ACCIDENT INVESTIGATION COMMISSION
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Safety recommendation: AIC 25-R12/25-1001

Addressed to: Tropicair Limited

Date issued: 08 July 2025

Investigation link: AIC 25-1001

Action status: Issued

Introduction

On 6 February 2025 at 11:09 local time (01:09 UTC), the AIC was notified by the operator via email of an accident at Kerema Airport, Gulf Province, that occurred on 6 February 2025 at 10:28 local, involving a DHC-6-400 Twin Otter aircraft, registered P2-AXL, owned by Lagavulin Asset Management Limited (Ltd) and operated by Tropicair Ltd. The AIC immediately commenced an investigation and deployed a team of investigators to perform on-site activities on 6 February 2025.

Occurrence

On 6 February 2025, at 10:28 local (00:28 UTC), a DHC-6-400 aircraft registered P2-AXL, owned by Lagavulin Asset Management Ltd and operated by Tropicair Ltd was conducting an IFR charter flight from Purari Airstrip to Kerema Airport, Gulf Province, Papua New Guinea, when during the landing roll, the aircraft experienced a loss of directional control, veered off the runway and impacted a drainage ditch that runs along the left side of the runway.

There were 10 persons on board: 2 pilots and 8 passengers. None of the aircraft's occupants were injured.

Safety Deficiency Description

Following touchdown, the PIC selected Beta mode in accordance with the operator's Standard Operating Procedures (SOPs) to assist with decelerating the aircraft. Recorded data showed that; after the first application of Beta the aircraft continued to maintain centerline tracking. There were no abnormalities in directional control during touchdown and initial landing roll.

Recorded data showed that; the PIC applied Beta for the second time. Subsequently, the aircraft began to drift towards the right edge of RWY 14. The PIC then advanced the power levers forward. The left power lever remained in the IDLE position while the right power lever was advanced further forward, which indicated that the PIC was applying asymmetric power. Simultaneously, the co-pilot applied full left rudder momentarily. Following this action, recorded data showed the aircraft yawed briefly to the left, before the co-pilot abruptly released pressure on the left rudder pedal. The aircraft then yawed to the right and continued to drift to the right.

The PIC stated during interview that he attempted to apply brakes to further reduce the aircraft's speed. During this action, he encountered difficulty in accessing the brakes when the sole of his footwear became lodged in the gap between the rudder pedals and brakes. Despite continued attempts, he was unable to gain proper access to the brakes.

Recognising the situation, the PIC instructed the co-pilot to assist in applying brakes. During AIC's interview with the co-pilot, he stated that he was not aware of the situation of the PIC's inability to access the brakes, however, following the PIC's instructions he stated that he lightly tapped the brakes as directed.

According to the PIC, he continued with the application of asymmetric power combined with rudder input, to steer the aircraft back onto the paved runway surface. However, the aircraft continued to travel forward on the grass surface of the runway edge on the right side, before it skidded left toward the paved runway surface. The crew stated that once back on the paved runway surface, the aircraft overshot the centreline and continued further left of RWY 14. They added that they were unable to maintain directional control. The PIC stated that he applied Reverse when the aircraft had skidded onto the grass surface of the left runway edge in an attempt to stop the aircraft.

Recorded data showed that the PIC continued to apply asymmetric power while the aircraft continued to drift further right of the runway on the grass surface of the runway edge, before making a sharp left turn. This was in response to the induced asymmetric thrust effect, with an increase of power in the right engine that generated a left yaw moment.

The aircraft then re-entered the runway and overshot the centreline before continuing further left onto the grass surface of the runway edge. The PIC applied Reverse, however, the aircraft continued to skid further left and eventually impacted the side of the drainage ditch.

The investigation revealed from recorded data and interviews with the AIC that the flight crew did not communicate effectively during the landing roll. Critical information, such as the PIC's difficulty in accessing the brakes due to the sole of his footwear being lodged in the gap between the rudder and brakes, was not promptly or clearly conveyed to the co-pilot. Additionally, there was no clear verbal coordination regarding the use of asymmetric thrust and rudder inputs.

Recommendation number AIC 25-R12/25-1001 to Tropicair Limited

The PNG Accident Investigation Commission (AIC) recommends that Tropicair Ltd implement targeted Crew Resource Management (CRM) reinforcement initiatives aimed at improving cockpit coordination during critical phases of flight. The effectiveness of these measures should be evaluated through routine flight checks and crew performance monitoring.

Action requested

The AIC requests that Tropicair Ltd note recommendation AIC 25-R12/25-1001 and provide a response to the AIC within 90 days of the issue date, but no later than 06 October 2025 and explain, including with evidence, how Tropicair Ltd has addressed the safety deficiency identified in the safety recommendation.

Maryanne J. Wal
Chief Commissioner