stall phenomenon, including angle-of attack (AOA) concepts and

how elements such as weight, center of gravity, turbulence, maneuvering loads, and other factors affect an airplane's stall characteristics.
- Remember that an aerodynamic stall can occur at any airspeed, at any attitude, and with any engine power setting.
- Remember that the stall airspeeds marked on the airspeed indicator (for example, the bottom of the green arc and the bottom of the white arc) typically represent steady flight speeds at 1G at the airplane's maximum gross weight in the specified configuration. Maneuvering loads and other factors can increase the airspeed at which the airplane will stall. For example, increasing bank angle can increase stall speed exponentially. Check your airplane's handbook for information.
- Reducing AOA by lowering the airplane's nose at the first indication of a stall is the most important immediate response for stall avoidance and stall recovery.
- Manage distractions when maneuvering at low altitude so that they do not interfere with the primary task of flying.
- Resist the temptation to perform maneuvers in an effort to impress people, including passengers, other pilots, persons on the ground, or others via an onboard camera. "Showing off" can be a deadly distraction because it diverts your attention away from the primary task of safe flying.
- Understand that the stall characteristics of an unfamiliar airplane may differ substantially from those of airplanes with which you have more flight experience.

See https://www.ntsb.gov/Advocacy/safety-alerts/Documents/SA-019.pdf for additional resources.

The NTSB presents this information to prevent recurrence of similar accidents. Note that this should not be considered guidance from the regulator, nor does this supersede existing FAA Regulations (FARs).

Administrative Information

Investigator In Charge (IIC):	Young, Joshua
Additional Participating Persons:	Mike Jones; FAA/FSDO; Atlanta, GA John Goebel; Cirrus Aircraft; Duluth, MN Julie Crowell; Continental Aerospace Technologies; Mobile, AL
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Investigation Class:	Class 3
Note:	
Investigation Docket:	https://data.ntsb.gov/Docket?ProjectID=199890

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The NTSB does not assign fault or blame for an accident or incident; rather, as specified by NTSB regulation, "accident/incident investigations are fact-finding proceedings with no formal issues and no adverse parties … and are not conducted for the purpose of determining the rights or liabilities of any person" (Title 49 *Code of Federal Regulations* section 831.4). Assignment of fault or legal liability is not relevant to the NTSB's statutory mission to improve transportation safety by investigating accidents and incidents and issuing safety recommendations. In addition, statutory language prohibits the admission into evidence or use of any part of an NTSB report related to an accident in a civil action for damages resulting from a matter mentioned in the report (Title 49 *United States Code* section 1154(b)). A factual report that may be admissible under 49 *United States Code* section 1154(b) is available here.