Republic of the Philippines
CIVIL AVIATION AUTHORITY OF THE PHILIPPINES

AIRCRAFT ACCIDENT INVESTIGATION AND INQUIRY BOARD

FINAL REPORT

RP-C2893
PA-23-250

OPERATOR: INDIANA AEROSPACE UNIVERSITY

TYPE OF OPERATION: FLIGHT TRAINING (PCAR PART 3)

DATE OF OCCURRENCE: AUGUST 5, 2023

PLACE OF OCCURRENCE: ORMOC AIRPORT, ORMOC CITY, SOUTHERN LEYTE, PHILIPPINES

BASIC INFORMATION

Aircraft Registration No.	:	RP-C2893
Aircraft Type/Model	:	Piper Aztec/PA-23-250
Operator	:	Indiana Aerospace University
Address of Operator	:	IAU Town Center, Kagudoy Rd, Basak, Lapu-Lapu City, Mactan, Philippines
Place of Occurrence	:	Ormoc Airport, Ormoc City, Southern Leyte Philippines
Date/Time of Occurrence	:	August 05, 2023/1028H/0228UTC
Type of Operation	:	Flight Training (PCAR Part 3)
Phase of Flight	:	Landing
Type of Occurrence	:	Belly Landing

EXECUTIVE SUMMARY

On or about 1028H, August 5, 2023, a Piper Aztec PA-23-250 type of aircraft with Registry Number RP-C2893 sustained substantial damage after landing on its belly at RWY 18 of Ormoc Airport, Ormoc City, Southern Leyte. The aircraft is being operated by Indiana Aerospace University under PCAR Part 3, Approved Training Organizations. On board were a flight instructor (FI) and a training flight instructor undergoing additional rating on the said aircraft. Visual Meteorological Conditions (VMC) prevailed at the time of the occurrence.

The training FI, as the pilot flying, admitted that the pre-landing checklist was not used while simulating landing with the left engine inoperative. It was on the 4th traffic pattern when the accident happened. Moreover, both the Flight Instructor (FI) and the Training Flight Instructor (FI) admitted that they were unaware that the three green lights were illuminating, indicating that the landing gears were down and locked. The aircraft initially landed on its belly, 240 feet from the displaced marker on RWY 18. There were 200 and 89 propeller strikes on both right and left propellers, respectively, as the aircraft continued to move forward on the runway. Both crews egressed safely after shutting down the engine**.** The aircraft's final resting point was located at 217 degrees and grid coordinates 11.3'46"N124.33'57"E.

PROBABLE CAUSE

- **Primary Cause Factor**

  Both pilot's omission of the key steps in the landing checklist that resulted in a belly landing.

- **Contributory Cause Factor**

  a. Breakdown of communication between both pilots.

  b. Both pilots lack situational awareness.

SAFETY RECOMMENDATIONS

The safety deficiencies detailed in this report have been fully addressed as a result of the safety measures implemented by the Operator. Consequently, no further safety recommendations are being proposed.

SAFETY ACTIONS

Safety Actions taken by the Operator

Following the serious incident, the Operator initiated the following safety corrective actions to prevent the probability of a similar occurrence happening again:

a. Checklist provision: A provision requiring checklist on critical aspects of the flight was added to the Training Procedures Manual. Said provision will reinforce the significance of disciplined checklist usage in the cockpit.

b. Threat and Error Management (TEM) principles was added and integrated to Training Procedures Manual. This will enhance pilot training to:

  1. Recognize and manage threats and error that could lead to procedural lapses.

  2. Develop strategies in dealing with unexpected challenges during critical phases of flight.

c. Crew Resource Management (CRM) principles was added and integrated to Training Procedures Manual, to enhance communication, situational awareness, pilot monitoring duties and assertation on both crew members in adhering to procedures.

d. Safety Promotion: Foster a safety-oriented culture with the institution by having monthly safety meetings, encouraging reporting of deviations and fostering an environment that promotes adherence to SOPs.

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