CIVIL AVIATION AUTHORITY OF THE PHILIPPINES
Aircraft Accident Investigation and Inquiry Board
Aircraft Incident Report

BASIC INFORMATION

Aircraft Registration	:	RP-C5319
Aircraft Type/Model	:	A320-232
Owner/Operator	:	Tiger Air Philippines (Seair) Inc.
Date/Time of Incident	:	August 26, 2013/0820H/0020Z
Type of Operation	:	Commercial /Air Transport
Type of Occurrence	:	Taxiing excursion at the far end of the runway after making 180 degrees turn
Place of Incident	:	Kalibo International Airport

EXECUTIVE SUMMARY

On or about 0820H 26 August 2013, SEAIR flight DG8802, an Airbus A320-232 Registry No. RP-C5319 with 6 aircrew and 49 passengers on board bound for Singapore was performing 180 degrees turn at the far end of Runway 05 in preparation for Runway 23 takeoff. During the turn, the aircraft Nose Landing Gear (NLG) veered off the runway threshold and skidded into the soft grassy portion followed by the left main landing gear and got stuck. The position of the aircraft during the incident was approximately 13ft pathway length of the nosewheel assembly on the soil area of runway 05. With the aircraft not able to be maneuvered to the runway by its own power, the pilot performed engine shutdown and all the passengers were guided to disembark in place and ferried back to the airport terminal. The disabled aircraft was extricated back to the ramp on or about 1400H on the same day.

PROBABLE CAUSE

The Aircraft Accident Investigation and Inquiry Board determined that the probable cause of this accident was:

- **Primary Cause Factor**

  Inadequate pilot knowledge and skill in 180 degrees taxiing turn. Human Factor. Pilot Error.

  The PIC performed the 180 degrees taxiing turn from the right of the runway turning left and maintained 45 degrees of divergence from the runway axis instead of 25

degrees divergence angle based on Airbus Flight Crew Manual. The PIC maintained such 45 degrees angle in previous flight.

- **Contributory Factor**

  Inadequate pilot recurrency training on operations procedures (in-house and simulator).

  The repeated wrong application of the PIC taxiing procedures (which was not given undue correction) despite the re-currency training being provided by the Service Provider every six (6) months.

- **Underlying Factor**

  Inadequate operations standards surveillance by the Service Provider and Regulatory Inspections.

  There was no record of findings by the assigned POI related to inadequacy of training, knowledge and skills of aircrew.

SAFETY RECOMMENDATION

As a result of this investigation, the Aircraft Accident Investigation and Inquiry Board made the following safety recommendation:

CAAP-FSIS shall ensure that Service Providers utilizing A319/320 aircraft to:

- Conduct standardization review on all pilots in the standards of performing 180 degrees taxiing turn.

- Conduct Crew Resource Management (CRM) Training to aircrew giving emphasis on the crew coordination in the cockpit to prevent unnecessary flight disruptions.

- Emphasize in Simulator Training the conduct of 180 degrees taxiing turn especially on runways without turning pads.

- Emphasize the proactive role of Principal Operations Inspectors in the surveillance to update operational standards of aircrew specially the pilots.

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