



Republic of the Philippines
DEPARTMENT OF TRANSPORTATION
CIVIL AVIATION AUTHORITY OF THE PHILIPPINES
MIA Road, Pasay City 1300

AIRCRAFT ACCIDENT INVESTIGATION AND INQUIRY BOARD

FINAL REPORT

RP-C8459
SIKORSKY 269C-1

OPERATOR: MASTERS FLYING SCHOOL

TYPE OF OPERATION: FLIGHT TRAINING (PCAR PART 3)

DATE OF OCCURRENCE : MARCH 30, 2022

***PLACE OF OCCURRENCE: BRGY. SAN ROQUE, SAN LUIS, PAMPANGA,
PHILIPPINES***



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BASIC INFORMATION

Aircraft Registration No. : RP-C8459

Aircraft Type/Model : Sikorsky 269C-1

Operator : Masters Flying School

Address of Operator : 2317 Nissan Car Lease Bldg., Aurora Blvd.,
Pasay City, Philippines

Place of Occurrence : Brgy. San Roque, San Luis, Pampanga,
Philippines

Date/Time of Occurrence : March 30, 2022/ 1300H

Type of Operation : Flight Training (PCAR Part 3)

Phase of Operation : Hovering

Type of Occurrence : Tail Skid Strike Accident

EXECUTIVE SUMMARY

On or about 1300H of 30 March 2022, a Sikorsky 269C-1 type of aircraft with Registry Number RP-C8459 encountered a tail skid strike accident during training at Brgy. San Roque, San Luis, Pampanga. The aircraft is being operated by Masters Flying School. On board the aircraft were one (1) Flight Instructor/FI and one (1) Student Pilot/SP.

The flight took-off from Plaridel Airport for a scheduled flight training at the flat lands (rice fields) of San Luis, Pampanga. On arrival at their designated training ground, they commenced their training activities by performing hovering maneuvers. During the process, the FI noted that the SP had some difficulty in handling the aircraft. Instructions were then given by the FI to make some corrections, but the SP was not able to understand what the FI was saying. The FI later took over the controls when he observed that the SP can no longer maintain control of the aircraft. However, the FI had difficulty taking over the aircraft controls because the SP became “frozen” at the controls. The aircraft tail skid got in contact with the ground followed by the tail rotor that resulted to the separation of the tail boom from the fuselage.

PROBABLE CAUSE

- **Primary Cause Factor**

- a. Loss of control while on stationary hover (Human Factor).

- **Contributory Factors**

- a. The Flight Instructor's lack of situational awareness on the potential threats while the aircraft is hovering.
- b. Absence of an established procedure pertaining to the specific transfer of control procedures for rotorcrafts.
- c. Inadequate standards during the conduct of rotorcraft training (i.e. opening/closing of aircraft doors, utilization of noise cancelling communication equipment).
- d. The organization's inability to identify and assess risk particularly on the effect of physical hazards during training with opened aircraft doors and communicating with face mask on.

SAFETY RECOMMENDATIONS

- For **CAAP-FSIS** to ensure that the Operator:
 - a. To emphasize during their regular pilots/instructor's safety meeting the importance of enhanced situational awareness during the conduct of flight operations.
 - b. Include in their company manual/s the following:
 1. Establish a specific transfer of control procedures for rotorcrafts during training.
 2. Defined SOP's during the conduct of training (i.e. opening/closing of aircraft doors, utilization of noise cancelling communication equipment).
 3. Documented procedure related to hazard identification, risk assessment and mitigation in the organization's day-to-day operations.
- For **CAAP-FSIS** to consider the inclusion in their surveillance program the recommendations under *4.1 item b* to address possible similar systemic issues across other rotorcraft Approved Training Organizations.

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