



Republic of the Philippines
CIVIL AVIATION AUTHORITY OF THE PHILIPPINES

AIRCRAFT ACCIDENT INVESTIGATION AND INQUIRY BOARD

FINAL REPORT

RP-C8798
C152

OPERATOR: AIRWORKS AVIATION COMPANY, INC.

TYPE OF OPERATION: FLIGHT TRAINING

DATE OF OCCURRENCE: APRIL 12, 2025

***PLACE OF OCCURRENCE: AIRWORKS RAMP, GENERAL AVIATION AREA, MACTAN-CEBU
INTERNATIONAL AIRPORT, LAPU-LAPU CITY, CEBU, PHILIPPINES***

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(Textron Aviation Inc. C152, RP-C8798 Final Report)

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FOREWORD

This report was produced by the Aircraft Accident Investigation and Inquiry Board (AAIIB), Civil Aviation Authority of the Philippines, MIA Road, Pasay City, Philippines.

The report is based upon the investigation carried out by the AAIIB in accordance with Annex 13 to the Convention on International Civil Aviation, Republic Act 9497 Section 42, and Philippine Civil Aviation Regulation Part 13.

Readers are advised that the AAIIB investigates for the sole purpose of enhancing aviation safety. Consequently, AAIIB reports are confined to matters of safety significance and may be misleading if used for any other purpose. It should be noted that the information in AAIIB reports and recommendations is provided to promote aviation safety, and in no case is it intended to imply blame or liability.

Furthermore, no part of the AAIIB report or reports relating to any accident or investigation shall be admitted as evidence or used in any suit or action for damages arising out of any matter mentioned in such report or reports.



FINAL REPORT

TITLE: An accident involving a C152 type of aircraft with Registry Number RP-C8798, operated by Airworks Aviation Company, Inc., had a ground accident (injuries-aircraft component) that happened at Airworks ramp, General Aviation Area, Mactan-Cebu International Airport, Lapu-Lapu, Cebu, Philippines, on April 12, 2025, at around 0729H.

Notification of Occurrence to National Authority

The accident was reported by the Head of Training-Airworks Aviation to CAAP Operations Center, which relayed the information to the CAAP AAIB on April 12, 2025.

Identification of the Investigation Authority

The Aircraft Accident Investigation and Inquiry Board (AAIB), the mandated accident investigation organization within the Civil Aviation Authority of the Philippines (CAAP), as the state of Occurrence/Registry/Operator, conducted the investigation.

Organization of the Investigation

In accordance with the provisions of the Philippine Civil Aviation Regulation (PCAR) Part 13, an Investigator-In-Charge was appointed.

Authority Releasing the Report

The Final Investigation Report was released by the Aircraft Accident Investigation and Inquiry Board (AAIB) and published on the CAAP website on **02 June 2025**.

Synopsis:

On or about 0729H of April 12, 2025, a C152 type of aircraft with registration number RP-C8798 was involved in a ground accident (injuries-aircraft component) in which a student pilot was seriously injured after being hit by the aircraft's propeller. The accident occurred at the Airworks ramp area, located within the General Aviation (GA) section of Mactan-Cebu International Airport, Lapu-Lapu City, Cebu, Philippines. The aircraft is owned and operated by Airworks Aviation Company Inc., an approved training organization. The aircraft was on a scheduled 150 NM navigation training flight with a Flight Instructor (FI) and one Student Pilot (SP) on board. The investigation determined that the probable cause of the accident was the SP's decision to egress the aircraft while the engine was still operating, indicating a significant lapse in situational awareness and a failure in judgment.

LIST OF ACRONYMS AND ABBREVIATIONS

AAIIB	:	Aircraft Accident Investigation and Inquiry Board
ASDA	:	Accelerated Stop Distance Available
ATOC	:	Aviation Training Organization Certificate
CAAP	:	Civil Aviation Authority of the Philippines
CCTV	:	Closed-Circuit Television
CoA	:	Certificate of Airworthiness
CoR	:	Certificate of Registration
CPL	:	Commercial Pilot License
CRM	:	Crew Resource Management
FI	:	Flight Instructor
HOT	:	Head Of Training
IFR	:	Instrument Flight Rules
LDA	:	Landing Distance Available
OFSAM	:	Office of the Flight Surgeon and Aviation Medicine
PCAR	:	Philippine Civil Aviation Regulation
PCN	:	Pavement Classification Number
SOP	:	Standard Operating Procedure
SP	:	Student Pilot
SPL	:	Student Pilot License
TODA	:	Take Off Distance Available
TORA	:	Take Off Run Available
VFR	:	Visual Flight Rules



1. FACTUAL INFORMATION

Aircraft Registration No. : RP-C8798

Aircraft Type/Model : C152

Operator : Airworks Aviation Company, Inc.

Address of Operator : Lot 30, General Aviation Area, Mactan-Cebu International Airport, Pajao, Lapu-Lapu City, Cebu, Philippines

Place of Occurrence : Airworks Aviation ramp, General Aviation Area, Mactan-Cebu International Airport, Lapu-Lapu, Cebu, Philippines

Date/Time of Occurrence : April 12, 2025, at about 0729H/2329 UTC

Type of Operation : Flight Training

Phase of Flight : Parking

Type of Occurrence : Injuries – Aircraft Component

1.1 History of the Flight

On or about 0729H of April 12, 2025, a C152 type of aircraft with registration number RP-C8798 was involved in a ground accident (Injuries-Aircraft Component) in which a student pilot was seriously injured after being hit by the aircraft's propeller.

The accident occurred at the Airworks ramp area, located within the General Aviation (GA) section of Mactan-Cebu International Airport, Lapu-Lapu City, Cebu, Philippines. The aircraft is owned and operated by Airworks Aviation Company Inc., an approved training organization. It was on a scheduled 150 NM navigation training flight with a Flight Instructor (FI) and one Student Pilot (SP) on board.

According to the interview with the Flight Instructor (FI), they departed at around 0630H without any unusual events, with the Student Pilot (SP) in control of the aircraft. While enroute to RPSM and upon reaching waypoint Tugas, the SP informed the FI that he was



feeling unwell and a bit dizzy. The FI took over control of the aircraft and asked the SP if he was okay. The SP responded that he just wanted to rest for a while, then adjusted his seat to make himself more comfortable. Sensing that the SP might not be able to continue the training, the FI decided to terminate the session and return the aircraft to base.

Upon landing, they taxied toward their ramp. During this time, the FI observed that the SP was already vomiting. After parking at their apron, and while the FI was performing the engine shutdown checklist, she noticed the SP exiting the aircraft. She called out to the SP but received no response. The marshaller shouted that the propeller had struck the SP moments later. It was observed that the SP had walked directly toward the front of the aircraft while the propeller was still spinning.

1.2 Injuries to Person (s)

Injuries	Crew	Passengers	Others
Fatal	0	0	0
Serious	1	0	0
Minor	0	0	0
None	1	0	0
Total	2	0	0

1.3 Damage to Aircraft

The aircraft sustained minor damage.



Figures 1 and 2 – Damage (nick) noted on the aircraft propeller.

1.4 Other Damages

There were no reported other damages due to of this incident.

1.5 Personnel Information

1.5.1 Flight Instructor

Gender	: Female
Date of Birth	: December 20, 1994
Nationality	: Filipino
License	: 102939 CPL/Fl, valid until May 31, 2026 (CPL) and July 12, 2025 (Fl)
Type rating	: Airplane: Single Engine Land – C152, C172
Medical Certificate	: Class 1, valid until February 06, 2026
Date of last medical	: January 25, 2025
Total flying time	: 3,617 + 27 Hours as of April 03, 2025
Total flying time on type	: 2,474 + 55 Hours as of April 03, 2025

1.5.2 Student Pilot

Gender	: Male
Date of Birth	: November 23, 2005
Nationality	: Maldivian
License	: 164492 SPL, issued on May 14, 2024
Type rating	: None
Medical Certificate	: Class 2, valid until March 16, 2026
Date of last medical	: March 16, 2024
Total flying time	: 23 + 05 Hours as of April 09, 2025
Total flying time on type	: 23 + 05 Hours as of April 09, 2025

1.6 Aircraft Information

The Textron Aviation Inc. C152 is a two-seat, single-engine, high-wing, fixed-wing aircraft that was introduced by Cessna Aircraft Company (now Textron Aviation Inc.) in 1977. It was developed as an improved version of the earlier Cessna 150, incorporating several upgrades to meet new noise regulations and offering better performance and handling.

The aircraft quickly became one of the most popular training and personal aircraft worldwide. Its reliability, simplicity, and low operating cost made it a favorite among flight schools and private owners. Despite production ending in 1985, thousands of C152s are



still actively flying.

1.6.1 Aircraft Data

Registration Mark : RP-C8798
Manufacturer : Textron Aviation Inc.
Country of Manufacturer : USA
Type/Model : C152
Operator : Airworks Aviation Company Inc.
Serial No. : 15283553
Year of Manufacture : 1979
Certificate of Airworthiness : Valid until March 05, 2026
Certificate of Registration : Valid until October 29, 2026
Category : Normal
Gross Weight : 760 kgs.
Number of Flight Crew : 1
Number of Passengers : 1
Airframe total time : 12,086+26 Hours since last C of A

1.6.2 Engine Data

Manufacturer : Lycoming
Type : Reciprocating
Model : O-235-L2C
Engine Serial No. : RL-23229-15
Engine TBO : 2,400 Hours
Engine TSO : 00 + 00 Hours since last C of A
Engine Total Time : 4,613 + 07 Hours since last C of A

1.6.3 Propeller Data

Manufacturer : Sensenich
Type : Fixed Pitch
Model : 72CK-S6-0-54
Propeller Serial No. : K4389
Propeller TBO : 2,000 Hours
Propeller TSO : 672 + 42 Hours since last C of A
Propeller Total Time : 12,085 + 51 Hours since last C of A

1.7 Meteorological Information

Wind Condition	Sky Condition	Visibility	Temperature	Dewpoint	QNH	Remarks
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340° at 4 knots	FEW 020, BKN 100	10 km	28°C	25°C	1010hPa	None
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1.8 Aids to Navigation

The flight was carried out under Visual Flight Rules (VFR).

1.9 Communications

The aircraft was equipped with a standard radio transceiver.

1.10 Aerodrome Information

Mactan-Cebu International Airport is the second busiest airport in the Philippines, after Ninoy Aquino International Airport (NAIA) in Manila. It serves as a vital domestic and international gateway for Cebu and the Central Visayas region, and is often considered the main air hub of Southern Philippines.

Aerodrome Name : Mactan-Cebu International Airport (RPVM)
 ARP Coordinates : 101827.2258N, 1235845.9830E.
 Aerodrome Operator : Mactan-Cebu International Airport Authority
 Types of traffic permitted: VFR/IFR
 Operational hours (AD) : 24 Hours
 Rescue and Firefighting : CAT IX
 Runway Physical Characteristics:

RWY Designation	Dimension of runway	Strength of the runway	Slope of runway
04	3,310m X 45m	PCN 70 F/B/W/T Concrete + Asphalt	0.122% uphill towards THR22
22	3,310m X 45m	PCN 70 F/B/W/T Concrete + Asphalt	

Runway Declared Distances:

RWY Designator	TORA	TODA	ASDA	LDA
04	3,310 m	3,510 m	3,359 m	3,310 m
22	3,310 m	3,460 m	3,367 m	3,310 m

1.11 Flight Recorders



The aircraft was not equipped with any flight recorders, and existing Philippine Civil Aviation Regulations do not require such for that type of aircraft.

1.12 Wreckage and Impact Information

The accident occurred while the aircraft was stationary at a full stop on the ramp. Minor surface damage, characterized by small nicks, was observed on the propeller. The airframe sustained no damage. The only point of contact was between the rotating propeller and the student pilot. No additional impact evidence or wreckage was identified at the scene.



Figure 3 – The student pilot after being hit by the propeller.

1.13 Medical and Pathological Information

Following the occurrence, the Flight Instructor underwent the mandatory drug and alcohol testing at a local hospital, with results indicating no presence of prohibited substances.

As for the injured Student Pilot, the medical abstract obtained from the hospital disclosed the following diagnosis:



- a. Massive laceration, right side of face from parieto-temporal area to mandibular area with parotid gland transection and mandibular fracture, comminuted and zygomatic arch fracture, right;
- b. Blunt abdominal trauma with avulsion wound abdomen, avulsion wound right thigh, traumatic amputation of right small finger.

Further, the following medical procedure was performed on the SP:

- a. Tracheostomy
- b. Debridement and primary repair of massive laceration with dental arch bar application with mandibular-maxillary fixation
- c. Exploratory laparotomy
- d. Debridement and repair of avulsion wounds
- e. Debridement and suturing of the amputated finger
- f. S/P ORIF of mandibular fracture with titanium miniplate
- g. Removal of dental arch bar
- h. Removal of tracheostomy

1.14 Fire

No reports were received regarding any post-incident fires.

1.15 Survival Aspects

The SP sustained serious injuries as a result of contact with the aircraft's rotating propeller during disembarkation on the ramp. Ground personnel initiated an immediate emergency response, contacting emergency medical services and administering initial first aid on-site. The SP was subsequently transported via ambulance to the nearest medical facility, where medical treatment was provided. Despite the severity of the injuries, they were assessed as survivable, attributed to the prompt emergency response and the timely delivery of medical care.

1.16 Test and Research

No additional inspection or functional testing of the aircraft was performed following the accident, as the event was determined to be primarily attributable to human factors. Furthermore, there were no reported anomalies or performance issues associated with the aircraft at the time of the occurrence. A comprehensive review of the aircraft's maintenance records revealed no discrepancies or outstanding maintenance items.

1.17 Organizational and Management Information



Founded in 1993, Airworks Aviation Company Inc. has become one of the Philippines' top flying schools. In response to the global demand for pilots, the school has expanded to Cebu.

It holds a CAAP-issued Aviation Training Organization Certificate (ATOC No. 94-04) and operates a fleet of twenty-three (23) aircraft, including BE-58, C152, C172, and PA-34 models.

Airworks is backed by Tao Corp. (Tri-Dharma Holdings, Inc.), a top 50 corporation in the Philippines, and a partner of leading Indonesian companies like P.T. Indofood and P.T. Mayora Indah.

Building on this strong foundation, Airworks has expanded its industry connections to support student career growth. Airworks Aviation has partnered with Cebu Pacific to offer a structured pathway for future pilot graduates to pursue careers with the Philippines' leading airline.

2. ANALYSIS

2.1 Human Factor

2.1.1 Personnel Training and Competence

The FI holds a valid Commercial Pilot License (CPL) and Flight Instructor License issued by the CAAP, with the appropriate ratings for the type of aircraft operated at the time of the accident. During the interview, it was learned that she completed her flight training in 2019. She joined Airworks in November 2024 and was released as one of its FIs in January 2025. Based on records, she had accumulated a total of 3,267 hours as an FI, of which 2,328 hours were on the C152 aircraft.

As for the SP, records indicate that he had recently begun his flight training. He started his actual flying lessons in March 2025 and completed his first solo flight on April 9, 2025, just a few days prior to the accident.

2.1.2 Fatigue and Health Factors

A review of the FIs schedule from January 2025 to April 11, 2025, revealed the following information:

- a.** In January 2025, the involved FI completed a total of eighteen (18) flights. During this period, she experienced two instances of being scheduled for seven (7) consecutive days. In the 1st instance, she was given one (1) day off following the straight duty. In the 2nd instance, which spanned the last week of January into



the 1st week of February, her schedule continued for an additional five days (5), resulting in a total of twelve (12) consecutive duty days without a break;

- b. In February 2025, the FI logged a total of twenty (20) flights. Records indicate one instance during which she was scheduled for nine (9) consecutive duty days, beginning in the last week of the month. This duty period extended into the first four (4) days of March, resulting in a total of thirteen (13) consecutive days on duty.
- c. In April 2025, she was on duty for eleven (11) consecutive days leading up to the accident, with the accident day itself marking her twelfth (12th) straight day on duty.

Under the Airworks Aviation Procedures Manual dated July 2022, Chapter 1.8.14 outlines the following company standards/policies on instructor duty periods:

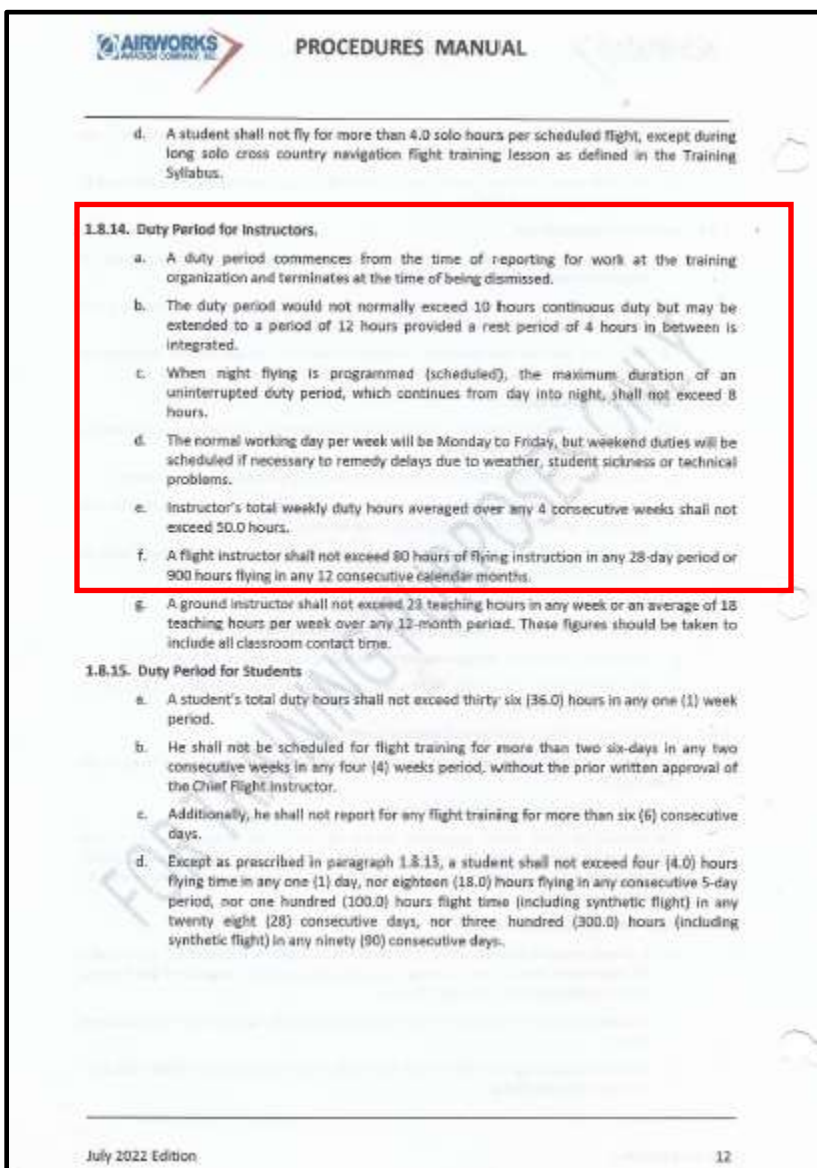


Figure 4 – Airworks Aviation Procedures Manual Chapter 1.8.14 – Duty Period for Instructors.

While the noted consecutive duty days may not have significantly contributed to the ground accident or constituted a deviation from the company procedures outlined above, such scheduling practices pose a potential hazard to the day-to-day operations of Airworks. If not appropriately managed, prolonged duty without adequate rest can impair the physical performance and situational awareness of FIs, thereby increasing the likelihood of safety-related occurrences.

For the involved SP, a review of his actual flying schedule from March up to the date of the accident showed that he had flown nine (9) times during this period, including the accident flight. His schedule did not reflect any pattern indicative of excessive workload or fatigue. However, a review of CCTV footage from the SP's dormitory and the Airworks hangar revealed the following:

- a.** On the night (April 11, 2025) before the accident, CCTV footage showed the SP returning to the dormitory at approximately 2153H. Based on interviews with his colleagues, he had gone out for dinner and subsequently visited a fellow Maldivian student to seek assistance in preparing for his navigation training scheduled the next day, before returning to the dormitory later that evening.
- b.** Between 0105H and 0109H on April 12, 2025, the SP was again seen on CCTV outside his room in the dormitory.
- c.** At 0506H on April 12, 2025, CCTV footage showed the SP arriving at the Airworks hangar in preparation for their scheduled flight training at 0600H.
- d.** At approximately 0514H, the FI was observed checking in at the hangar for their scheduled flight with the SP.

Based on the above, the observed timeline suggests that the involved SP may not have complied with the company's published rest period requirements, as outlined in Chapter 1.18.16 of the Airworks Aviation Procedures Manual. This provision mandates a minimum of 10 hours of rest before reporting for flying duty. The SP's activities prior to the scheduled training flight on April 12, 2025, appear inconsistent with this requirement.

This observation is further supported by a shared screenshot of a conversation between the FI and the SP, indicating that at approximately 0352H on the day of the flight, the SP was already awake and able to send a message to the FI regarding matters related to their scheduled training.

Furthermore, the planned interview with the SP to further assess his physical condition did not take place, as he was still undergoing medical treatment and recovery in the hospital during the report preparation period due to injuries

sustained in the accident. Similarly, the hospital was unable to perform the requested drug and alcohol testing despite having collected blood samples from the SP. This omission was attributed to an administrative oversight. It was also verified that the SP held a valid medical certificate issued by the CAAP.

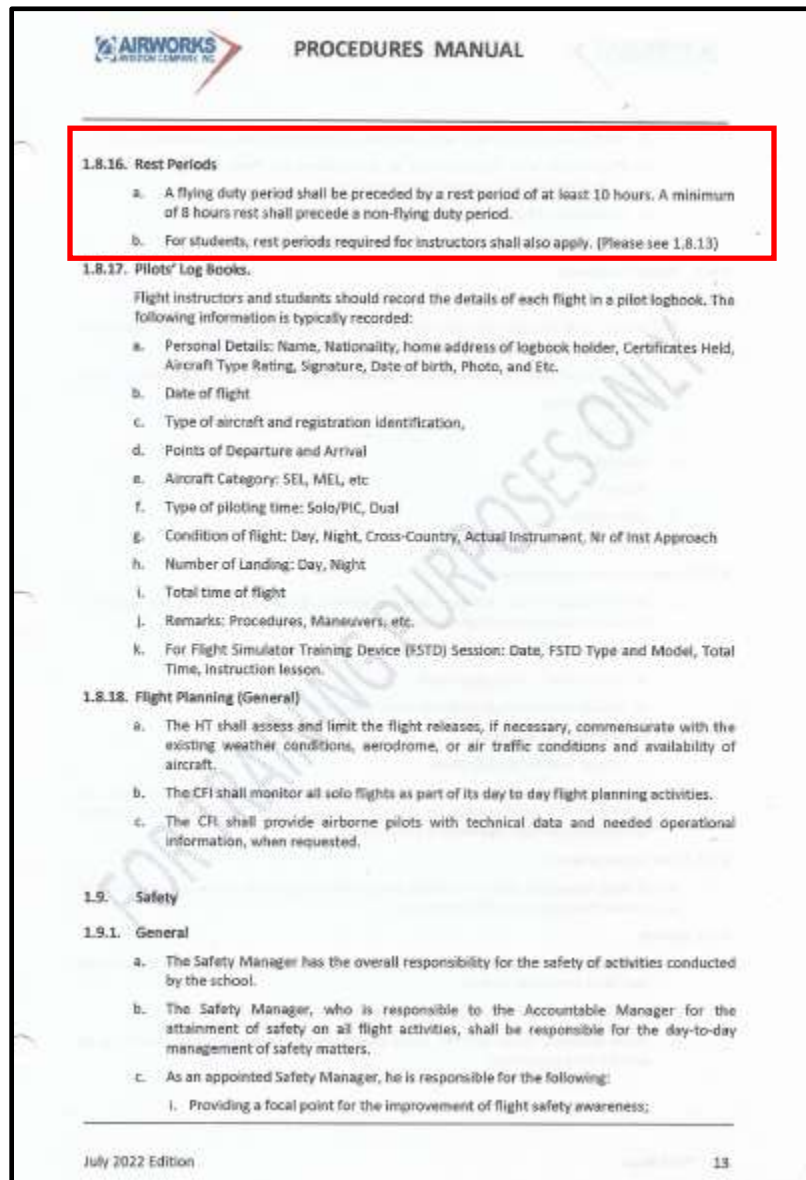


Figure 5 – Airworks Aviation Procedures Manual Chapter 1.8.16 – Rest Periods.

2.1.3 Situational Awareness and Decision Making

In this accident, the FI's situational awareness and sound judgement were demonstrated by her action to discontinue the training session as soon as she assessed the condition of her student. Her immediate action reflected an appropriate and safety-oriented response, prioritizing the well-being of the student. Moreover, continuing the flight under such circumstances, where the

student was unable to effectively participate or benefit from the training, would have been unproductive and counter to the objectives of effective flight instruction.

With regard to the circumstances that led to the ground accident after the aircraft had parked, the SP's decision to exit the aircraft while the engine was still running demonstrated a lack of situational awareness and poor judgment. This action deviated from general safety practices, which typically require the engine to be fully shut down and cleared before any crew member disembarks. However, it was noted that Airworks did not have a published SOP explicitly requiring this procedure until after the RP-C8798 incident.

As for the FI, her attempt to prevent the SP from exiting the aircraft was ultimately unsuccessful. CCTV footage revealed that within seconds of the aircraft coming to a complete stop, the SP had already moved to exit, with his foot visibly extending outside the aircraft. This indicates that the SP had already made a quick and independent decision to disembark, leaving the FI with little to no opportunity to intervene effectively.

2.2 Operations

2.2.1 Pre-Flight and Training Preparation

During the interview, the FI stated that when she arrived at the Airworks office on the day of the accident, the SP was already present, preparing their flight documents. She assisted the SP with the flight plan, and after it was filed, they conducted their pre-flight briefing. The briefing primarily concentrated on the operational aspects of the training, in compliance with the company's Training Manual. It was observed that the briefing did not include safety protocols around the aircraft, as these are not specifically required by the current manual, and, additionally, the SP had prior experience being around the aircraft.

Additionally, a review of the current ground training materials revealed that they do not clearly outline critical "Dos and Don'ts" or include any published SOPs related to safe movement around the aircraft, such as the need to keep clear of or avoid the propeller danger zone.

Furthermore, there is currently no pre-flight procedure or process requiring the FI to assess the physical readiness of the SP before the flight, such as verifying whether the SP has adhered to the required rest period, as this is generally

considered the responsibility of individual flight crew members to ensure they are physically fit before each flight.

With the above-noted areas for improvement in Airworks' internal procedures, it may be an opportunity to consider enhancing the scope of existing pre-flight briefings and the documentation of SOPs to emphasize not just flight safety, but also ground safety. Additionally, incorporating a simple check of the SP's physical readiness, i.e., observance of a rest period, into the FI's pre-flight responsibilities could further support safe flight operations.

2.2.2 Aircraft Parking, Ramp Safety and CRM

Aircraft parking at the Airworks ramp generally follows a nose-in procedure, with the aircraft facing the hangar. This arrangement has been in place for some time, as it allows for easier access for flight crews and maintenance personnel while also accommodating the movement of aircraft from operators in the adjacent hangars. However, if situational awareness is low or degraded, this configuration can increase the risk of inadvertently entering the propeller danger zone.

Given this typical parking position, it is likely that the SP's movement toward the front of the aircraft on the day of the accident was influenced by this layout. Upon arrival, crew members often follow the path parallel to the aircraft's position, which, if not approached with caution, can place them dangerously close to the propeller. Ideally, crew members moving from the aircraft to the hangar should approach from the side or wingtip area, avoiding direct paths toward the propeller danger zone.

Additionally, a possible breakdown in good Crew Resource Management (CRM) practices may have contributed to the occurrence. The SP did not communicate his intention to exit the aircraft to the FI, and the FI, in turn, did not provide clear instructions regarding their actions upon arrival, which could have helped prevent the SP from moving into a hazardous area. This lack of coordination and communication likely compounded the risk created by the parking configuration, contributing to the SP's movement into a hazardous area.

2.3 Organizational Factor

2.3.1 Safety Culture and Management Support

Airworks, through its Head of Training (HOT), has demonstrated a strong commitment to promoting safety within the organization. During the interview, it was learned that regular safety meetings are conducted to communicate and resolve safety matters. It can also be said that the company endeavors to have all its procedures documented to ensure uniform understanding and guidance to all its personnel. Furthermore, the HOT highlighted the strong management support for implementing safety protocols, emphasizing their critical role in ensuring the safety of daily operations. Additionally, a visit to the Airworks premises shows that the company provides adequate facilities and resources to support its safety programs, demonstrating a clear commitment to fostering a safe and secure working environment.

2.3.2 Company Training Programs

During the interviews conducted with key personnel and review of employee files, it was found that the company consistently provided several training opportunities to its personnel. These opportunities were designed to enhance both technical skills and safety awareness, ensuring that personnel were well-equipped to perform their duties effectively. These trainings are clearly defined under its Procedures Manual issued in July 2022. Furthermore, personnel were always informed of the latest developments in the organization, as well as any information relevant to the company's operations. Likewise, personnel also participate in relevant aviation forums, contributing to their growth and fostering a culture of continuous improvement within the organization.

2.3.3 Maintenance Program

Records and interviews with personnel revealed that aircraft maintenance schedules for RP-C8798 were consistently followed in accordance with regulatory and manufacturer requirements. An evaluation of the aircraft flight and maintenance logbook also showed that noted defects were addressed promptly and appropriately. Interviews confirmed that issues were effectively communicated between maintenance personnel and pilots.

3. CONCLUSIONS

3.1 Findings

- 3.1.1** The involved FI and SP hold valid pilot licenses and medical certificates issued by the CAAP.
- 3.1.2** The company has a valid CAAP issued Aviation Training Organization Certificate and Training Specifications.

- 3.1.3** The FI holds the appropriate rating to perform her functions for that specific type of aircraft. Likewise, the FI is part of the company's approved Training Specifications.
- 3.1.4** The aircraft has valid Certificates of Airworthiness and Registration. In addition, the aircraft involved is included in the company's approved Training Specifications.
- 3.1.5** The aircraft was released for flight without any recorded maintenance issues. Likewise, documentation of the aircraft maintenance is available and in proper order.
- 3.1.6** From January 2025 until the date of the accident, there were three (3) instances where the involved FI was on flight duty for twelve (12) or thirteen (13) consecutive days without a day off. While these extended duty periods may not have directly contributed to the ground accident or violated company procedures, such scheduling practices present a potential hazard to the daily operations of Airworks. Without proper management, prolonged duty without adequate rest can impair the physical performance and situational awareness of FIs, increasing the risk of safety-related incidents.
- 3.1.7** The SP's activities prior to the scheduled training flight on April 12, 2025, appear inconsistent with the requirement under Chapter 1.18.16 of the Airworks Aviation Procedures Manual, which mandates a minimum of ten (10) hours of rest before reporting for flying duty. Based on CCTV footage from the SP's dormitory and the SMS message sent by the SP to his FI on the day of the accident, the SP had approximately 2 hours and 43 minutes of rest before the training flight on April 12, 2025.
- 3.1.8** The SP's decision to exit the aircraft while the engine was still running demonstrated a lack of situational awareness and poor judgment. This action deviated from general safety practices, which typically require the engine to be fully shut down and cleared before any crew member disembarks, although this procedure had not been formally emphasized or documented by Airworks until after the RP-C8798 incident.
- 3.1.9** Under Airworks current Training Manual, which outlines pre-flight briefing requirements, it was noted that the focus is primarily on the operational aspects of the training. It was observed that the briefing does not include matters related to safety protocols in and around the aircraft.
- 3.1.10** A review of the current ground training materials revealed that they do not clearly outline critical "Dos and Don'ts" or include any published SOPs related to safe movement around the aircraft, such as the need to stay clear of or avoid the propeller danger zone area.

- 3.1.11** There is currently no pre-flight procedure or process requiring the FI to assess the physical readiness of the SP before the flight, such as verifying whether the SP has adhered to the required rest period, as this is generally considered the responsibility of individual flight crew members to ensure they are physically fit before each flight.
- 3.1.12** The existing parking configuration at the Airworks ramp likely influenced the SP's movement toward the front of the aircraft on the day of the accident. Given that crew members often follow the path parallel to the aircraft's position upon arrival, this movement, if not taken with caution or if situational awareness is degraded, can place personnel dangerously close to the propeller hazard area.
- 3.1.13** There was a breakdown in the practice of effective CRM between the SP and the FI. The SP did not communicate his intention to exit the aircraft, and the FI, in turn, did not provide clear instructions regarding their actions upon arrival, which could have helped prevent the SP from moving into a hazardous area.

3.2 Probable Cause

3.2.1 Primary Cause Factors

- a. The student pilot's decision to egress the aircraft while the engine remained operational demonstrated a significant lapse in situational awareness and a deviation from standard safety protocols, indicative of impaired judgment.

3.2.2 Contributory Cause Factor

- a. The student pilot's failure to observe the required rest period, which may have impaired his judgment and situational awareness.
- b. The lack of documented ground safety procedures and safety briefings of critical "Dos and Don'ts" for safe movement around the aircraft contributed to the student pilot's reduced awareness of potential hazards.
- c. A breakdown in Crew Resource Management between the student pilot and the flight instructor, particularly regarding communication about post-flight actions, which could have prevented the unsafe act.
- d. The aircraft parking position at the ramp may have unintentionally directed the student pilot toward the front of the aircraft, increasing the likelihood of encountering the propeller danger area.

4. SAFETY RECOMMENDATIONS

4.1 In consideration of the internal corrective actions already undertaken by the training organization, as detailed in Section 5.1 – Safety Actions, the AAIIB issues the following additional safety recommendations to the CAAP-FSIS to ensure that the training organization, Airworks Aviation Company, Inc.:

- a.** Establish and strictly enforce a documented procedure requiring the engine to be fully shut down and cleared before any crew member disembarks the aircraft. This should be included as part of the standard pre-flight and post-flight safety protocols to eliminate the risk of propeller-related accidents.
- b.** Enhance and implement comprehensive ground safety briefings and SOPs that clearly outline critical "Dos and Don'ts" for safe movement around the aircraft, including procedures for avoiding the propeller danger zone.
- c.** Strictly enforce and reiterate to all personnel the minimum rest period requirements outlined in the Procedures Manual to prevent fatigue-related safety lapses.
- d.** Reinforce the practice of effective Crew Resource Management among all flight crew members, including possible enhancement of training to address identified communication and coordination gaps.
- e.** Review the current pre-flight procedures and consider implementing a system to assist flight instructors in assessing the physical readiness of student pilots before each flight, such as verifying whether the SP has adhered to the required rest period.
- f.** Establish and enforce clearer duty time limitations and minimum rest requirements for flight instructors, including a maximum number of consecutive duty days without a day off.

5. SAFETY ACTION

5.1 Following this occurrence, Airworks Aviation Company, Inc. initiated the following safety corrective actions (Ref: Airworks internal memorandum dated April 15, 2025, and evidence submitted on May 09, 2025):

- a.** A revised aircraft movement and parking protocol was issued and implemented by the company's Head of Training, which requires aircraft to be positioned facing the runway, rather than the hangar, to isolate the propeller danger area during crew embarkation/disembarkation.

- b.** A number of informative visual signages have been placed within the working areas of the Airworks hangar to inform all personnel about the propeller danger zone.
- c.** A safety briefing for all personnel was conducted by the Head of Training on April 14, 2025, to discuss matters related to the accident and the actions to be taken to prevent similar occurrences.

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