**RECORD OF CONVERSATION**

**Mitchell Gallo**
**Aviation Accident Investigator**
**Central Region**

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**Person Contacted: Danny Brickey; Aviation Safety Inspector – Airworthiness**
**Little Rock Flight Standards District Office**
**NTSB Accident Number: CEN16LA197**

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**Narrative:**

During a telephone conversation, Danny Brickey, the Federal Aviation Administration (FAA) coordinator for the accident, the pilot stated that he was not wearing an airplane supplemental oxygen system crew mask during the flight.

Post-accident examination of the airplane revealed that the cockpit supplemental oxygen supply gauge indicated about 17 "psi x100," which was in the gauge's green arc of 16-18 psi x100.

The cockpit supplemental oxygen system switch was in the "Normal" position (which would have provided oxygen to the cabin masks). The cabin oxygen masks were not deployed. The pilot stated that the switch was in the "Crew" position, and he did not know how or why it was in the "Normal" position. The pilot later told the Daniel Brickey that he (the pilot) changed the oxygen switch position after the accident.

The aft pressure bulkhead check valve flapper had half of its non-metallic flapper fractured into several pieces, which were resting on the fuselage floor. The second half of the check valve flapper was intact in valve body. The air conditioning system's primary pressurization duct leading to the cabin was separated from its connection with the water separator. The duct's metal worm-gear retaining clamp was resting around the duct and away from its attachment point to the separator. The clamp's retaining screw was in place. The clamp was not fractured and was resting around the metal duct leading to the separator.

Mitchell Gallo