Belize Department of Civil Aviation

Report No.:	A-001-11-2017
Name:	Accident Investigation Final Report
Registration:	V3-HGX.

CESSNA 208B GRAND CARAVAN
17 NOVEMBER 2017
PLACENCIA AIRPORT, PLACENCIA VILLAGE
STANN CREEK DISTRICT, BELIZE C.A.

Investigators: Shaun Young (Investigator in Charge) Francis Lizama (Accident Investigator)
Approved by: Minister of Tourism and Civil Aviation
Publication date:

FINAL REPORT

In accordance with the Aircraft Accident and Incident Investigation Regulations (BCAR 13) of the Civil Aviation Act, Chapter 239 of the Laws of Belize, R.E. 2011



INTRODUCTION

In accordance with The Belize Civil Aviation Act, Chapter 239 of the substantive laws of Belize; BCAR 13 and Annex 13 of the Convention on International Civil Aviation, the objectives of an aircraft accident/incident investigation is not to apportion blame or liability, nor impose any legal responsibility. The sole purpose of the investigation is the prevention of accidents and incidents.

The Belize Department of Civil Aviation Aircraft Accident and Incident Investigator is responsible for all activities deriving from any technical investigation in relation to accidents/incidents investigations involving national and international aircraft within the territory of Belize, in order to promote aviation and operational safety. In accordance with the mandate granted to the BDCA under the Belize Civil Aviation Act.

Any investigation conducted in accordance with the provisions of the Civil Aviation Act Chapter 239 Part II (5), BCAR 13 Chapter 3 (BCAR 13.7) and Annex 13, shall be separate from any judicial or administrative proceedings to apportion blame or liability.

FINAL REPORT V3-HGX



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0.02 **DEFINITIONS** Accident.

An occurrence associated with the operation of an aircraft which, in the case of a manned aircraft, takes place between the time any person boards the aircraft with the intention of flight until such time as all such persons have disembarked, or in the case of an unmanned aircraft, takes place between the time the aircraft is ready to move with the purpose of flight until such time as it comes to rest at the end of the flight and the primary propulsion system is shut down, in which:

- a) a person is fatally or seriously injured as a result of:
 - 1) being in the aircraft, or
 - 2) direct contact with any part of the aircraft, including parts which have become detached from the aircraft, or
 - 3) direct exposure to jet blast,
 - 4) except when the injuries are from natural causes, self-inflicted or inflicted by other persons, or when the injuries are to stowaways hiding outside the areas normally available to the passengers and crew; or
- b) the aircraft sustains damage or structural failure which:
 - 1) adversely affects the structural strength, performance or flight characteristics of the aircraft, and
 - 2) would normally require major repair or replacement of the affected component, *except* for engine failure or damage, when the damage is limited to the engine, its cowlings or accessories; or for damage limited to propellers, wing tips, antennas, tires, brakes, fairings, small dents or puncture holes in the aircraft skin; or
- c) The aircraft is missing or is completely inaccessible.

Accredited representative.

A person designated by a State, on the basis of his or her qualifications, for the purpose of participating in an investigation conducted by another State. Where the State has established an accident investigation authority, the designated accredited representative would normally be from that authority.

Adviser.

A person appointed by a State, on the basis of his or her qualifications, for the purpose of assisting its accredited representative in an investigation.

Aircraft.

Any machine that can derive support in the atmosphere from the reactions of the air other than the reactions of the air against the earth's surface.

Probable Causes.

Actions, omissions, events, conditions, or a combination thereof, which led to the accident or incident. The identification of probable causes does not imply the assignment of fault or the determination of administrative, civil or criminal liability.

Flight recorder.

Any type of recorder installed in the aircraft for the purpose of complementing accident/incident investigation.

Investigation:

A process conducted for the purpose of accident prevention which includes the gathering and analysis of information, the drawing of conclusions, including the determination of causes and, when appropriate, the making of safety recommendations.

Investigator-in-charge:

A person charged, on the basis of his or her qualifications, with the responsibility for the organization, conduct and control of an investigation.

Maximum mass: Maximum certificated take-off mass.

Operator:

A person, organization or enterprise engaged in or offering to engage in an aircraft operation.

Preliminary Report:

The communication used for the prompt dissemination of data obtained during the early stages of the investigation.

Safety recommendation:

A proposal of an accident investigation authority based on information derived from an investigation, made with the intention of preventing accidents or incidents and which in no case has the purpose of creating a presumption of blame or liability for an accident or incident. In addition to safety recommendations arising from accident and incident investigations, safety recommendations may result from diverse sources, including safety studies.

Serious incident:

An incident involving circumstances indicating that there was a high probability of an accident and associated with the operation of an aircraft which, in the case of a manned aircraft, takes place between the time any person boards the aircraft with the intention of flight until such time as all such persons have disembarked, or in the case of an unmanned aircraft, takes place between the time the aircraft is ready to move with the purpose of flight until such time as it comes to rest at the end of the flight and the primary propulsion system is shut down.

Note 1. The difference between an accident and a serious incident lies only in the result.

Serious injury:

An injury which is sustained by a person in an accident and which:

- a) requires hospitalization for more than 48 hours, commencing within seven days from the date the injury was received; or
- b) results in a fracture of any bone (except simple fractures of fingers, toes or nose); or
- c) involves lacerations which cause severe hemorrhage, nerve, muscle or tendon damage; or
- d) involves injury to any internal organ; or
- e) involves second or third degree burns, or any burns affecting more than 5 per cent of the body surface; or
- f) Involves verified exposure to (infectious) substances or injurious radiation.

State of Design:

The State having jurisdiction over the organization responsible for the type design.

State of Manufacture:

The State having jurisdiction over the organization responsible for the final assembly of the aircraft.

State of Occurrence:

The State in the territory of which an accident or incident occurs.

State of the Operator:

The State in which the operator's principal place of business is located or, if there is no such place of business, the operator's permanent residence.

State of Registry: The State on whose register the aircraft is entered.

MET Meteorological 0.03 **ABBREVIATIONS** Meteorology Meteorological services A AD Airworthiness Directive MHz Megahertz AGL Above ground level min Minute(s) ATC Air Traffic Control mm Millimeter(s) MSL Mean sea level N BCAR Belize Civil Aviation Regulation BDCA Belize Department of Civil Aviation N North NOTAM Notice to airmen C Degrees Celsius (Centigrade) NM Nautical mile(s) Centre (runway identification) CAVOK Visibility, cloud and present weather OAT Outside air temperature better than prescribed values and **OPS** Operations conditions (cloud and visibility OK) CG Centre-of-gravity PIC Pilot-in-command C of A Certificate of airworthiness **CPL Commercial Pilot License** R RA Radio altimeter CRM Crew resource management RF Radio frequency D RPM Revolutions per minute \mathbf{E} ELT Emergency locator transmitter S s Second(s) SB Service Bulletin FOD Foreign object damage (also the object) S/N Serial number STOL Short take-off and landing g Normal acceleration GPS Global positioning system TAF Terminal aerodrome forecast TAS True airspeed h Hour(s) HSI Horizontal situation indicator TDP Take-off decision point TODA Take-off distance available TORA Take-off run available IFR Instrument flight rules IIC Investigator-in-charge TWR Aerodrome control tower J K UTC Coordinated Universal Time Kg Kilogram(s) Km Kilometer(s) VFR Visual flight rules Kt Knot(s) VHF Very high frequency (30 to 300 MHz) VMC Visual meteorological conditions L L Liter(s) VSI Vertical speed indicator

> W X

Y

 \mathbf{Z}

LDA Landing distance available

MEL Minimum equipment list

M Meter(s)

FINAL REPORT Aircraft Accident Registration Mark V3-HGX

PART 1.0 - FACTUAL INFORMATION

1.0. INFORMATION:

Manufacturer:	Cessna Aircraft Co.

Model: Cessna 208 B Grand Caravan

Serial Number: 208B1162 Type Certificate number: A37CE

Category: Normal passenger

Colors: White with maroon stripes and company logo

Date of Accident: 17 November 2017
Coordinates of Accident location: N 16* 32' 14.9"
W 088* 27' 33.2"

Elevation of accident site: 12 feet

Approximate time of the Accident: 0846 am local time

1446 UTC

Proprietor or operator: Tropic Air Limited

Airworthiness Certificate: G/209

Date of issue: 15 January 2010
Date of expiry: 31 July 2019

Aircraft Insurance Policy: Insurance Corporation of Belize

Date of issue: 3 November 2017 Date of expiry: 3 November 2018

Limitations: Coverage area: Belize, Guatemala, Honduras,

El Salvador, Nicaragua, Costa Rica, Panama, Mexico, and Caribbean, USA in respect of flights for maintenance/repair/ferry purpose and worldwide with respect of products.

Accident Site: 200-300 feet North East of the end of

Runway 07 at Placencia. Aircraft ditched in

the Caribbean Sea

Flight Crew Information

Pilot in Command: Male (Captain)
Type and license number: CPL #P

Issuing authority: BDCA (BELIZE)

Validity of Pilot License: VALID

Initial Date of issue:

October 2010

Date of expiry (at last renewal):

October 2018

Medical Information

Validity of Medical certificate: VALID

Certificate type: 1st class (commercial operations)

Date of issue:

Date of expiry:

September 2017

March 2018

Nationality: Belizean

Flight hrs at last medical check-up: PIC Flight hours Total hours on aircraft type: Total hours:

Number of Persons on Board: Phase of flight which the accident Occurred:

Total time of the aircraft on its last A/W certificate renewal:

0 hrs

12,092 hrs (As of 16 Nov, 2017) 19,040 hrs at September 2017

11 Passengers /1 Crew Take-off (Initial climb shortly after rotation)

1054.3 hours (Last Annual Inspection 5 October 2016)

1.00.1 SYNOPSIS: On 17 November at approximately 8:46 am (local time), a Tropic Air Cessna C208B Grand Caravan with registration V3-HGX, was ditched in the Caribbean Sea shortly after taking off from runway 07 at the Placencia airstrip with 11 passengers and 1 crew on board. All 11 passengers successfully exited the aircraft with only minor injuries and were taken for medical attention. This was a regular commercial passenger flight from Sir Barry Bowen Municipal Airport with 2 stops and final destination being Punta Gorda. The accident occurred during the transition from take-off roll/rotation to initial climb out whilst the aircraft had just been airborne at 5.4 feet AGL and at a distance of 28 feet past the end of runway 07 of the Placencia airport. A part of the landing gear made contact with the upper portion of the front passenger door frame of a sport utility vehicle that was driving along the main road. The impact caused the aircraft to deviate from its normal climb profile which caused the pilot to ditch the aircraft in the water (approximately 200-300 feet) northeast from the main shoreline (see Figure 1).

HISTORY OF FLIGHT: On 17 November, 2017, a Tropic Air Cessna 208B Grand Caravan with registration V3-HGX, departed from the Sir Barry Bowen Municipal Airport at approximately 7:15 a.m. local time with one aircraft captain, 11 passengers and 1 crew on board. The flight was a regular operated commercial passenger flight with scheduled stops in Dangriga, Placencia and with the final destination being Punta Gorda. The pilot reported that the portion of the flight from Belize City to Dangriga was uneventful and normal and so was the landing at Placencia.

At approximately 8:40 a.m. local time the airplane taxied from the Tropic Air ramp and taxied towards the west on runway 25. The pilot did a turnaround using all the available runway at normal speed and started his takeoff run to the east on runway 07. The pilot proceeded down the runway in a normal takeoff roll with normal takeoff speed and prior to reaching the end of the runway, he rotated the aircraft and lifted the nose wheel to get airborne. At exactly 28 feet past the end of runway 07 and during the initial climb phase, a part of the aircraft landing gear made contact with the upper part of the front right-hand passenger door frame of a vehicle that had breached the area in front of the runway which is normally protected by traffic barriers. The impact caused the aircraft to deviate from its initial climb profile, and the pilot reported that the engine was working for a couple seconds and it abruptly shut down shortly after. The pilot realized that he was unable to return to the airport.

The pilot carried out emergency drills for engine loss after take-off over water and decided to ditch the aircraft in the sea, which was approximately 200-300 feet from the main shoreline in front of the Placencia airport. The flight crew and all passengers were safely evacuated from the fuselage with the assistance of witnesses and passing boats which provided an impromptu rescue for the passengers. All passengers received only minor injuries.



1.00.2 PLACE OF IMPACT: The aircraft made impact with the Caribbean Sea approximately 200-300 feet to the northeast from the end of runway 07 at Placencia (figure 1 Google Earth Map 1). The pilot ditched the aircraft after the right main wheel made contact with the right side of a vehicle (see figure 3) at approximately 28 feet east from the end of Runway 07. The aircraft was airborne at an altitude of approximately 5.5 feet above ground level when it made contact with the top vehicle. (See figures 1, 2 and 3 below).



FIGURE 1: Google Earth Map 1- Impact Point & Final Resting Position



FIGURE 2: Google Earth Map 2 – V3-HGX/SUV IMPACT AREA



FIGURE 3: Vehicle Impact whilst on Placencia Road

1.01. INJURY TO PERSONS:

INJURY	Crew	Passengers	Others	Total
Fatal	0	0	0	0
Serious	0	0	0	0
Minor	1	11	*2	14
None	0	0	0	0
TOTAL	1	11	2	14

^{*} denotes 2 occupants of the vehicle

TABLE 1: Injury to persons

1.02. AIRCRAFT DAMAGE:

The damage to aircraft is also documented in the airworthiness investigation report which is attached at Annex G. The following are the damages that were seen to the aircraft during the data gathering phase of the investigation process:

- a) Cargo pod was completely torn up to the second compartment.
- b) All propeller blades had structural damage.
- c) Engine exhaust was completely compressed due to the impact.
- d) STBD wing and aileron were broken at aileron center station.
- e) Landing gear fairing.
- f) Water damage to the entire structure. (See Figure 4 below)



FIGURE 4: AIRCRAFT DAMAGE

1.03. Other Damages: The only other damage caused during this accident was limited to the top of the vehicle which was being driven along the Placencia road. (See figure 3 for Subaru damage).

1.04. PERSONAL INFORMATION OF THE PILOT:

The pilot, a male, age 50 (DOB) held a commercial pilot license (CPL) # P- issued by the BDCA with ratings for Airplane Single Engine Land, Instrument Airplane, Airplane Multi Engine Land – (VFR Only). He is English language proficient to Level 6. He satisfactorily completed an instrument proficiency check in the RBFM1001 (Flight Simulator) and C208B Cessna Caravan on 15 September 2017. He had a grand total time of 19,040.00 flying hours. He received a first-class medical certificate on 19 September 2017.

According to the Pilots logbook, these are his/her hours before the accident:

Flight hours of the pilots in:

Last 12 months 640 hrs
Last 6 months 440 hrs
Last 3 months 100 hrs
Last month 35 hrs

Last week 17 hrs (approximately)
Last 48 hrs 9 hrs (approximately)

Last 24 hrs 5 hrs
Day of the accident: 2 hrs

Total hours on aircraft type: 12,092 hrs (As of 16 Nov 2017)
Total hours: 19,040 hours at September 2017

1.04.1 PERSONAL INFORMATION OF THE CO-PILOT:

Not applicable as there was no proper declaration of a First Officer on board. The name was written in pencil.

1.05. AIRCRAFT INFORMATION:

The aircraft was delivered to Tropic Air on 20th October 2005. The Certificate of Registration was initially issued on 15th November 2005 when the aircraft was registered under the BDCA registry as V3-HGX and the initial issue of the Certificate of Airworthiness was issued on 16th December 2005. A conformity check was carried out in March 2009 by a BDCA Airworthiness Inspector. V3-HGX is a Cessna C208B Grand Caravan equipped with G1000 integrated flight instrument system, with manufacture Serial #208B1162. It had a reading of 2106.1 on the Hobbs meter at the time of the accident. Maintenance was performed in accordance with BCAR 145 requirements by Tropic Air Maintenance personnel. Attached at **Annex "A"** are the current Certificate of Airworthiness and Certificate of Registration. The maintenance performed on the aircraft is provided in **1.05.1** – **History of aircraft.**

1.05.1. HISTORY OF THE AIRCRAFT:

The aircraft had major works and defect rectification as detailed below:

- a) Engine was installed January 12, 2016. (Work Order 20154306).
- b) 100 hours Inspection on 8 February 2016. (Work Order 20160569).
- c) Pratt @Whitney 100 hours Inspection 21 March 2016. (Work Order 20161317).
- d) 100-hour Inspection 13 April 2016. (Work Order 21061727).
- e) Yellow Alert on turbine tracker 24 April 2016. (Work Order 20161858).
- f) P3 inlet /outlet port inspection for corrosion and debris. None found 16 May 2016. (Work Order 20162179).
- g) 100-hour inspection 16 May 2016. (Work Order 20162115).
- h) Inspected P3 and PY at FCU for moisture, none found, 18 May 2016. (Work Order 20162211).
- Fuel Pump inlet screen / outlet screen, engine chip detector bridge test and borescope and fuel nozzle servicing complied with June 15, 2016. (Work Order 20161985).
- j) Engine report engine at 840 degrees Celsius and went up to 880 degrees Celsius. (Action: troubleshoot carried out on engine for hot start. The following were inspected: P3 bleed air, check for leaks, P3 @ PY lines check for looseness. EPH readjusted to full closed position, removed free play linkage, P3 filter check for condition. All inspection carried out found in satisfactory condition. (Work Order 201171344).
- k) Trouble shoot carried out due to high ITT, fuel flow divider serial number L1036 was removed, inspected, and replaced in service condition. (Work Order 20171810).

- 1) Trim harness replaced due to hot start. (Work Order 201721882).
- m) Removed and installed BOV to inspect bearing area 26 May 2016. (Work Order 20172485).
- n) FCU and fuel pump removed in serviceable condition to service V3-HHI July 19, 2017.
 (Work Order 20172951).
- o) FCU and fuel pump installed. (Work Order 20172952).
- p) ECTM report engine start of ITT 872 degrees Celsius for duration of 7.81 seconds, August 20, 2017. According to Pratt @ Whitney Canada, over temperature limits, no action is required and falls within area A of graph. (Work Order 201733385). An external inspection was carried out on, September 28, 2017. and found to be satisfactory (Work Order 20174168).

Other Significant Reports and Inspections

- a) 28 September 2017, Pilot report –delayed acceleration on take-off at airport. Initial trouble shooting resulted in the replacement of the FCU and aircraft was flown to maintenance facility for further trouble shooting.
- b) 29 September 2017, Pilot report trouble shooting on previous defect continued (delayed acceleration). Due to engine not attaining full torque, propeller carbon brush and bleed air heat tube flange attached to engine gasket were replaced. The FCU previously removed was reinstalled. Aircraft was released to service.

1.05.1.1 Summary of inspection and repairs within the last eleven (11) months

27 th October 2017	FCU inspection for corrosion in P3 adapter.
25 th September 2017	#5 engine fuel nozzle tip replaced due to nozzle tip
	voids/streaking.
26 th September 2017	100-hour inspection
28 th Sept 2017	Due to engine not attaining full torque, propeller carbon
	brush and bleed air heat tube flange replaced
4 th Jul7 2017	AGB scavenge pump inlet screen cleaned
19 th July 2017	FCU and fuel pump removed in serviceable condition to
	service another aircraft.
	FCU SN f66824 Fuel Pump SN 003975
7 th August 2017	FCU and fuel pump installed
	FCU F66892 Fuel Pump SN 004172
20 th August 2017	ECTM report 872 °C engine ITT at start for duration of 7.81
	seconds. Over temperature inspection carried out and was
	result was found within limits.
5 th July 2017	Engine preserved for 30 days.
6 th June 2017	Pratt & Whitney S.I. complied with.
12 th June 2017	Engine High Idle adjusted from 58%Ng to 64% Ng.
13 th June 2017	Removed and replaced oil filter housing packing due to
	suspect of leak at compressor inlet. No leaks found after
	ground run. Removed and reinstalled BOV to inspect #1
	bearing area.

24 th June 2017	P3 air filter replaced due to base damaged.
27 th June 2017	Pratt & Whitney 100-hour inspection
26 th May 2017	Trim Harness replace due to hot start.
	Pratt & Whitney 100-hour inspection.
28 th April 2017	Trouble shoot carried out due to high ITT. Fuel flow divider
	was removed, inspected and replaced
8 th April 2017	FCU inspection for corrosion in P3 adapter.
18 th April 2017	Complied with Pratt & Whitney Service Instruction 58-
	2016106-2015R1
20 th April 2017	Pratt & Whitney 100 Hour Inspection
23 rd March 2017	Pratt & Whitney 100 Hour Inspection
27 th March 2017	Report of engine starting at 840°C and goes up to 880°C.
	Troubleshoot for hot start.
	The following were inspected leaks, P3 bleed air, P3 and Py
	lines checked for looseness.
	EPH re-adjusted to fully closed position. All condition
4	satisfactory.
28 th March 2017	Engine starts at high temperature. Fuel nozzles/flow divider
	removed, cleaned inspected, torqued and reinstalled.
	Borescope inspection carried out and a few cracks were
	noted on inner starter vane ring.
	No leaks found.
28 th February 2017	Pilot reports starts having ITT greater than 800°C
24 th February 2017	LH & RH Igniters replaced
31st January 2017	Fuel Pump inlet screen, engine chip detector bridge test

TABLE 2: Summary of aircraft inspection and repairs within the last eleven (11) months

MOTOR AND PROPELLERS:

1.05.2. Motor: PT6A-114A

Mark and Manufacture: Pratt and Whitney (Canada)

Type: PT6A-114A Turboprop Gas Turbine Engine

Serial Number: PC 2179

Series: PT6A Small Series
Total time: 8,157.10 hrs.
Time since repair: 1,895.9 hrs.

1.05.2.1 Propeller: Hartzell Propeller Inc.

Mark and Manufacture: HC-B3MN-3/M10083 overhauled propeller

Model: HC-B3MN-3/ M10083

Serial Number: 29105

Series: HC-B3MN-3
Total time: 4,590.5 hrs.
Time since repair: 2,536.4 hrs.

1.05.3 FUEL:

Fuel Onboard aircraft: 800 pounds (119 Gallons),

Fuel Type: Jet A

1.05.4 AUXILLARY EQUIPMENT:

Not applicable.

1.05.5 DEFECTS: All engine and aircraft defects are included in the airworthiness investigation report which is described at 1.05.1. History of the aircraft.

1.05.6 WEIGHT AND BALANCE:

See attached appendix M the passenger manifest including weight and balance calculation, C of G envelope and cargo weight information.

1.06. METEOROLÓGICAL INFORMATION:

The Meteorological conditions on the day of the accident were as follows:

On Friday, November 17, 2017 the 05:43 am. Aviation Forecast (Area Forecast for the Country of Belize) scattered clouds at 2000 ft, the surface wind 320 degrees 05 knots BECMG 050 degrees 07 knots, temperature 29-32 (C), and visibility greater than 10 km.

The hourly report at Placencia Station - 9920201 at 08:40:00 on 17 November 2017 was 004 degrees 7 knots (average), at 08:45:00 was 004 degrees 7 knots.

Special Features: mainly fair conditions prevailed.

See attached at Annex "H", weather report.

1.07. NAVIGATIONAL AIDS:

Placencia airport is an uncontrolled government aerodrome and as such there are no navigational aids other than a windsock.

1.08. COMMUNICATIONS:

As Placencia is an uncontrolled aerodrome, all radio transmissions from the aircraft were made by the Captain on 122.8 MHz (Unicom frequency) and company's base radio (when applicable). The normal radio call is to report the pilot's position to the Placencia ground station followed by notification of how many persons are arriving at Placencia and confirmation that they are on the ground.

1.09. AERODROME INFORMATION:

Placencia Aerodrome is located in Placencia Village, Stann Creek District in Belize, Central America. The aerodrome reference coordinates are 16 32' 13" N/ 088 21' 42" W. The length is 2,135 feet and width 25 feet, with an elevation of 12 feet AGL. Runway orientation is 07 / 25 with an asphalt surface and Aerodrome Rating (AR) is 1A.

1.9.1 History of the aerodrome

The airport was built around the main public access road which joins Placencia to the southern highway. The location of the aerodrome presents an inherent hazard of having motor vehicles drivers, who are not aware of the danger of aircraft taking off/landing, driving in front of the approach or landing path of aircraft and causing a aircraft and vehicle collision. The Belize Airport Authority, prior to this accident, had installed barriers and signage on the main road to warn/prevent/stop vehicles that were approaching the end of runway 07 and were not cognizant of the fact that aircraft are operated at a very low altitude when crossing over this portion of the road (See figure 5 map below).



FIGURE 5: Google Earth Map 1- Map of the accident site

1.10. FLIGHT RECORDERS:

The data information collected for this accident was compiled using the ADAS Box information from this aircraft. The ADAS box was shipped for readout at a recognized facility and the read out was facilitated by the Accredited Representative of the NTSB.

1.11. WRECKAGE OF THE AIRCRAFT AND IMPACT INFORMATION:

Photos of the remains of the aircraft are attached at Figure 4 including the remains of the aircraft and the vehicle (Figure 4). See Annex M for pictures of remains of the aircraft. The aircraft's remains were safely removed from the sea and transported to a secure facility near the Placencia airport where the investigators continued their investigation. When the remains were no longer needed for the purposes of the investigation, they were returned to the Operator.

1.11.1 Impact Information

The aircraft made contact with the vehicle and this led to damage to the vehicle. After losing power the pilot carried out ditching procedures, the aircraft made impact with the sea. The force of the aircraft crashing into the sea caused significant damage to the undercarriage and the airframe. This type of damage occurs when an object is dropped from a high altitude at a high rate of speed and collides with water, which is an incompressible fluid and will cause the aircraft to display signs of crashing into a solid object.

1.12. FIRES:

There was no evidence of pre-impact nor post impact fires seen during this investigation. There was no signs or evidence of an engine fire and witnesses did not report seeing a fire at any stage of the accident.

1.13. SURVIVAL ASPECTS:

The aircraft made impact with the water and as a result it started sinking a few moments after impact. The depth of the water in this area is approximately 15-20 feet. The specifications of the caravan show a height of 14.9 feet and a wingspan of 52.1 feet. Upon impact the aircraft started to take in water rapidly. Two employees of the company who were sitting near to the rear of the aircraft quickly released their seatbelts and opened the emergency exits. The witness stated that the aircraft took water in so quickly that the cockpit was almost full of water within a couple of minutes. Passengers made their

way to the emergency exits with guidance from Tropic Air employees who assisted in getting all persons out of the aircraft and onto the wing. The aircraft's nose sank into the mud below due to the weight and this led to the tail being raised slightly over the top of the water. The aircraft was not totally submerged in water but only the tail section was visibly out of the water.

The chance of survival in this type of accident was medium to high due to the relatively shallow depth of water, assistance of the Tropic Air staff and the assistance that arrived from boats that were passing near to the scene of the accident. The passengers had life jackets that offered them some level of protection. All passengers exited the aircraft with minor injuries and were taken for medical attention. There were no fatalities reported as a result of this accident.

1.14. TEST AND RESEARCH:

Test and research done during the investigation were as follows:

- 1. The ADAS box was removed, placed in fresh water, and sent to the manufacturer for data analysis. The box was shipped to the NTSB recommended facility for readout analysis. The ADAS data was used to calculate actual aircraft takeoff roll, speed, and altitude (See Annex H).
- **2.** The aircraft engine was removed, prepared, packaged, and sent to the manufacturer where it was dismantled and analyzed to determine any malfunction.

1.14.1. TEST AND RESEARCH OF TURBINE COMPRESSOR:

See attached report at Annex E from Pratt and Whitney providing factual notes of engine teardown. Section 3.2.1 details the testing of compressor section, and section 3.2.3 details testing of the turbine section.

1.15. INFORMATION ABOUT ORGANIZATION AND MANAGEMENT:

Tropic Air management structure is detailed in the Tropic Air GOM. Aircraft operations are planned by the operations center located in San Pedro, Ambergris Caye. The Director of Operations is responsible for the planning and scheduling of all flights. Passenger and cargo requests are then passed down to station managers who oversee that the correct number of passengers and cargo are loaded prior to the dispatch of aircraft. Pilots are responsible for signing manifests as being true and accurate and are tasked with the safe and professional conduct of flights.

1.16. ADDITIONAL INFORMATION:

Not applicable

1.17. USEFUL AND EFFECTIVE RESEARCH TECHNIQUES:

- **1.17.1.** DATA GATHERING AND ANALYSIS. The investigators carried out a review of the crash site, the aircraft documentation and conducted interviews of the crew, passengers, and witnesses in accordance with Annex 13 investigation procedures. Upon arrival at the scene there were several witnesses who gave an account of the story and the rescue effort needed to rescue the passengers. This was useful because there were several aspects of the events that were not accurately recalled by all the passengers on board and the witnesses assisted in this area.
- 2. WITNESS INTERVIEWS. The aircraft passengers were interviewed, and their statements recorded and played back to confirm their recollection of the events of the accident, including pre-crash and post-crash.
- 3. FLIGHT PARAMETER RECORDINGS. The ADAS box data was used to ascertain the actual conditions of the aircraft during the accident. The data was extrapolated to obtain the correct values for the exact time the aircraft made contact with the vehicle, the events occurring immediately after the

aircraft hit the car and information available prior to the engine shutting down. This information was then analyzed by the investigation team.

1.18. PHOTOGRAPHY INFORMATION:

The evidence collected during this investigation included photos of most of the perishable evidence due to the location of the crash scene being in the Caribbean Sea. A lot of evidence was lost due to the corrosive effect that the salt water had on the aircraft components. As a result, photographs were primarily taken to provide evidence of components prior to corrosion. Photographic evidence of the engine teardown will also be provided when it becomes available from the manufacturer.

PART 2 – ANALYSIS OF DATA

- **2.0 ANALYSIS:** Analysis of the factual information gathered revealed several shortcomings in various areas; a combination of some of these failures contributed to this accident.
- **2.1 FINDINGS:** The following findings have been formed after analysis of the data gathered and has been divided into different areas:
 - 1. PRE-EXISTING CONDITIONS
 - a.) The aircraft experienced delayed acceleration 49 days prior to the accident. On 28th September 2017, V3-HGX experienced delayed acceleration whilst at BZE. The event was documented, and maintenance was called in to diagnose the problem. The FCU was replaced and the aircraft was flown to San Pedro for further diagnosis. The next day, 29TH September 2017, the aircraft maintenance engineers did further troubleshooting of the previous defect. The maintenance engineers installed the previously removed FCU. The maintenance then released the aircraft to service.
 - b.) It is a common practice that when simultaneous take offs (Maya followed by Tropic) occur at Placencia, the ground crew from Maya would put down the barrier prior to the aircraft taking off. Maya ground crew would then lift the barrier to allow waiting traffic to pass whilst the Tropic Air aircraft is back tracking on Runway 07. Tropic Air ground crew would then lower the barrier to allow its aircraft to take off and then lift it again after departure.
 - c.) Standard weights of 189 lbs (males) and 149 lbs (females) are currently being used by local operators to calculate weight & balance and to calculate other values pertaining to the operation of the flight such as take-off weight of the aircraft. However, by using standard weights it leads to the aircraft actually having more weight than what is shown on the passenger manifest because in some instances the actual weights of both females and males significantly exceed the standard weights being used. On a small aircraft 10 (ten) persons who actually weigh a minimum of 25 lbs more than standard weight would result in the aircraft being approximately 250 lbs over the documented weight. Having more take-off weight results in the aircraft requiring a longer take-off roll. At small aerodromes with short runways the margin for error on calculation of take-off roll is minimal.
 - d.) During the interview, the pilot was asked whether, if he receives a manifest that reflects inaccurate weight and balance information, if he will exercise his command authority. He responded "Yes, I always do that, but some people are not happy with me doing it". (It was found that the manifest had a person's name which was written in pen/pencil and his weight was not accounted for in the weight and balance calculation. However, the PIC signed the manifest but did not exercise his command authority at this time.

e.) The pilot did not recall the last time he received ditching training from the operator and the procedures he followed during the accident were based solely on instincts.

2. THE EVENT (THE ACCIDENT)

- a.) The aircraft departed from Sir Barry Bowen Municipal Airport with thirteen (13) passengers and one (1) crew and landed at Dangriga without incident. At Dangriga, four (4) passengers came off and two (2) passengers boarded. There were nine (9) declared passengers on the manifest but in reality, there were 10 passengers and one (1) crew on board as it was found that a Tropic Air employee's name was written onto the manifest in the section titled "First Officer" in pen/pencil. The aircraft departed Dangriga and landed at Placencia uneventfully.
- b.) The passenger manifest did not accurately reflect that there were ten (10) passengers and one (1) crew on board. Instead, it reflected nine (9) passengers and one (1) crew on. This was an indication that the aircraft weight and balance was inaccurate.
 The pilot signed for this inaccurate passenger manifest and did not verify the section on the front page which indicates passenger names, weight and gender with the fuselage station section on the back page which indicates the weight of passengers and where they are seated. It was also found that the dispatcher did not sign the manifest.
- c.) The pilot back tracked runway 07 for departure and stated that he used all the runway available to him. The pilot also stated that he was halfway down the runway when he saw a vehicle which had already passed the barrier/speed bump. The vehicle was turning around the curve of the road which leads directly in front of the take-off path of runway 07. The pilot mentioned that he "was hoping the vehicle would stop".
- d.) The pilot continued his take-off roll and upon reaching near to the end of runway 07 he rotated the aircraft and mentioned that the stall warning horn sounded during the take-off. He stated that his normal rotation speed was 65 knots. Shortly after he became air borne, he stated that he felt like he had hit something; he said that the impact felt like he went over a speed bump. He stated he was unaware of what exactly he had hit and was unsure of what side of the aircraft was hit. The pilot believed that the stall warning horn went off because the angle of attack was two degrees higher than what it should have been.
- e.) The aircraft continued to climb for approximately five (5) to ten (10) seconds after it made contact with the vehicle and subsequently the engine shutdown.
- f.) After the aircraft engine shutdown, the pilot made the decision to ditch the aircraft in the sea. He did not unlatch nor attempt to open his door until after the aircraft touched down in the water. This is contrary to the proper ditching procedure which includes unlatching the door as a part of the procedure. He also stated Mr. Villafranco could not open the co-pilot's door and as a result, he then went to the back of the aircraft. The door at the back was opened by another Tropic Air employee that was on board. The co-pilot's door was difficult to open due to high pressure against it from the sea water. This then revealed that both PIC and acting copilot were not fully aware of proper ditching procedures for this type of aircraft.
- g.) The pilot stated he did the required passenger briefing at all three (3) stops, however, during interviews, some passengers stated that they do not recall getting any safety brief by the pilot. Conduct of the passenger brief establishes amongst other things that the pilot has explained to

his passengers the actions to be taken in case of an emergency and where their life preservers are located.

- h.) The PIC stated that he cannot swim and as such, he was unprepared to deal with emergencies involving aircraft evacuation whilst in water.
- i.) The life vests on board the aircraft were not easy to open due to the type of packaging and locating them was difficult which increased the passenger response time to the emergency.
- j.) The pilot lost consciousness for a few seconds after hitting his head when the aircraft made impact with the water and this caused a delayed response to the evacuation procedures.
- k.) The pilot stated that with a competent first officer he would have been able to respond differently to this type of emergency because the first officer would have been able to relieve him of some duties during the emergency.
- I.) Post-crash events began when the aircraft hit the water and persons were ushered out of the aircraft by a Tropic Air employee who was on board at the rear of the aircraft. The PIC was reportedly not involved in the evacuation process.
- m.) Some workers who were passing by the main road attempted to rescue the passengers. However, the vessel that was brought for rescue was severely inadequate to hold the number of persons and it also had a leak. One female passenger stated that all the men boarded the leaking vessel first. Shortly after, two tourist boats came to the rescue of the passengers in the water. Although the rescue boats came, there was no direct coordination, by any employee of the operator nor the aerodrome management, to facilitate a water rescue.
- n.) The response to the emergency was inadequate, uncoordinated, and the official aerodrome emergency plan (airport emergency contingency plan) did not function as it DOES NOT include provisions for water rescue. The operator's station managers and personnel tried to deal with the emergency in accordance with the operator's SOPs, however, these SOPs also did not take into consideration the need to rescue persons from the water. There was no prior coordination with rescue boats, ambulance services nor first responders (emergency response) services.
- o.) The angle at which the aircraft made contact with the vehicle was not directly head on, but off to the right-hand side of the road. The aircraft did not fly along the path of the runway extended center line which is standard operating procedure, but instead, the trajectory of the aircraft shows the pilot's inputs resulted in the aircraft making a slight right turn immediately after the wheels were off the ground.
- p.) According to data calculations (performance charts), take off would have been possible at 1,263 feet from the beginning of runway 07 (length 2,135 feet). A distance of 872 feet of available stop distance remained for the pilot to abort the take-off, however, this was not done as the pilot stated he believed he had past the point of no return.

3.) THE FLIGHT CREW/MACHINE/ENVIRONMENT

PART I: THE FLIGHT CREW

- a. Shortly after the accident occurred, the PIC was facilitated with a flight to Punta Gorda by the Operator. In Punta Gorda, a BDCA inspector assigned to assist in the investigation informed the pilot that he needed to take a drug and alcohol test; the pilot refused to do so in contravention of BCAR 13.45. BCAR 13.45 Medical examinations: "When appropriate, the BDCA conducting an investigation shall arrange for medical examination of the crew, passengers and involved aviation personnel, by a physician, preferably experienced in accident investigation. These examinations shall be expeditious". The Pilot did not take the required medical examination the following day.
- b. The pilot, by his own admission, stated that he could not swim and this prevented him from carrying out his duties and responsibilities after ditching, such as ensuring the safety of all passengers on board and assisting passengers to evacuate the aircraft. A competent second crew member would have been able to assist him in carrying out his duties if he was incapacitated for a short period of time.

PART II: MACHINE

- a. On the 20th August 2017, the engine condition trend monitoring reported 872 degrees centigrade engine ITT during start for duration of 7.81 seconds. This was documented as high ITT due to the period of time that the event lasted. Over temperature inspection was performed in accordance with the maintenance manual high temperature inspection procedures and the result was found to be within acceptable limits.
- b. There were two recent aircraft maintenance log entries (dated the 28th and 29th of September 2017) where delayed acceleration was reported and the FCU was replaced. After troubleshooting, the old FCU was replaced on the aircraft engine. The action taken by Tropic Air maintenance personnel was to replace propeller carbon brush and bleed air heat tube flange attached to engine gasket. After this was done, the aircraft was released to service. Note that the accident occurred 48 days after delayed acceleration was reported.
- c. The normal operation of this type of aircraft into and out of Placencia with full weight and full passengers should allow that the aircraft wheels are off the ground at a distance of 1,681 feet with a maximum take-off weight of 9,062 lbs at an outside air temperature of 32 Degrees Celsius (89*F) and at sea level with winds calm. The calculations show that the aircraft should have not been at an altitude of 5.3 feet above ground level at 28 feet past the end of runway 07.

PART III: THE ENVIRONMENT (Placencia Aerodrome)

- a. The Tropic Air station supervisor at Placencia notified the airport management (BAA) via email that one of the barriers at Placencia were inoperative. This was done a couple of days prior to the accident.
- b. The runway at Placencia airport has a take-off path for runway 07 and a landing path for runway 25 that are both intersected by a main public road. The presence of vehicles on this specific portion of the road constitutes a permanent hazard for aircraft operating at this airport. This hazard becomes elevated to a high risk when vehicles that are driving on the

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above-mentioned portion of the road **are not properly controlled** by means of adhering to traffic signs of low flying aircraft and dual sided road barriers that are working properly.

- c. The problem of drivers not complying with traffic signs and persons driving around the barrier is a recurrent issue in Placencia. This is not the first instance that low flying aircraft have come in close contact or have had near misses with vehicles operating along the road. There are traffic signs in place warning motorists of low flying aircraft and instructing them to give way to low flying aircraft. Currently, there is a fining system in place. However, when drivers do not comply with the system they are not fined because the system is not effectively implemented to include surveillance. The Ministry of Transport personnel are not present in Placencia on a regular basis to enforce traffic fines. As a result, the fining system is not functioning for those drivers who do not stop at the barriers or yield to low flying aircraft.
- d. The operation of the barriers (a safety net) is primarily the responsibility of the aerodrome management (BAA). Presently, the responsibility has been given to the operators via a letter from BAA which was accepted by both major local operators. However, there still seems to be operational issues when the barrier switch is inoperative, although BAA is informed of the problem, the operators do not take the initiative and physically send out persons to stop oncoming traffic. There have been instances where aircraft still land and take off without both barriers being properly placed and functioning.
- e. Private aircraft operating into Placencia airport are not being protected from motorists that have passed the warning signs and fail to give way to low flying aircraft. Private operators do not have ground personnel with whom they can communicate and who can inform them that they are about to land or take-off.

4.) HUMAN FACTORS

- a. Lack of CRM (Crew Resource Management) in the cockpit did not allow for the person who sat in the co-pilot's station to adequately assist the PIC in dealing with the emergency at hand although he has been operating under the Tropic Air First Officer Program.
- b. The one crew operation of the Cessna caravan in such an emergency did not permit the pilot to delegate tasks to other flight crew members during the emergency. Such tasks may have included: radio calls, directives for passengers to put on life preservers, directions to emergency exits, assistance in ditching procedures and confirmation that all emergency checklist items have been completed (if time permitted). This would have been done whilst the pilot focused only on dealing with the emergency at hand.
- c. The operator did not ensure that the flight crew was adequately trained to respond to an emergency that resulted in the aircraft being ditched. Lack of proper ditching training and a PIC who cannot swim, led to a very ineffective pilot response to this type of emergency (in water).

2.2 APPRECIATION OF THE EMERGENCY LANDING AREA:

The emergency landing area was in the Caribbean Sea at a distance of 200-300 feet to the northeast of the main shoreline located directly in front of the runway 07 at Placencia Airport. (See Figure 1 – Google Earth Map 1). The depth of water did not exceed 25 feet of salt water.

PART 3 CONCLUSIONS AND CONTRIBUTING FACTORS

3.00 CONCLUSION(S): This accident is the result of an accumulation of failures in the areas of road traffic management and operator standard operating procedures, and a lack of implementation of aviation industry best practices.

3.01 CONTRIBUTING FACTORS: The following are factors that are derived from the failures in the areas mentioned in section 3.00 (conclusions):

- a. There is a lack of traffic surveillance to ensure that drivers comply with the warning signs of low flying aircraft and do not breach the barriers when they are down or inoperative. The left barrier at Placencia was reportedly inoperative and the right barrier was said to be working. As a result, this removed a significant level of protection for vehicles which operate on the portion of the road which intersects the departure path of aircraft. The purpose of the barriers is to protect vehicles from coming in close contact with low flying aircraft. The driver of the vehicle failed to adhere to traffic warning signs regarding low flying aircraft and drove his vehicle directly into the departure path of an aircraft (Probable cause).
- b. ADAS data calculations showed that the pilot had a period of 13.33 seconds when he achieved take off performance, but he did not rotate the aircraft. Although the aircraft engine performance was normal, the actual take-off weight was within limits and the distance available to the pilot to abort the take-off was 872 feet; the pilot still flew the aircraft at a dangerously low altitude over the road and did not properly assess the risk at hand which was a vehicle advancing into the aircraft's departure path which could cause a collision. (Probable cause).
- c. The angle at which the aircraft made contact with the vehicle was not a direct head on angle, but the contact was made when the vehicle was off to the right-hand side of the extended centerline of runway 07. The aircraft did not follow the direct path of the extended center line of runway 07 prior to making contact, but instead it made a slight right turn shortly after the wheels left the ground. The pilot did not take collision avoidance (evasive) measures in a timely manner (probable cause).
- d. The pilot did not demonstrate adequate knowledge of proper ditching procedures which led to an inadequate response to the emergency at hand. The operator did not provide the flight crew with the proper ditching training.

3.02 PROBABLE CAUSES:

- 1. The driver of the vehicle failed to adhere to traffic warning signs regarding low flying aircraft and drove his vehicle directly into the departure path of an aircraft.
- 2. The pilot flew the aircraft at a dangerously low altitude over the road and did not properly assess the risk at hand which was a vehicle advancing into the aircraft's departure path which could cause a collision.
- 3. The pilot did not take collision avoidance (evasive) measures in a timely manner.

PART 4 – SAFETY RECCOMENDATIONS

4.00 SAFETY RECOMMENDATIONS:

All Aircraft operators

a) All operators who operate any type of aircraft in Belize into small uncontrolled aerodromes where landings and take offs take place over water, must ensure that all flight crew are competent enough and prepared to deal with emergencies involving ditching. BDCA must confirm that this is done by all operators including revision of records and approval of training.

Civil Aviation Department

- b) The Department of Civil Aviation should apply the relevant fines against the pilot and the operator, in accordance with BCAR 13, for the pilot's outright refusal to take the mandatory drug and alcohol test when so informed by the BDCA Inspector.
- c) The BDCA inspectorate should immediately start to conduct random checks for the quick access and serviceability (opening and deploying) of life preservers (jackets) for all aircraft that operate overwater.
- d) BAA and all local operators should update and test their aircraft emergency response plan and shall include therein, provisions for water rescue at aerodromes where landing and take-offs are conducted over a body of water (regardless of the size). The BDCA must verify that a copy of this plan is available at all stations and ensure the plan has been updated and include water rescue procedures. Coordination must also be done with the National Emergency Management Organization (NEMO) and the local village councils. These plans must also be tested and the BDCA shall be represented at these mock exercises.

Transport Department

e) The Ministry of Transport should revise its traffic fining system for offences relating to violations around Placencia airport with a view of increasing fine amounts and implementing continuous surveillance.

Long term recommendations

Belize Airports Authority

f) A study should be done to determine the feasibility of displacing the end of runway 07 by at least 1,000 feet to the west and extending the beginning of runway 07 to the west by at least 1,000 feet or a study should be done to determine the feasibility of rehabilitating the runway at Riversdale to allow for constantly increasing local operations.

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Section 5.00 Annexes

LIST OF ANNEXES, FIGURES AND TABLES ATTACHED

Annex A: Certificate of Airworthiness, Certificate of Registration of the aircraft.

Annex B: Passenger Manifest front and back pages

Annex C: Passenger Seating and Actual Weights

Annex D: Aircraft calculated ground roll distance

Annex E: Summary of the engine factual data report of engine teardown

Annex F: Airworthiness report including aircraft and vehicle damages

Annex G: ADAS box data showing aircraft performance

FIGURE 1: Google Earth Map 1- Impact point & final resting position (page 9)

FIGURE 2: Google Earth Map 2 – V3-HGX/SUV Impact Area (page 10)

FIGURE 3: Photo of Vehicle after impact on Placencia Road (page 10)

TABLE 1: Injury to persons (page 11)

FIGURE 4: Aircraft damage (page 11)

TABLE 2: Summary of aircraft inspection and repairs for last eleven (11) months (page 14-15)

FIGURE 5: Google Earth Map 1- Map of the accident site (page 16)

Company Company		BELIZE MENT OF CIVIL AVIATIO	
1.Nationality and R	egistration Marks 2.1	Manufacturer and Model CESSNA AIRCRAFT CO. C-208R	3. Aircraft Serial Number 208B1162
4. Category	10000	Type Certificate No. A37CE	
7th December 1944 of the above ment therefers 4p, be, in applicable compre International Civil is	the Belize Civil Aviation ioned aircraft which has condition for safe open herisive and detailed air aviation. It remain onboard the air 8. Name and Signature	Act and the Belize Civil Avia a been inspected and found ration, and has been show worthiness code as provide craft. 9 BDCA St.	on international Civil Aviation da tion Regulations (BCARs) in resp to confirm to the Type Certific in to meet the requirements of d by Annex 8 to the Convention amp
10. BDCA File Regi Revision: Original	Ster No. G/209	11, MTOW:	9,062 LBS
Revision: Original 12. Pe of Validity This Certificate is valid shown below	for the period(s)	Signature, 'Stamp and	Form BDC.
Revision: Original 12. Pe of Validity This Certificate is valid	ster No. G/209	Signature, Stamp and C.	Form 60C
Revision: Original 12. Pe of Validity This Certificate is valid shown below	for the period(s)	Signature, Stamp and	cial de
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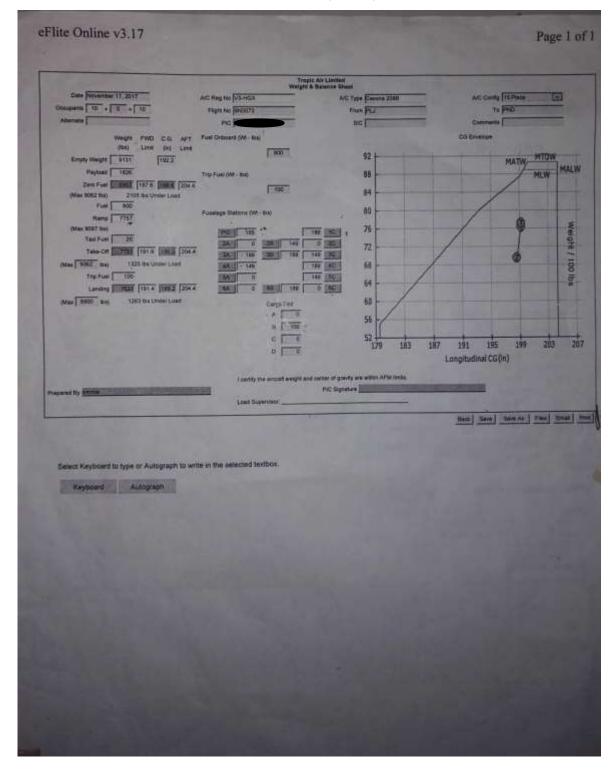
Annex A: Aircraft Airworthiness Certificate



Annex A (Cont...): Aircraft Certificate of Registration



Annex B: Passenger Manifest Front Page



Annex B (cont...) Passenger Manifest back page



Annex C: Passenger seating configuration and actual weights.

 Note: All passengers were interviewed to confirm their actual seating position on the day of the accident and to confirm their actual weight.

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Annex D: Aircraft calculated ground roll distance

Note: This graphic shows the calculated take off distance of the aircarft calculated using
the actual weights and actual meterological conditions that existed on the day of the
accident. It shows the distances that should have been attained by the aircraft and the
calculated altitudes that the aircraft should have attained at various points of the take
off climb.

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Annex E: Summary of engine teardown by Pratt and Whitney Canada

The following is a summary of the engine teardown inspection done at the Manufacturer facility.

The engine manufacturer, Pratt & Whitney Canada, examined the engine under the supervision of an investigator from the Transportation Safety Board of Canada who acted as the accredited representative for the country of Belize (State of occurrence).

- The engine was covered with salt deposits. The compressor and power rotors did not rotate. The reduction gearbox housing was perforated at 1 and 9 o'clock positions due to Corrosion. There was no damaged observed to the exhaust duct and gas generator case except spot corrosion. The AGB housing surfaces showed paint flaking, pitting holes and flanges thinning due to corrosion. In addition, the housing was perforated at 1, 5 and 6 o'clock positions due to corrosion.
- There was no metal particle debris observed on the chip detectors. The P3 air filter had water contamination and salt deposits and the oil filter showed normal coloration and water contamination.
- On the compressor section, there was salt deposits and no damage observed. The No.1 & No. 2 bearing had no rotation due to salt deposits.
- Dents were observed on the 1st stage rotor air foils leading edge. The stator and shroud, spacers and impellers were covered with salt deposit and no damage observed.
- On the combustion section, the liners were covered with salt and had corrosion. The large and small exit ducts were also covered with salt with no damage observed.
- The power turbine section was also covered with salt deposits.
- The front and rear reduction gear boxes were mostly destroyed due to corrosion. No damages were observed.
- The fuel control unit was not tested and was covered with salt. It was disassembled and salt deposits were observed internally. The bellows were tested, and no leaks were found.
- The fuel oil heater was covered with salt and no damage was observed. No test was performed.
- Propeller governor and propeller over speed governor were covered with salt. No test performed.
- The overall inspection on the engine shows that it had saltwater contamination with no other form of damage observed.

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ANNEX F - Airworthiness report including damages to the aircraft

On November 17, 2017 at about 9:30 am the Belize Department of Civil Aviation received a call that a Tropic Air airplane was involved in an accident at the Palencia Airstrip.

BDCA Operations and airworthiness inspectors Mr. Charles Meighan and Mr. Deon Anthony boarded a Tropic Air aircraft from the Philip Goldson International Airport to the Placencia Airstrip at 10:00 am. They reported that upon arrival at about 10:30 am at the Placencia Airstrip they observed a SUBARU FORESTER vehicle with license plate SC C-12483 parked in the middle of the main road. About 28 ft from the end of the run way, also was a Tropic Air aircraft with registration mark V3-HGX submerged in the Caribbean Sea at about Two hundred and fifty feet (250') from the end of the runway 07.

Further investigation revealed that the aircraft was airborne and was approximately twenty-eight feet from the end of the runway at an altitude of four (4) to five (5) feet when the right hand main wheel made contact with the left-hand side of the vehicle as shown below. The aircraft lost its engine shortly after and crashed in the Caribbean Sea.





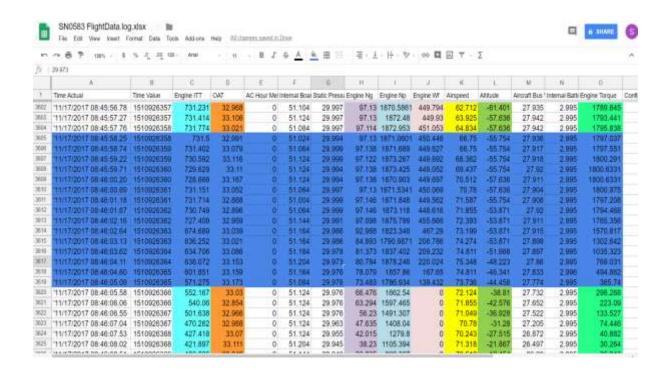
Damages to Aircraft and vehicle The windshield and roof of the vehicle were extensively damaged as a result of the impact of the aircraft as shown below.

- 1. The aircraft was extensively damaged due to the impact from crash landing in the Caribbean Sea as shown in the picture below.
- 2. The aircraft was removed from the sea and the engine was removed from the airframe for further investigation.









ANNEX G – ADAS box data showing aircraft performance values

Color Legend:

Blue – Aircraft performance data during the event which shows aircraft performance at 66 kts to 73 kts for 13.33 seconds. 66 Kts is the airspeed that allow the aircraft to be rotated for takeoff.

Turquoise: Engine ITT parameters

Orange: OAT

Yellow: airspeed values Olive green: altitude

Green: Engine torque values