

Thomas P. Turner's Mastery of Flight®

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FLYING LESSONS for February 19, 2026

FLYING LESSONS uses recent mishap reports to consider what *might* have contributed to accidents, so you can make better decisions if you face similar circumstances. In most cases design characteristics of a specific airplane have little direct bearing on the possible causes of aircraft accidents—but knowing how your airplane's systems respond can make the difference in your success as the scenario unfolds. So apply these FLYING LESSONS to the specific airplane you fly. Verify all technical information before applying it to your aircraft or operation, with manufacturers' data and recommendations taking precedence. **You are pilot in command and are ultimately responsible for the decisions you make.**

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This week's LESSONS

Last week I began a focus on engine failure accidents with discussion prompted by the known facts of a [G36 Bonanza engine-out landing](#) in the crowded streets of Gainesville, Georgia. I used the evidence released of that event so far as a reminder of the two sometimes very different goals as speeds of Best Glide and Landing Without Power/Engine Out Approach Speed, which is closer to a least rate of descent speed but perhaps with some additional speed to provide control authority to flair for touchdown.

At the end of last week's LESSONS I wrote:

A FLYING LESSONS reader emailed me asking me to compare and contrast this event with a recent Cirrus engine failure accident. Unless some major crash draws more attention before then, I'll address this comparison next week.

Well, something else did indeed come up.

See:

<https://thomaspturner.com/flying-lessons-weekly/flying-lessons-for-february-12-2026/>

<https://www.wrdw.com/2026/02/09/i-love-them-so-much-ga-pilot-feared-message-would-be-his-last/>

A well-known and highly accomplished instructor and his wife perished this week in the crash of an A36 Bonanza. I knew them both; I've worked with the pilot off and on for over 20 years. I'd invited him to be a speaker at an event and shared the podium with him there just a month ago. Perhaps because of the prominence of this instructor and the wide distribution of news of the tragedy the NTSB released a detailed preliminary report unusually quickly, within a week of the event. [Read the full report here](#); here's an abridged version:

The airplane departed from Orlando, Florida, stopped at DeFuniak Springs, Florida, then flew to the Center Municipal Airport (F17), Center, Texas. The airplane then departed from F17 about 1635 central standard time toward Tyler, Texas. Shortly after crossing Lake Palestine, the pilot contacted air traffic control and declared an emergency stating that there was oil on the airplane's windscreen. The pilot told the controller that he was going to land at the Echo Lake Airport (TX40), Murchison, Texas. The ADS-B data showed the airplane flew to the north of TX40, turned to the south, and shortly after the data terminated.

During the emergency landing, the airplane impacted pine trees and a power line pole. The airplane came to rest on the eastern side of the airport on the front lawn of a private residence. The empennage was found resting on a power line. The airplane came to rest at a nose down attitude.

Examination of the wreckage found two holes in the engine crankcase above the location of the Nos. 2 and 4 cylinders. Oil was observed on the windscreen, the area above the windscreen on the fuselage, the left side of the engine, and the underside of the fuselage.

See <https://thomaspturner.com/wp-content/uploads/2026/02/2026.0211-A36-TX.pdf>

I've recently written about inflight emergencies for which we might practice procedures and develop strategies but for which the outcome depends heavily on luck—luck in the remaining capabilities of the aircraft, and luck in the terrain over which the event occurs. Three such types of events come immediately to mind: midair collision, an inflight fire that won't go out, and as happened this time, any situation (engine-failure oil or ice) that results in an inability to see through the windscreen and perhaps obstructs vision out the side windows as well.

But there is more evidence from the Texas crash that was not addressed in the NTSB's preliminary report. The day after the crash I heard from a source who told me he'd seen post-crash photographs of the front of the Bonanza—photos he was not permitted to show me—in which the oil filler cap is noticeably absent. It's will be interesting to see if the NTSB finds the dipstick at the last fuel stop, or if it is lodged somewhere else in the wreckage of the engine compartment, or if they never find it. It will also be instructive to learn of the filler port is found to be damaged such that the oil cap was sheared off by the catastrophic engine failure, a situation no one I've spoken with has ever heard happen. Was the oil cap somehow torn from the aircraft? Or was the missing oil filler cap the cause of oil loss that ultimately resulted in catastrophic engine failure?

Aviation safety Youtuber and *FLYING LESSONS* reader Scott “Gunny” Perdue shows the photo and discusses this aspect of the crash in [this video, which I encourage readers to watch](#). I won't repeat Scott's conclusions now but he makes several suggestions that I also teach and write about.

See <https://youtu.be/n3jKHaAL3YI?si=0Tu7zUHW1oJVV9TV>

Before I get to LESSONS about obscured-windscreen engine failure—a harrowing situation in its own right—this week I want to touch on “the little things” that can have a massive impact on flying safety...including ensuring the oil cap is secure before flight. For this I'll delve deeply into the *FLYING LESSONS* archives for an item that back then was inspired by aviation education legend Rod Machado:

The Little Things

What might you think is the single most common factor in aircraft accidents? Engine failure? Aerodynamic stalls? Fuel starvation? Loss of directional control on the runway? All these terms feature prominently in the accident record. But these accident scenarios, what the NTSB calls the “probable cause,” are really outcomes. In many cases they are what happens after something else occurs. Take for example this Final Report from a crash that occurred in December 2023 (NTSB Accident Number ERA24LA064):

The right seat pilot [in a 1980 A36] reported that after performing a preflight inspection, he anticipated the airplane would need to be refueled and subsequently left the fuel caps unlocked. After a discussion with the left seat pilot (who was acting as the pilot-in-command), they decided they would not need to refuel before the flight. Both pilots performed another walk around inspection and neither pilot noticed that the fuel caps remained unlocked.

Shortly after takeoff, the right seat pilot noticed that both fuel caps were not secure, and that fuel was escaping from both main fuel tanks. He elected to make return to the departure airport and land on the opposite direction runway. The pilots were both manipulating the controls when they landed the airplane “hard” on the main landing gear. The airplane then bounced and veered to the right of the runway, impacting a terminal sign and taxi light. The hard landing and subsequent runway excursion resulted in substantial damage to the wings and fuselage. The pilots reported that there were no pre-accident mechanical malfunctions or failures with the airplane that would have precluded normal operation.

The National Transportation Safety Board determines the probable cause(s) of this accident to be the pilots' improper landing flare, which resulted in a hard landing, runway excursion, and subsequent impact with a terminal sign and taxi light.

Neither pilot would be considered inexperienced. The left-seat pilot, 73 years old at the time and serving as pilot-in-command (PIC), holds a Private certificate (with no ratings beyond Airplane Single-Engine Land) with a third class medical certificate issued about 14 months before the accident and a 17-month-old Flight Review. At the time he reported 1341 hours total time, all aircraft, including 360 hours in the A36. The right seat pilot, 67 at the time of the crash and also a Private Pilot with no ratings other than Airplane Single-Engine Land, held an FAA third class Special Issuance medical issued about six months earlier. His most recent Flight Review or equivalent occurred in November 2017, six years before the crash. This pilot reported 1562 logged hours in all aircraft, including 1312 in make and model. Given the right-seat pilot's lapsed Flight Review he had no official role on board this aircraft beyond being a passenger—unless he was serving as a safety pilot.

The weather at Sidney, Ohio, was visual meteorological conditions (VMC), clear with at least 10 miles visibility with winds from 270 degrees at 14 gusting to 20 knots. The NTSB report does not indicate the pilot's choice of runway for takeoff, but it stands to reason it was the 5,000-foot Runway 28 given the wind direction.

So what happened?

- Two experienced pilots, one long out of currency, began a flight together.
- A change in plans led to inadvertently taking off with the fuel caps insecure.
- The right seat pilot, who was not current to act as PIC, noted fuel siphoning from the insecure fuel caps.
- The right seat pilot, not the PIC, decided to return to the airport and land in the opposite direction from takeoff with a strong, gusty tailwind, presumably to expedite landing for fear of fuel starvation or exhaustion.
- The PIC, according to the report, was not making command decisions for the safe outcome of the flight.
- “Both pilots” were “manipulating the controls” when the airplane landed hard.
- The airplane bounced, veered off the runway and impacted a terminal sign.
- Photos in the NTSB docket suggest the main gear was twisted or torn from the structure and driven upward into the wings in the hard landing.

THAT COMMON FACTOR

In this article's first paragraph I suggest there's a common factor to many aircraft accidents that sets up conditions for what is eventually found to be the probable cause of the crash. An accident investigator and flight instructor friend of mine once told me that the NTSB is very good at determining what happened at the moment of impact, but it doesn't have the resources or staffing to work backward in time to determine why that “what” took place. Clearly the damage in this A36's case was the result of the hard landing. But why the Bonanza landed hard is another story.

That common factor in many aircraft accidents, I believe, is **distraction**. Something grabs the pilot's attention—often, some small detail or abnormality that does not present an immediate threat—diverting the pilot from more important things. I've had fuel cap venting in a Bonanza. It looks like a lot of gas going overboard, and it is, but not so much you can't fly a normal pattern if you see fuel venting shortly after takeoff. It's the little things like this, or a malfunctioning radio (leaving you with backups), or an instrument failure (again, even with backups), or a sick passenger, or another aircraft you see (or hear about but don't see) in the vicinity, or any number of other distractions that draw you away from your primary task of flying the airplane. Often, as

reported in this case, distraction creates a false urgency that leads the pilot to do things he/she would not otherwise do.

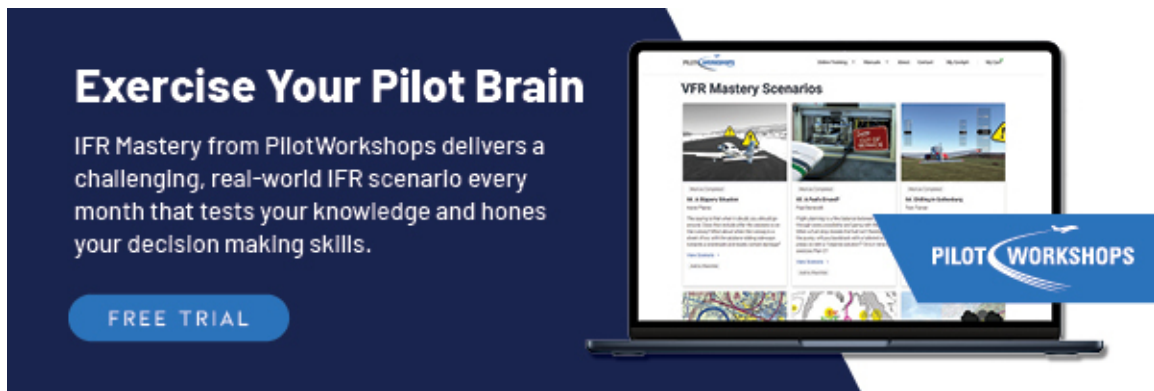
The most important skill we must have as pilots is prioritization: the ability to see the big picture, including distractions, and still direct our attention to those most important in that moment. Our friends in the Cirrus instructor community are fond of saying, "loss of control of an aircraft is always preceded by loss of command of that aircraft." Watch for the little things that create distraction and can begin a sequence of events that leads to disaster. But remain in command of your aircraft for a safe arrival.

Could something have distracted the pilot of the February 11 fatal crash that caused him to miss securing the oil cap? Had he added oil, or simply removed the cap after engine shutdown to vent the oil system (this is more about corrosion prevention between periods of flight and does nothing to aid in hot-starting after a quick shutdown, but some pilots do it regardless)? We may never know.

Still, this tragic loss is a reminder to confirm the security of oil (and fuel) caps before flight. Doing so as a well-practiced habit is a *LESSON* that can prevent at least one possible cause of this crash.

And for the reader who asked about the Cirrus crash, including several follow-up questions since his first, I will come back *LESSONS* from that event.

Questions? Comments? Supportable opinions? Let us know at mastery.flight.training@cox.net.



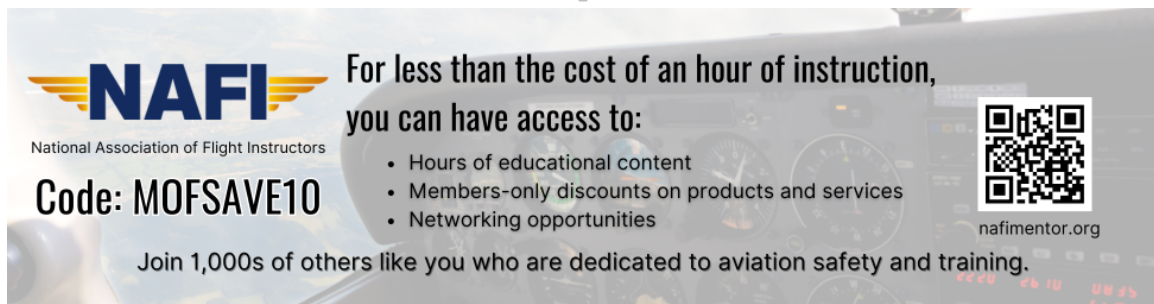
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