ACCIDENT INVESTIGATION COMMISSION

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MEDIA RELEASE

RELEASE OF FINAL REPORT ON KOBIO AVIATION LTD DHC-6-300 TWIN OTTER AIRCRAFT ACCIDENT AT KAIRIK AIRPORT, ENGA PROVINCE, PNG.

The Accident Investigation Commission (AIC) today published the Final Report on the investigation conducted into an accident involving a DHC-6-300 Twin Otter aircraft that occurred at Kairik Airport, Enga Province, Papua New Guinea.

On 19 October 2024, at 15:00 local time (05:00 UTC), a De Havilland Aircraft of Canada Ltd DHC-6-300 Twin Otter aircraft registered P2-KAL, owned by ASHE Aircraft Enterprises Limited, and operated by Kobio Aviation Limited, was conducting a VFR charter flight from Kairik Airport, Enga Province to Mt. Hagen Airport, Western Highlands Province, Papua New Guinea, when during the take-off roll, it experienced a runway excursion and rolled into a drainage ditch, which runs along the left side of the runway, and impacted an embankment. There were five (5) persons on board: two (2) pilots and three (3) passengers. No injuries were reported.

The pilot flying was occupying the left seat and was the pilot In-Command Under Supervision (ICUS). The pilot monitoring was occupying the right seat and was the Instructor Pilot (IP).

The AIC was notified on 19 October 2024 at 16:05 local time (06:05 UTC) of the accident and immediately commenced an investigation in accordance with its mandate under the PNG Civil Aviation Act 2000 and pursuant to ICAO Annex 13 to the Convention on International Civil Aviation.

The investigation determined that the accident resulted from a combination of operational, human, and environmental factors. It was identified that during a tight left turn onto RWY 05 for line up in preparation for take-off, excessive tiller inputs led to subsequential overcorrections, misaligning the nosewheel to the right of the centerline. The crew omitted a 3 metre forward roll to verify nosewheel alignment with the centreline, which is a requirement outlined in the aircraft manufacturer's procedures but was not included in the operator's SOP, preventing detection of this misalignment. When the take-off roll began, the aircraft veered right. In response, the crew applied left rudder and asymmetric power; however, the inputs were excessive, causing a sharp left veer across the centerline and a loss of directional control.

Despite attempts to regain control, the aircraft continued onto the grass to the left of the runway. The wet and slippery grass surface significantly reduced tyre traction and rendered recovery efforts ineffective as the aircraft continued to roll and the left wingtip struck an embankment, causing a sharp turn and a nose impact with a drainage ditch.

Ineffective Crew Resource Management in the cockpit and pairing of a newly endorsed pilot ICUS with a new IP increased risks during this high-workload phase. This, combined with procedural gaps, improper control inputs, and wet and slippery surface conditions on the side of the runway, contributed to the accident. The investigation also identified other safety deficiencies or concerns during the course of the investigation that should be addressed with the aim of accident prevention.

The Final report includes safety recommendations made by the AIC to the operator, with the intention of enhancing operational safety. According to ICAO Annex 13 Standards, identified safety deficiencies and concerns must be raised with the persons or organisations best placed to take safety action.

The Final Report of the investigation is available on AIC's website www.aic.gov.pg

Authorised for release by:

Maryanne J. Wal
Chief Commissioner