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-C1789
TECNAM P2006T

OPERATOR: ALL ASIA AVIATION ACADEMY

TYPE OF OPERATION: FLIGHT TRAINING (PCAR PART 3)

DATE OF OCCURRENCE: NOVEMBER 22, 2022

PLACE OF OCCURRENCE: IBA COMMUNITY AIRPORT, IBA, ZAMBALES, PHILIPPINES

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(Tecnam P2006T, RP-C1789 Final Report)

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.

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FINAL REPORT

TITLE: Incident involving a Tecnam P2006T type of aircraft with registry number RP-C1789 owned and operated by All Asia Aviation Academy that had a gear-up landing resulting to Runway Excursion at Iba Community Airport, Iba, Zambales, on November 22, 2022 at about 1555H/0755 UTC.

Notification of Occurrence to National Authority

The notification of incident to AAIIB CAAP was relayed by the Operator of the aircraft at 1200H (local) on November 22, 2022.

Identification of the Investigation Authority

The Aircraft Accident Investigation and Inquiry Board (AAIIB), 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 provisions of Philippine Civil Aviation Regulation (PCAR) Part 13, an Investigator-In-Charge and Deputy Investigator-In Charge were appointed.

Authority Releasing the Report

The Final investigation report was released by Aircraft Accident Investigation and Inquiry Board (AAIIB) and published at the CAAP website on **26 January 2024**.

Synopsis:

On November 22, 2022 at about 1555H (local), a Tecnam P2006T type of aircraft with registry number RP-C1789 operated by All Asia Aviation Academy had a gear-up landing resulting to runway excursion at Iba Community Airport, Iba, Zambales. The three (3) occupants onboard did not sustain any injuries, however the aircraft sustained minor damage as a result of the incident. Visual Meteorological Condition (VMC) prevailed at the time of the incident. The cause of the occurrence was attributed to the failure of the FI and his trainee to perform landing checklist procedures leading to a gear-up landing and a lateral runway excursion.

LIST OF ACRONYMS AND ABBREVIATIONS

AAA	:	All Asia Aviation
AAIIB	:	Aircraft Accident Investigation and Inquiry Board
ADF	:	Automatic Direction Finder
CAAP	:	Civil Aviation Authority of the Philippines
COA	:	Certificate of Airworthiness
CPL	:	Commercial Pilot License
CRM	:	Crew Resource Management
DME	:	Distance Measuring Equipment
FAA	:	Federal Aviation Administration
FI	:	Flight Instructor
FIT	:	Flight Instructor Trainee
FT	:	Feet
M	:	Meter(s)
OBS	:	Observer
OFSAM	:	Office of the Flight Surgeon and Aviation Medicine
OPCEN	:	Operation Center
PCAR	:	Philippine Civil Aviation Regulation
PF	:	Pilot Flying or Pilot in control of the aircraft
PNF	:	Pilot Not Flying or Pilot not in control of the aircraft
RWY	:	Runway
SA	:	Situational Awareness
UTC	:	Universal Time Coordinated
SCT	:	Scattered
SOP	:	Standard Operating Procedures
VFR	:	Visual Flight Rules
VMC	:	Visual Meteorological Condition

1. FACTUAL INFORMATION

Aircraft Registration No.	:	RP- C1789
Aircraft Type/Model	:	Tecnam P2006T
Operator	:	All Asia Aviation Academy
Address of Operator	:	Iba Community Airport, Iba, Zambales
Place of Occurrence	:	Iba Community Airport, Iba, Zambales
Date/Time of Occurrence	:	November 22, 2022 at about 1555H/0755 UTC
Type of Operation	:	Flight Training (PCAR Part 3)
Phase of Flight	:	Landing
Type of Occurrence	:	Wheels-up landing - intentional

1.1 History of Flight

On or about 1555H local time on November 22, 2022, a Tecnam P2006T type of aircraft with registry number RP-C1789, operated by All Asia Aviation Academy sustained substantial damage following a runway excursion after a gear-up landing. Onboard the aircraft were the Flight Instructor (FI), the Flight Instructor Trainee (FIT), and an Observer (Obs). Visual Meteorological Condition prevailed at the time of the incident.

After finishing eight (8) touches and gos, the crew executed a “go-around” over Runway (RWY) 14 of Iba Community Airport due to the presence of a stray dog on the runway as seen by the pilots. Additionally, in anticipation of the closing of operations at the airport at 1600H/ 0800UTC, the FI commanded the FI trainee to perform a short pattern approach. However, during the approach, the crew failed to extend the aircraft's landing gears before touching down. The aircraft touched down 250 meters after the threshold of runway 14 and continued to move forward for another 160 meters directly over the runway centerline, then started to veer off to the right, creating runway scars and dents underneath the aircraft fuselage. The aircraft entered the grassy portion of the runway and stopped ninety-five (95) meters before the number #2 runway 14 marker, approximately 475 meters from the threshold of runway 14 with coordinates 15°19'32.43"N 119°58'6.59"E and a heading of 260 degrees (Figure 1).

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Duty airport personnel, together with their company maintenance group, responded immediately to assist the occupants and secure the aircraft. The airport caretaker contacted CAAP-OPCEN, informing them of the occurrence on the airport/runway and requesting closure due to disabled aircraft on the runway effective 1600H (0800UTC) as a result of the incident. Even though the runway was cleared at 1430H (0630UTC) on November 23, 2022, with the relocation of the disabled aircraft to the operator's designated hangar (Figure 2), normal airport/runway operation resumed at 0800H (0000UTC) the following day, as decided by the airport caretaker.

Figure 1: The aircraft at its final resting point.

Figure 2: The aircraft was relocated to the hangar.

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1.2 Injuries to Person (s)

Injuries	Crew	Passengers	Others	TOTAL
Fatal	0	0	0	**0**
Serious	0	0	0	**0**
Minor	0	0	0	**0**
None	3	0	0	**3**

1.3 Damage to Aircraft

The aircraft sustained damage on the blade tip of the left-hand propeller assembly; impact damage on the left wing approximately one (1) meter from the tips; damage on the DME, ADF, transponder, and Com-1 radio antennas; and deep scars and dents underneath the aircraft fuselage.

1.4 Other Damages

There were no reported other damages in relation with the event.

1.5 Personnel Information

1.5.1 Flight Instructor (FI)

Gender	:	Male
Date of Birth	:	July 14, 1990
Nationality	:	Indian
License	:	125937 – CPL 125937-FI
Valid up to	:	February 28, 2026 (CPL) March 31, 2024 (FI)
Type rating	:	Single & Multi Engine Land - C152, C172, P2006T, Red Bird MCX (FI)
Medical Certificate Valid up to	:	Class 1 valid until September 03, 2023
Time on Aircraft	:	300+00 Hours as per Pilot logbook
Grand Total time	:	3,600+00 Hours as per Pilot logbook

1.5.2 Flight Instructor Trainee

Gender	:	Female
Date of Birth	:	May 17, 2001
Nationality	:	Indonesian
License	:	149666 – CPL
Valid up to	:	August 31, 2027
Type rating	:	Single Engine Land - C152, C172. Instrument

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Medical Certificate Valid up to	:	Class 1 valid until June 01, 2023
Time on Aircraft	:	12+00 Hours as per Pilot logbook
Grand Total time	:	191+00 Hours as per Pilot logbook

1.6 Aircraft Information

The Tecnam P2006T is an all-metal, twin-engine, high-wing FAA Part 23-certified airplane, four-seat aircraft powered by two four-cylinder four-stroke 100-horsepower Rotax 912 series engines.

1.6.1 Aircraft Data

Registration Mark	:	RP-C1789
Manufacturer	:	Costruzioni Aeronautiche Tecnam S.P.A.
Country of Manufacturer	:	Italy
Type/Model	:	Tecnam P2006T
Operator	:	All Asia Aviation Academy
Serial No./Line No.	:	137
Year of Manufacture	:	2013
Certificate of Airworthiness	:	Valid until May 10, 2023
Certificate of Registration	:	Valid until May 5, 2023
Category	:	Utility
Number of Flight Crew	:	2
Number of Passenger	:	2
Airframe total time	:	1,810 + 46 Hours

1.6.2 Engine Data

The Rotax 912 engine series is a horizontally-opposed four-cylinder, natural aspirated, 4 stroke aircraft engine with a reduction gearbox. It features liquid-cooled certificated form for use in ultralights and motor gliders.

Manufacturer	:	ROTAX
Type	:	Piston
Model	:	912S3 (1)/ 912S3 (2)
Engine SN#	:	4.924.515 (1)/ 4.924.528 (2)
Engine total time	:	1,810 + 36 Hours (1)/ 1,810 + 36 Hours (2)

1.6.3 Propeller Data

Manufacturer	:	MT Propeller
Type	:	Constant Speed
Model	:	MTV-21-A-C-F 912S3 (RH)/ MTV-21-A-C-F 912S3 (LH)
Propeller SN#	:	190360 (RH)/ 190361 (LH)
Date last Installed	:	December 01, 2021 (RH)/ December 01, 2021 (LH)
Propeller total time	:	1,833 + 05 Hours (RH)/ 1,833 + 05 Hours (LH)

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1.7 Meteorological Information

Visual Meteorological Conditions (VMC) prevailed at the time of the occurrence.

1.8 Aids to Navigation

The flight was carried out under Visual Flight Rules (VFR). Using VFR, the pilot must be able to operate the aircraft with visual references to the ground and visually avoiding obstructions and other aircraft.

1.9 Communications

The aircraft is equipped with a standard radio transceiver. Communications were carried out between the pilot and the duty air traffic controller within the area.

1.10 Aerodrome Information

Iba Community Airport Cauayan airport is an airport serving the general area of Iba, located in the province of Zambales in the Philippines. It is one of the five airports in Zambales. It is classified as a feeder airport by the Civil Aviation Authority of the Philippines, a body of the Department of Transportation that is responsible for the operations of not only this airport but also of all other airports in the Philippines except the major international airports. Iba Airport serves as a training area for the Philippine Air Force and today, most of the traffic that goes in Iba Airport are general aviation.

1.10.1 General Information

Aerodrome Name	:	Iba Community Airport (RPUI)
Coordinates	:	N15°19'53.8213" E119°58'05.1856"
Aerodrome Operator	:	Civil Aviation Authority of the Philippines Iba Airport, Iba Zambales 2201
Runway Direction	:	14 / 32 (140º MAG) / (320º MAG)
Runway Length	:	900M
Runway Width	:	30M
Surface	:	Concrete/Asphalt
Types of traffic permitted	:	VFR
AD Operator	:	Airport Operations: 2300 - 0800
Security	:	2200 - 1000
Restaurants	:	At the airport and at the town proper
Transportation	:	Vehicle for hire.
Medical facilities	:	Within the town proper
AD category for fire fighting	:	CAT III.
Rescue equipment	:	Wheel Type Fire Extinguisher. SIDES DODGE VIRM 13.
Capability for removal of disabled aircraft	:	Nil.

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TORA 14/32	:	900M
TODA 14/32	:	980M
ASDA 14/32	:	980M
LDA 14/32	:	900M

1.11 Flight Recorders

The aircraft is not equipped with any flight recorders, and the existing Philippine Civil Aviation Regulation does not require them to be installed for that type of aircraft.

1.12 Wreckage and Impact Information

The aircraft touched down 250 meters after the threshold of runway 14 and continued to move forward for another 160 meters directly over the runway centerline, then started to veer off to the right, creating runway scars and dents underneath the aircraft fuselage. The aircraft entered the grassy portion of the runway and stopped ninety-five (95) meters before the number #2 runway 14 marker, approximately 475 meters from the threshold of runway 14 with coordinates 15°19'32.43"N 119°58'6.59"E and a heading of 260 degrees. The aircraft incurred serious damage on the tip of its left-hand propeller (Figure 3); serious dents on the left-side leading edge and aileron (Figure 4); and deep scars on the aircraft's belly or under carriage with damaged communication and navigation antennas (Figure 5).

Figure 3: Propeller damage

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Figure 4: left wing damage

Figure 5: fuselage/antenna damage.

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1.13 Medical and Pathological Information

Both pilots' medical certificates were current and met the CAAP-OFSAM medical standards to exercise the privileges of their license. There was no medical impediment on both pilots that could have had a bearing on this occurrence.

1.14 Fire

There was no reported post-crash fire during on-site investigation.

1.15 Search and Survival Aspects

The incident was survivable, as the integrity of the aircraft was not compromised and it only sustained minor damage. Likewise, the occurrence happened within the airport area, so airport personnel were able to immediately assist the occupants of the aircraft.

1.16 Test and Research

The aircraft landing gear system was checked during the recovery operations by lifting the whole aircraft using an improvised lifter or hoist on November 23, 2022, under the supervision of AAA Academy Management and Maintenance Technicians and AAIIB Investigators. The lifting of the aircraft was to verify if there were any issues in the landing gear system that could be attributed to the incident. During the said activity, no abnormalities were found on the aircraft's landing gear system since the landing gears were extended after activating the landing gear lever inside the cockpit with the battery or power on. The landing gears were kept extended, which made its towing easier up to its relocation to the designated hangar.

With the admission of the pilots' unintentional omission to extend the landing gears before touching down, it was then established that the aircraft's landing gear system was airworthy during the day of operation. During the activation of the landing gear extension by putting the lever down, a loud sound or aural cues were continuously heard coming from the cockpit until the gear's full extension.

1.17 Organizational and Management Information

All Asia Aviation Academy (AAA academy) is the only flight school in the Philippines that was established under Japanese Management Standards. AAA academy is also backed up by the KTC Group, an international organization which is also – one of the largest business conglomerates in Japan today. This allows AAA Academy to be able to provide the necessary and needed investment in equipment, human resources and facilities in order to provide you the best in pilot training and also contribute to the overall future of aviation. AAA Academy operates as an Approved Training Organization under Certificate Number 2007-03 valid until January 20, 2023. Its base of operations is located at Iba Community Airport, Brgy. Lipay Dingin, Iba, Zambales 2201.

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2.0 ANALYSIS

2.1 General

The FI was certified and qualified under PCAR for such a type of aircraft and to perform instructional functions. He is currently employed at All Asia Aviation Academy as a Chief Flight Instructor.

For the aircraft, it has an issued Certificate of Registration valid until May 5, 2023, and a Certificate of Airworthiness valid until May 10, 2023.

2.2 Flight Crew

The FI has been with All Asia Aviation Academy as a full-time FI since CY 2016. He is rated as FI for the C152, C172, and Tecnam P2006T types of aircraft. During the time of the incident, he has logged a total of 300+00 hours on the involved type of aircraft.

As for the FI trainee, she completed her CPL at AAA Academy in December 2021. Moreover, she is the holder of the CAAP-issued license with ratings on C152 and C172. She has already logged a total of 12 hours on a Tecnam P2006T type of aircraft.

In the interview with both pilots, they stated that they were mentally and physically prepared to take the flight that day as scheduled and had no prior conditions that might impair their performance. With regards to the involved FI trainee, she was scheduled to fly that day for his FI training in the Tecnam P2006T platform. She already logged a total of 12 hours or equivalent to six (6) sorties, going to her 7th flight for the said type of aircraft.

The FI further stated that he was scheduled for two training flights for that day, one in the morning and one in the afternoon, and the incident happened on his second training flight. Prior to the occurrence, there were no reports of any issues with the training or the aircraft being operated that day. However, he stated during the interview that he was a bit stressed and needed some break.

2.3 Flight Training

On the day of the incident, the FI narrated that he observed a tailwind during the earlier patterns for normal or routine touch-and-go landings. He then communicated an advisory for a change in runway in use from RWY 32 to RWY 14. After a series of touch and go, approximately on the 8th pattern, the FI commanded a “go around” due to distraction or obstruction over the runway (an alleged presence of a stray dog), which the FI trainee corroborated during her interview.

During “Go Around," the aircraft was under the FI trainee’s control, wherein she performed the gear and flap retraction procedures on the upwind leg. In the interest of time, since the runway operations were about to close at 1600H, the FI commanded a short pattern or approach for full-stop landing so as not to exceed the down and park time. However, the control of the aircraft was in an obscure or gray area since the FI trainee assumed that it was “on dual control” since the short pattern or approach was new to her. However, the FI insisted that it was the FI trainee

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who was in control at that time since it was still her time as an FI trainee. He also noted that the FI trainee has the tendency to forget procedures, just as with the previous sorties. Hence, he was just intervening, correcting silently, or giving reminders using his hands, pointing to what procedures she had missed. The FI stated that the FI trainee performed the flaps extension, the gears down, or the extension on the base leg, but he did not confirm visually that the FI trainee did it. Then they turned to the final approach for a full-stop landing, with 80 down to 70 knots. On the final leg, FI stated that flaps were switched to full or landing configuration, maintaining 70 knot approach speed. The FI claimed they had a good approach for full-stop landing in terms of airspeed, altitude, and alignment to the runway 14 centerline, even though there was a varying crosswind factor of 20–25 knots as reflected by the Garmin 950 on board the aircraft.

During the transition from level-off to round-out attitude, the FI, FI trainee, and Obs noticed a longer-than-usual round-out and a little lower or closer view of the aircraft to the runway surface. After a few seconds, the aircraft touched down with a loud breaking or scratching sound, but the crew continued as if it were a normal landing roll. The FI noticed that the aircraft had started veering off to the right side of RWY 14, which he anticipated would take over control. When the aircraft reached its final resting place at the grassy area just beside or on the edge of RWY 14, the FI immediately performed engine emergency shutdown procedures, then instructed the other crew to leave the aircraft. One of the witnesses, the duty airport guard on the right side of the runway, stated that the last approach to landing was just a normal one, as he observed on the aircraft's earlier touch-and-go landings. He then stated that it was a normal approach of the aircraft, but without gears, as it passed by his view before it touched the surface of the runway, then was followed by a loud sound upon impact. The loud sound of impact upon touching down called the attention of other witnesses who were inside their respective offices or buildings. They immediately rushed to the accident site to extend help and assistance.

With the above information, the following have been established:

a. During "Go Around," it was the FI trainee's full control, and she admitted that she's the one who performed the gears and flaps retraction while continuing on the upwind leg. However, when the FI commanded to perform a short pattern or approach for full stop landing so as to beat the 1600H cutoff time of the airport, the FI trainee expected that they were "on dual control" since the short pattern or approach using the Tecnam P2006T aircraft was new to her. On that phase of the flight, the FI was just cautioning or reminding the FI trainee. He did not even take control, but he admitted to touching the yoke from time to time to infuse corrections.

b. While performing the short pattern or approach for full stop landing, the FI trainee admitted that she did not perform the flaps operation or even the switching of landing gear to the down position since she expected the FI to do it. Apparently, the FI also admitted that he did not perform either the flaps operation or landing gear extension because, according to him, it was still under FI trainee's control or flight training time. But he did not confirm that the FI trainee did perform those procedures. They both admitted that they usually do not use checklists for pre-landing checks, nor do they use checklists for confirmation or calling out after performing a certain procedure as indicated on the checklist.

c. After the go-around, it was established that the flight crew deviated from the normal traffic pattern procedures while still getting over the distraction or obstruction over RWY 14. The decision to perform a short pattern or approach for full-stop landing was for them to beat the

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1600H cutoff time or the airport's operation closing time. According to the management, the 1600H cut-off time was just set to remind all pilots to proceed back to the station (Iba Airport) before 1700H as the official down and parked time.

2.4 Continuation Bias.

This accident started to occur during the approach and landing phases of the flight when they got distracted by an alleged distraction or obstruction over the runway (the presence of any stray dog), wherein the FI commanded the go-around with FI trainee on the control. However, after putting the aircraft in a clean configuration still on the upwind leg, the FI commanded a short pattern/ approach for a full-stop landing. The FI trainee just assumed that they were on "dual controls" since the short/pattern of approach on that platform was new to her. The snowball effect on their flight was aggravated when the FI was focused on performing an immediate full-stop landing since it was already near 1600H/ 0800 UTC, which was the prescribed closing time for the runway/airport operation. Aural and visual cues on the flap's operation in full-down position were disregarded, much more the confirmation of three green lights to signify that all gears were fully extended.

The FI trainee's inappropriate actions, which coincided with the FI's inaction in controlling the aircraft for full-stop landing, have resulted in errors in landing procedures. The investigation depicts that the FI did not closely monitor the FI trainee's performance during that specific and last pattern after the go-around, wherein the FI could have aborted the landing and performed or given commands for another go-around. When continuation bias interferes with the pilot's ability to detect important cues, or if the pilot fails to recognize the implications of those cues, breakdowns in situational awareness (SA) occur. Continuation bias is the unconscious cognitive bias to continue with the original plan in spite of changing conditions. These breakdowns in SA can result in non-optimal decisions being made, which could compromise safety.

2.5 Aircraft

A. Review of the aircraft maintenance records was made and found the following to be in order:
   a. Aircraft Pre-Flight Checklist dated November 22, 2022;
   b. Aircraft Flight and Maintenance Logbook dated November 22, 2022;
   c. 100 hours Inspection dated July 06, 2022;
   d. 50 hours Inspection dated November 2022;
   e. Airframe/Propeller/Engine logbooks available.

B. There was no recorded maintenance issue on the aircraft prior to its flight last November 22, 2022.

2.6 Airport Condition

A. Ocular inspection of the runway was made last November 23, 2022 and during this visit, it was found that the runway surface condition had no physical deficiencies (i.e. potholes/uneven pavement/slippery areas) that might pose hazard to the take-off/landing of aircraft. Likewise, markings and markers are available within the aircraft movement area to serve as reference to pilots.

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B. As for the weather, the data provided by Subic aerodrome (RPLB) with METAR data shows good meteorological condition during the time of the occurrence.

Date/ Time	Wind Direction	Wind Speed	Visibility	Sky Condition	Temperature	Dew Point	QNH
Nov 22, 2022/ 1400H/ 0600 UTC	*080*	*10 kts*	*10 kms*	*SCT 020*	*31*	*23*	*1009*
Nov 22, 2022/ 1500H/ 0700 UTC	*090*	*9 kts*	*10 kms*	*SCT 020*	*32*	*23*	*1009*
Nov 22, 2022/ 1556H/ 0756 UTC	*100*	*8 kts*	*10 kms*	*SCT 020*	*31*	*23*	*1009*

3.0 CONCLUSIONS

3.1 Findings

a. The FI was qualified on the Tecnam P2006T type of aircraft.
b. The FI trainee was qualified on the Tecnam P2006T type of aircraft.
c. The aircraft was properly released for flight without any discrepancies noted on its logbook.
d. The aircraft has a valid Certificates of Airworthiness and Registration.
e. The aircraft was equipped and maintained in accordance with CAAP-PCARs and approved manufacturer's procedures.

3.2 Probable Cause

3.2.1 Primary Cause Factor

a. Failure of the FI and FI trainee to perform landing gear extension procedures leading to a gear-up landing resulting to a lateral runway excursion.

3.2.2 Contributory Cause Factor

a. Unable to identify and recognize visual and aural cues inside cockpit that gave the pilots signals as to the aircraft's current configuration due to the encountered distractions and self-imposed urgency to immediately land the aircraft which led to the omission important in-flight procedures, particularly the pre-landing checks and approach to landing procedures;

b. Lack of proper Crew Resource Management (CRM) between the pilots; and

c. Pilot's complacency by not using the checklist; and the non-confirmatory actions inside the cockpit between the pilot-flying and the pilot-not-flying during the flight's critical phase, specifically during landing.

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4.0 SAFETY RECOMMENDATIONS

4.1 For **CAAP-FSIS** to ensure that the Operator (All Asia Aviation Academy):

a. Emphasize to all flight crew the importance of following SOPs during touch and go patterns, particularly the gear and flap extension/retract procedures.

b. Reinforce training and practice for flight crews on CRM (pilot-flying and pilot-not-flying duties and responsibilities). This will ensure a sterile cockpit in order to prevent the breakdown of the situational awareness of pilots and crew, especially during critical phases of the flight.

-----END-----

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