



# Quarterly Aviation Report

April - June 2024

# Q2 2024



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# Investigations

Within the Aviation sector, the Dutch Safety Board is required by law to investigate occurrences involving aircraft on or above Dutch territory. In addition, the Board has a statutory duty to investigate occurrences involving Dutch aircraft over open sea. Its investigations are conducted in accordance with the Safety Board Kingdom Act and Regulation (EU) no. 996/2010 of the European Parliament and of the Council of 20 October 2010 on the investigation and prevention of accidents and incidents in civil aviation. If a description of the events is sufficient to learn lessons, the Board does not conduct any further investigation.

The Board's activities are mainly aimed at preventing occurrences in the future or limiting their consequences. If any structural safety shortcomings are revealed, the Board may formulate recommendations. The Board's investigations explicitly exclude any culpability or liability aspects.



## On-site investigation yields valuable information

'In an ideal world, an aircraft always lands perfectly on the runway. In practice, however, an aircraft can sometimes veer off the runway. An example of such a runway excursion occurred on 28 June 2024.

*A Cessna Citation took off from Oxford Airport in the United Kingdom for a ferry flight to Schiphol. Upon landing, the aircraft came to a stop beside the runway due to an issue with the landing gear. Fortunately, the occupants (two pilots and a flight attendant) were uninjured.*

For some occurrences, we can suffice with gathering information remotely. However, for others, our aviation investigators go on-site. In the second quarter of 2024, this occurred on multiple occasions, as it did with the occurrence mentioned above.

On-site investigation requires weighing various and sometimes conflicting interests: a runway must be cleared as quickly as possible, while for the investigation, it is crucial to carefully secure the evidence.

On-site investigation can yield valuable information for aviation investigators:

- securing 'fleeting' information, such as evidence that may not be available the next day. This could include traces left by the aircraft on the runway or witness statements.
- securing the flight data recorder or other data carriers on board the aircraft. The flight data can then be downloaded and analysed later.

Therefore, it remains a matter of balance: our investigators work as quickly as possible, but as slowly as necessary.'

Chris van Dam  
Chairman of the Dutch Safety Board

# Occurrences into which an investigation has been launched

## Disconnected control cable, PZL-Bielsko SZD-51-1 "Junior"

glider airfield De Voorst, 29 April 2024

While landing, the pilot heard a bang, after which the glider on the ground veered to the left. It turned out that the control cable of the right pedal had come loose.

**Classification:** Serious incident

**Reference:** 2024081

## Misaligned take-off, British Aerospace Jetstream 32

Bonaire International Airport, 18 May 2024

During take-off from Runway 10 at Bonaire International Airport (TNCB) in Caribbean Netherlands, the nose landing gear hit several runway edge lights. The flight continued. The aircraft suffered minor damage to a tire of the nose landing gear.

**Classification:** Serious incident

**Reference:** 2024074

▼ *The Jetstream 32.*



## Runway excursion, Diamond Aircraft Industries GmbH DA 40

Ameland Airport, 26 May 2024

During the take-off from Runway 08 at Ameland Airport (EHAL), the aircraft did not accelerate sufficiently and did not come off the runway. It eventually passed the runway threshold, shot through the airport fence and came to rest in the dune area behind it. The four occupants were unharmed and the aircraft was severely damaged.

**Classification:** Accident

**Reference:** 2024080

## Blocked rudder, Schempp-Hirth Flugzeugbau GmbH Arcus M

Terlet glider airfield, 26 May 2024

After the self-launch, the pilots noticed at a height of approximately 40 metres that the rudder movement was limited. The pilots decided to immediately join the circuit and land with the engine idling. After landing, damage was found to the motor glider, including a crack in the bottom of the rudder.

**Classification:** Accident

**Reference:** 2024104

▼ *The Diamond DA 40 after the runway excursion.*



## Runway excursion, Groupe Aérospatiale SOCATA TB 9

Lelystad Airport, 31 May 2024

During landing, the aircraft ended up next to the runway and the right wing hit the ground.

**Classification:** Serious incident

**Reference:** 2024109

## Hit tree and fence on final, Alexander Schleicher GmbH & Co ASK 21

Haamstede glider airfield, 9 June 2024

On final, the pilot lowered the nose of the glider to increase the speed. When he raised the nose again, the left wing came into contact with a small tree and a barbed wire fence. The pilot then made a safe landing. The left wing suffered damage.

**Classification:** Accident

**Reference:** 2024097

▼ *Damage to the left wing. (Source: Glider club)*



## Runway excursion, APEX Aircraft DR 400/140 B

Rotterdam The Hague Airport, 19 June 2024

During take-off, the DR 400 veered off the runway and hit a Precision Approach Path Indicator (PAPI) lamp with its left wing. The aircraft suffered damage to this wing.

**Classification:** Accident

**Reference:** 2024104

- ▼ *The DR 400 after the runway excursion.*  
(Source: Rotterdam The Hague Airport)



## Emergency landing, Van's Aircraft, Inc. RV-7

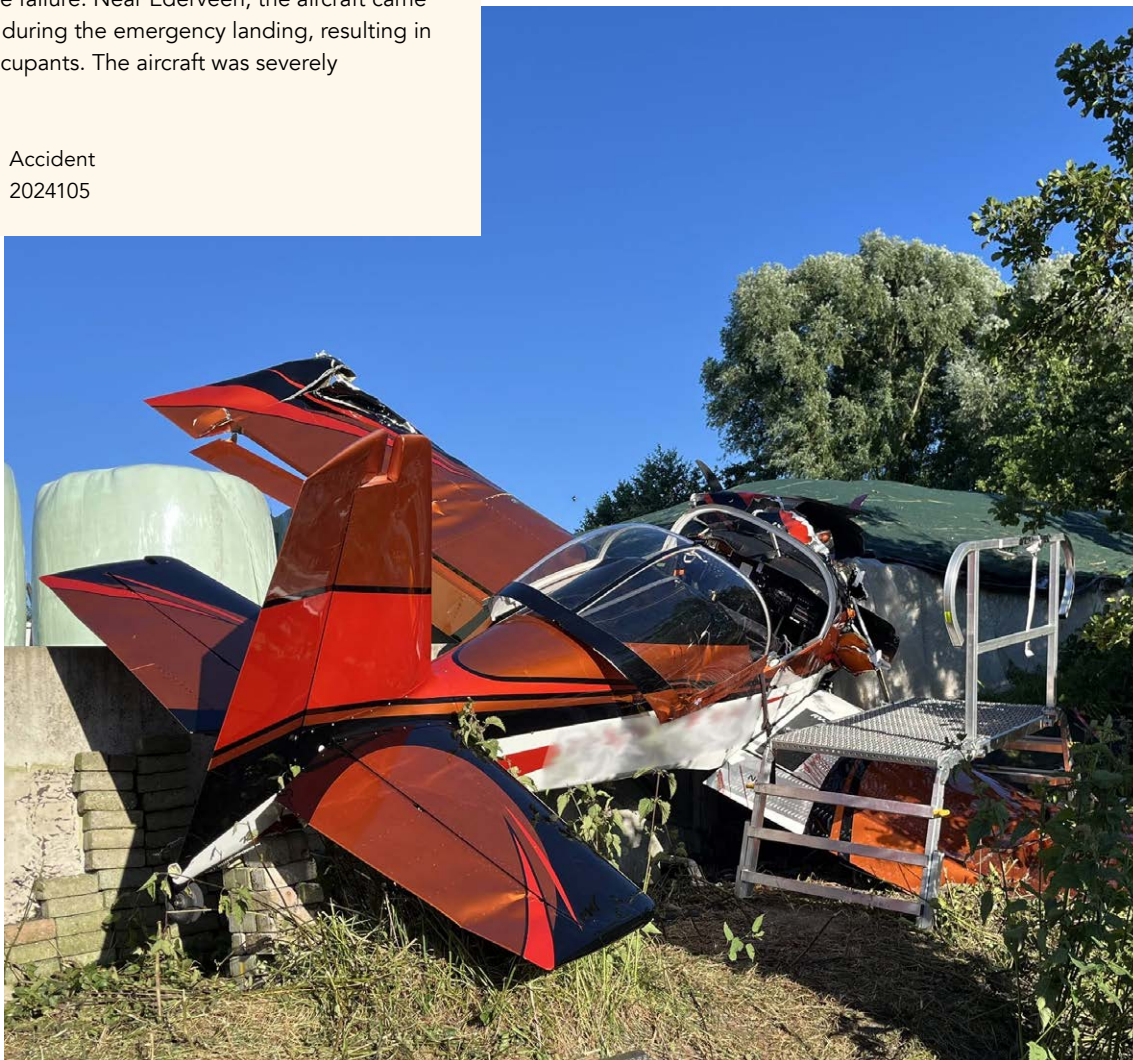
Ederveen, 19 June 2024

The Van's RV-7 – a home-built aircraft – had departed from Teuge International Airport (EHTE) for a local flight. On board were the pilot and a passenger. After some time, the pilot reported an engine failure. Near Ederveen, the aircraft came to a halt on a wall during the emergency landing, resulting in injuries to both occupants. The aircraft was severely damaged.

**Classification:** Accident

**Reference:** 2024105

▼ *The crashed RV-7.*





## Accident on final, Schempp-Hirth Flugzeugbau GmbH Discus-2T

Hoogeveen Airport, 19 June 2024

Following a winch launch from Runway 09 at Hoogeveen Airport (EHHO), the pilot tested the turbo engine, which functioned properly. After searching in vain for thermals for some time, he returned to the airport. Just south of the downwind leg, the pilot attempted to start the turbo engine. When this failed, he returned to the airport with the engine

extended. Just outside the airport, the right wing hit a lamppost, causing the aircraft to rotate around its vertical axis and come to a stop on the edge of a ditch. The pilot was uninjured. The glider sustained severe damage.

**Classification:** Accident

**Reference:** 2024106

▼ *The crashed Discus-2T. (Source: pilot)*



## Runway excursion, Cessna Citation 560XLS

Amsterdam Airport Schiphol, 28 June 2024

The Cessna Citation had departed from Oxford Airport in the United Kingdom (EGTK) for a ferry flight to Amsterdam Airport Schiphol (EHAM). On board were two pilots and one flight attendant. During the landing, the aircraft encountered an issue with its landing gear, causing it to slide off the runway. None of the occupants sustained injuries.

**Classification:** Accident

**Reference:** 2024118

▼ *The Cessna Citation after the runway excursion.*



# Occurrences into which an investigation has been launched (abroad)

## High-speed rejected take-off, Boeing 787-10 and Boeing 787-9

Toronto / Lester B. Pearson International Airport (Canada), 23 March 2024

The Boeing 787-10 (hereafter 787-10) was waiting to depart at the head of Runway 06L. Meanwhile, Boeing 787-9 approached that runway in order to land on it. After Boeing 787-9 (hereafter 787-9) had landed, 787-10 was given permission to line up on the runway in preparation for an immediate take-off. As 787-9 was about to leave the runway via Taxiway C5, 787-10 was given permission to take off immediately and began its take-off run. However, 787-9 did not leave the runway via Taxiway C5 but continued on to C7, near the end of the runway. The air traffic controller then instructed 787-10 to abort its take-off. 787-10 aborted its take-off at a speed of about 110 knots and then left the runway via Taxiway D1. The minimum distance between the two aircraft was about 1650 metres. Wet snow conditions had been reported for the runway.

*The Transportation Safety Board of Canada has launched an investigation into this occurrence. Given that a Dutch airline was involved, the Dutch Safety Board has offered to assist.*

**Classification:** Incident  
**Reference:** 2024034

## Runway excursion, Fokker F28 Mk 0070

Wilson Airport (the Republic of Kenya), 26 March 2024

During landing, the Fokker 70 veered off the runway and came to a stop with its nose wheel in the grass. The three occupants were unharmed.

*The Aircraft Accident Investigation Department of the Republic of Kenya has launched an investigation following this occurrence. The Dutch Safety Board has offered assistance, as the aircraft was designed and manufactured in the Netherlands.*



▲ *De Fokker 70 after the runway excursion. (Bron: Aircraft Accident Investigation Department, the Republic of Kenya)*

**Classification:** Serious incident  
**Reference:** 2024038

## Runway excursion, Fokker F27 Mk 0050

Moheli Bandar es Salam Airport (the Union of the Comoros), 5 May 2024

During the take-off from Runway 31, the crew of the Fokker 50 aborted the take-off at high speed. The aircraft came to a stop past the end of the runway. Of the 58 occupants, one person was seriously injured.

*The Ministry of Maritime and Air Transport of the Union of the Comoros has launched an investigation following this incident. The Dutch Safety Board has offered assistance, as the aircraft was designed and manufactured in the Netherlands.*

**Classification:** Accident

**Reference:** 2024060

## Lightning strike, Fokker F28 Mk 0100

en route (the Islamic Republic of Iran), 24 May 2024

During the approach to Tabriz int'l Airport (OITT), the Fokker 100, with 110 occupants, experienced a lightning strike at FL240, causing several systems (including the weather radar, the Ground Proximity Warning System and the transponder) to fail and problems with the cabin pressure developed. The crew diverted to Ardabil Airport (OITL), the nearest airport, where the aircraft made a safe landing.

*The Aircraft Accident Investigation Board of the Islamic Republic of Iran has started an investigation following this occurrence. The Dutch Safety Board has offered assistance, as the aircraft was designed and manufactured in the Netherlands.*

**Classification:** Serious incident

**Reference:** 2024084

## Off-airfield landing after engine problem, Schempp-Hirth Discus-2cT

Unterhaching (Germany), 17 June 2024

The motor glider experienced engine problems and the pilot made an off-airfield landing. He suffered serious injuries. The aircraft suffered severe damage.

*The German Federal Bureau of Aircraft Accident Investigation (BFU) has started an investigation following this occurrence. The Dutch Safety Board has offered assistance, as the aircraft has Dutch registration.*

**Classification:** Accident

**Reference:** 2024117

## Completed investigations

### Oven overheat in aft galley, Boeing 777-200, PH-BQQ

Mediterranean Sea south of Marseille (France),  
9 February 2023

On 9 February 2023, a Boeing B777-200 on a flight from Amsterdam Airport Schiphol (hereafter Schiphol) in the Netherlands to Johannesburg - OR Tambo International Airport in South Africa (FAOR) experienced smoke in the cabin after being in flight for about 1 hour and 20 minutes. The smoke originated from an oven located in the aft galley of the aircraft. The purser immediately started fire-fighting activities and was assisted by several cabin attendants. She observed that a thick brown smoke was emitting from the oven and subsequently discharged a Halon fire extinguisher into the oven several times.



▲ *The failed oven.*

The purser informed the captain about smoke in the aft galley. He immediately started the electronic Smoke, Fire or Fumes checklist but did not complete the checklist, as he wanted to make his own assessment about the situation in the aft galley. The captain therefore made his way to the aft galley to assess the situation himself. He asked the purser if the galley area main power had been switched off, which

she confirmed, after which the captain encouraged the cabin crew to continue using ample Halon fire extinguishers to fight the oven fire. Upon return to the flight deck, the captain continued the Smoke, Fire or Fumes checklist. The whole event lasted about 20 minutes before the smoke stopped. In total, six fire extinguishers were emptied into the oven.

After consultation with the operator's Operations Control Centre and later with the senior purser, the decision was made, when the aircraft was near Marseille in France, to return to Schiphol. In the captain's opinion, this was warranted by the fact that the oven smoke was under control and an immediate diversion to a nearby airport was not needed. However, as the aircraft still exceeded its maximum landing weight, the flight crew had to jettison fuel. Three crew members as well as twelve passengers suffered from breathing difficulties. Medical assistance was available upon return to the airport.

The investigation into this serious incident revealed that the use of a meal tray carrier with a mostly closed backside extended the heating time of the oven significantly and disturbed the airflow in it. This led to a raised temperature behind the oven, inadvertently influencing the electronic control circuitry in such a way that the heating elements of the oven were commanded on. It caused the temperature behind the oven to increase even further and kept the power control board in a faulty condition. At this point, the 3-phase safety device was already damaged and inoperable and could not disconnect the electrical power to the oven. Consequently, the temperature inside the oven continued to rise to such a degree that it overheated and smoke was emitted from the oven into the galley.

Disconnection of electrical power to the oven by the cabin crew, as dictated by the Oven smoke/fire procedure, did not occur throughout the entire oven overheat event. Furthermore, at no point was the correct position of the

main power switch of the galley area verified by checking the power supply of other electrical equipment in the galley, nor were they required to do so. The circuit breaker of the oven was not pulled by the cabin crew as it was not an item of the Oven smoke/fire procedure. The flight crew did not switch off the utility bus as directed by the Smoke, Fire or Fumes checklist as they considered it unnecessary. As a result, the oven remained powered during the entire overheat event as well as on the return flight to Amsterdam.

As a result of the failure of the heating elements by the prolonged heating at maximum temperature, the temperature behind the oven dropped significantly so that the power control board functioned correctly again. Then, the oven control module transmitted the commanded 'off' signal to the heating elements. The oven overheat event thus stopped. All heat damage remained limited to the inside of the oven and did not cause damage to the surrounding area of the oven.

The operator indicated that Service Information Letter H0212-25-0164 (as incorporated in the Components Maintenance Manual), issued by the oven manufacturer, had not been incorporated in maintenance procedures. This service information letter gives additional instructions for the checking of the 3-phase safety device and its replacement every five years.

Service Bulletin 2000-25-0001, which is also issued by the oven manufacturer, recommends the incorporation of an improved power module, motor, fan, and heating elements among other upgrades, and had not been incorporated either by the operator. The incorporation of this service bulletin has been proven to prevent a potential failure of the power control board from controlling the temperature in the oven. The implementation of this service bulletin was deemed unsuitable by the operator due to certification requirements of the modification and limitations on the use of the oven.

No flames were observed inside the oven. The amount of smoke generated by the overheat event, especially the smoke coming from the cavity between the oven and the galley board, let the cabin crew believe that a fire must have been present. For the cabin crew this justified the use of Halon fire extinguishers. The application of Halon into the oven did not provide any cooling effect and increased the emission of smoke. The Halon gas was exposed to temperatures above its decomposition temperature and became toxic. In the case of a fire, Halon shall be used to extinguish it. It will extinguish the fire quickly. As a result, the temperature will not become as high as in the incident oven and the decomposition temperature of Halon is not reached. The use of a Halon fire extinguisher agent aggravated the circumstances during the oven overheat event and was therefore inappropriate.

The training provided to cabin crew stressed the importance of not manipulating and not resetting tripped circuit breakers. This led to a general understanding among the cabin crew that pulling a circuit breaker was not allowed, even in the presence of fire or smoke emitting from electrical equipment. Company procedures dictated that only after consultation with the flight crew, the pulling of a circuit breaker was allowed.

During the investigation, the operator was already alerted by the Dutch Safety Board on the importance of the implementation into the crew procedures of a check that all power to a failed oven has indeed been switched off. Also, the importance of keeping the oven door shut during an overheat event was pointed out by the Dutch Safety Board during the investigation, as the oven is designed to confine high temperatures to the inside of the oven.

The Dutch Safety Board published the [report](#) on 10 June 2024.

**Classification:** Serious incident  
**Reference:** 2023012

## Near collision, Cessna 208B, PH-JBR and Robin DR 400/180, PH-SSZ

Midden-Zeeland Airport, 8 October 2023

On October 8, 2023, a near collision occurred near Midden-Zeeland Airport (EHMZ) between a tug plane, a Robin DR 400, and an aircraft used for parachuting, a Cessna 208B. The planes flew in such proximity to each other that the Robin suffered damage to the canopy and rear-view mirrors.

At around 13.04 hours, the Robin took off from the glider strip south of Runway 27 for its first glider tow flight of the day. After consulting with the glider pilot, the Robin headed northeast to take advantage of the expected thermals. A few minutes after take-off, at an altitude of around 1,100 feet, the Robin crossed the circuit followed by a climb in north-easterly direction to 1,640 feet. After the glider had been released, the Robin banked left to descend in the direction of the circuit entry point.

▼ Cessna 208B and Robin DR 400 flight data. (Data source: EasyVFR (Robin DR 400) and SkyDemon (Cessna 208B), map source: OpenStreetMap)



The Cessna 208B, which had dropped parachutists on its seventh sortie, approached the entry point from the northwest around the same time. The Cessna pilot radioed that he was at 3,000 feet. The Robin pilot overheard this and radioed in from a position north of the entry point. However, the latter message was not heard by the Cessna's pilot due to interference on the radio channel. Shortly after both planes came too close to each other. The pilot of the Robin heard a loud bang and then saw the Cessna, coming from behind, fly overhead. The Cessna pilot stated that he had pulled up at the last moment, but was unable to prevent the aircraft from getting close to the Robin. The radar data shows that the Cessna was flying 60 knots faster than the Robin at the time of the occurrence. Both aircraft were able to continue flying and land at Midden-Zeeland Airport without any further problems.

- ▼ *Left: archive picture of the Robin DR 400/180, showing the position of the rear-view mirror. (Source: Werner Verbogt)*  
*Right: view of the Robin DR 400/180's windscreen divider with the rear-view mirror missing after the occurrence. (Source: Police, Aviation Supervision Team)*



The Robin was equipped with two mirrors. One mirror was attached to the canopy's windscreen divider. This allowed the pilot to view the glider during the tow. The second mirror was attached to the left wing. This also offered the pilot a view of the glider, as well as a view of the person holding the wingtip during the beginning of the take-off, when on the ground. After the occurrence, it was found that the Robin's canopy mirror had detached. Furthermore, the left wing tip mirror was cracked, with paint damage visible on the wing around the mirror. No damage was found on the Cessna.

Both aircraft were equipped with an aircraft collision avoidance system for approaching aircraft, but these were not compatible with each other. The Cessna was equipped with an ADS-B transponder, while the Robin had a FLARM system. Therefore, no warning was generated in either aircraft. Usually, parachutists taking off from Midden-Zeeland Airport were dropped off by a Cessna 208A that is equipped with FLARM.



Data from the Royal Dutch Meteorological Institute show that the visibility around Midden-Zeeland Airport was between 10 and 15 km, decreasing at times to approximately 8 km. North of the airport, low-lying clouds (FEW SCT) were present at altitudes between 500 and 1,000 feet. The pilot of the Robin stated that there were no clouds visible below 1640 feet. Despite good visibility, the 'see-and-avoid' principle<sup>1</sup> could not prevent the incident. Additionally, a speed difference of 60 knots has a negative impact on the effectiveness of the 'see-and-avoid' principle. It is therefore important that pilots of faster aircraft adapt their speed in and near the circuit, where slower traffic can also be expected, to the slow-flying traffic. By doing so, they create more time to avoid conflicting traffic. Besides flying at an appropriate speed in and near the circuit, the method of merging into the circuit is also relevant. Merging for standard circuits must take place downwind opposite the centre of the runway. The approach to this merging position must be perpendicular to downwind.<sup>2</sup> Even more, the interference on the radio channel and the warning systems being incompatible with each other may have contributed to the occurrence of this incident.

**Classification:** Serious incident

**Reference:** 2023205

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- 1 A technique in which pilots visually scan the airspace to detect other aircraft and avoid collisions by taking evasive action in time.
  - 2 Standard air traffic circuit regulations, Article 7, paragraph c - <https://wetten.overheid.nl/BWBR0006175/2014-12-12> .

## **Airprox, AQUILA Aviation GmbH AT01-100, PH-BAN and APEX Aircraft DR 400/140 B, PH-NSC**

Breda International Airport, 10 February 2024

The AQUILA, with an instructor and student on board, was making a local flight from Breda International Airport (EHSE). The DR 400, with an instructor and student on board, had made a flight from Rotterdam The Hague Airport (EHRD) to EHSE, where it had made five touch-and-goes on Runway 24.

The AQUILA flew downwind behind the DR 400 for Runway 24. Due to an easterly wind component, Runway 06 was taken into use at that time. The DR 400 therefore left the circuit and flew around the village of St. Willebrord. The AQUILA followed the DR 400. The DR 400 then flew back into the circuit area via the entry point, followed by the AQUILA. According to the instructor on board the AQUILA, the distance between the two aircraft was about 1.5 km at the time. The student in the DR 400 was supposed to make a short-field landing and therefore flew a wide circuit, followed by a longer and flatter final than normal. The speed for the final was also slower than the DR 400's normal approach speed. The aircraft dropped slightly below the planned flight path, after which the student selected a high level of engine power to correct the flight path. On its short final, the AQUILA was slightly above and to the right of the DR 400. At that point, the occupants of the two aircraft had not observed one another for some time. When the student on board the AQUILA made the 'short final' call, the instructor on the DR 400 immediately responded by also reporting that they were flying on short final. When the instructor in the DR 400 sighted the AQUILA, he took over the controls from the student. Shortly after, the aircraft entered the AQUILA's wake turbulence. The DR 400's left wing then suddenly dropped, whereupon the instructor immediately applied full right rudder and selected full power to rectify the situation. The DR 400 then made a go-around and climbed out to the left. The AQUILA made a touch-and-go. When the occupants of

the AQUILA saw the DR 400 climbing out to the left, they climbed out to the right. Both aircraft then landed without any further problems.

The minimum horizontal distance between both aircraft was 7 metres with a vertical distance of 75 feet. This was at 13.10:44 hours. The minimum vertical distance between both aircraft occurred 4 seconds later and was 25 feet; the horizontal distance was then 20.5 metres.

The occupants of both aircraft stated that they had radioed their position a number of times while in the circuit, but that they had not heard all of one another's calls.

The DR 400 left the circuit area on the downwind leg and flew back into it on final. As described in the AIP, the air traffic circuit must be flown within the lateral boundaries of the circuit area. This is particularly important if there are several aircraft in the circuit area. The risk of an airprox in the circuit area can be reduced in this way.

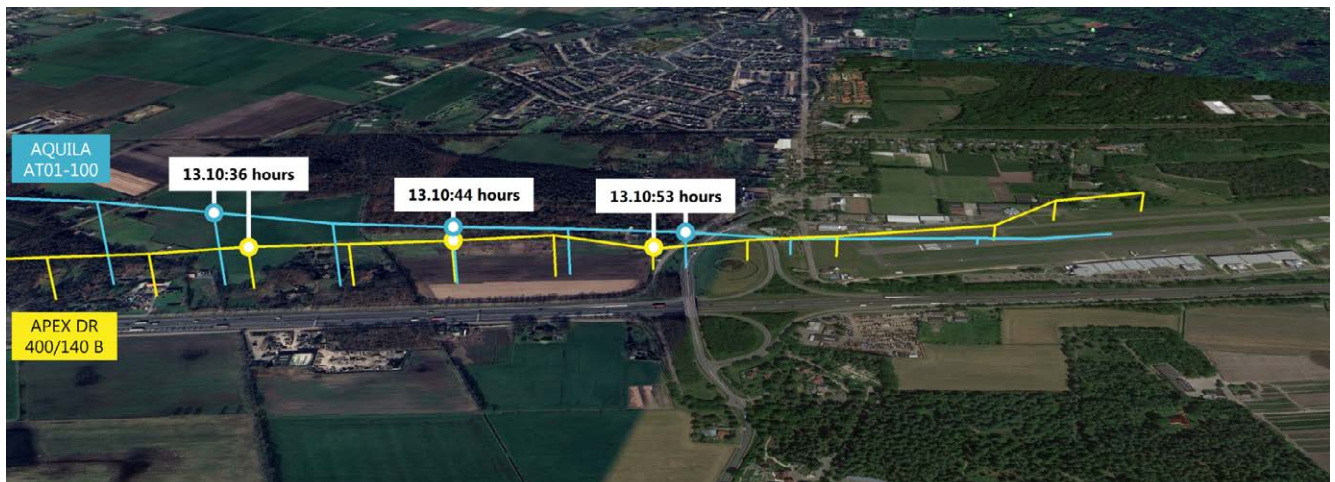
▼ *Three-dimensional view of the flight paths of the two aircraft during the final approach to Runway 06. (Source: radar data LVNL, map: Google Earth)*



▲ *Two-dimensional view of the flight paths of the two aircraft in the circuit for Runway 06. (Source: radar data LVNL, map: OpenStreetMap)*

**Classification:** Serious incident

**Reference:** 2024027



## Fly-away after loss of connection, DJI Mavic 2

Amsterdam, 24 February 2024

Shortly after taking off, the unmanned aircraft (UA) lost its connection to the remote control. The aircraft's position had not yet been correctly determined using a Global Navigation Satellite System (GNSS). The UA flew away and disappeared behind a building, where it was later found damaged.

An investigation by the operator did not reveal the cause of the UA losing its connection to the remote control. Because its position had not been determined by GNSS, no HomePoint had yet been recorded. As a result, the UA initiated landing immediately after losing its connection to the remote control. The Dutch Safety Board did not investigate the occurrence any further.

**Classification:** Accident

**Reference:** 2024018



## Precautionary landing after smoke in cockpit, Cessna Aircraft Company 172P, PH-SEL

Sommelsdijk, 7 April 2024

The Cessna 172P was carrying out a VFR training flight from Rotterdam The Hague Airport (EHRD) with an instructor and student on board. Approximately 45 minutes into the flight, the student initiated a descent to 2,000 feet in the direction of EHRD. Just before the aircraft reached that height, the red low voltage light came on, after which the displays for the radios and transponder failed. Some smoke came out of the centre console where these instruments are located. The reading on the oil temperature gauge was high, with the pointer in the red zone. The instructor activated the *Emergency Locator Transmitter* and decided to make a precautionary landing in a meadow. After she turned off the main switch, the smoke disappeared. The landing was without incident.

An inspection by a maintenance company revealed that an alternator failure had occurred, causing the voltage in the on-board system to be too high. As a result, a number of units failed. The smoke and a pungent smell were caused by one of the units becoming hot. The oil temperature gauge incorrectly showed too high a value. The voltage regulator, which serves as a protective device, did not switch off the system. The maintenance company was unable to identify the cause of this. The voltage regulator and a few other parts were replaced, after which the fault did not re-occur.

**Classification:** Serious incident

**Reference:** 2024040

◀ *The Cessna after the precautionary landing.*  
(Source: Dutch Aviation Police)

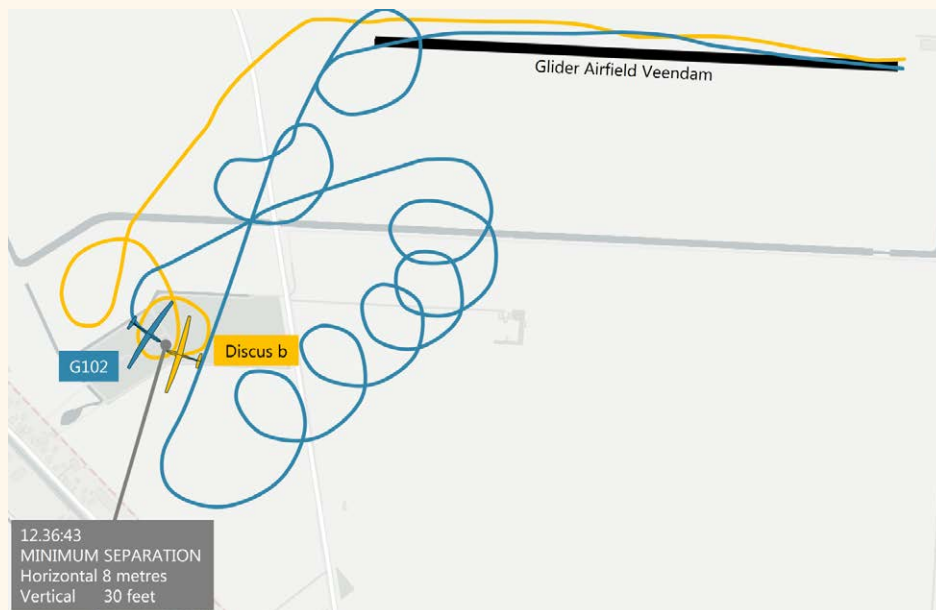
## Airprox, Burkhart Grob Flugzeugbau G102 "CLUB ASTIR III b", PH-1159 and Schempp- Hirth Flugzeugbau GmbH Discus b, PH-1148

Veendam glider airfield, 13 April 2024

The Burkhart Grob G102 (referred to below as the G102) took off from Veendam glider airfield at around 12.31 hours by means of a winch launch. The pilot, a solo student pilot, then made a left turn, flew into a thermal and began spiralling. At about 12.34 hours, the Schempp-Hirth Discus b (referred to below as the Discus) was also winch-launched. The pilot of the Discus saw the G102 spiralling. In order to maintain horizontal separation from the G102, the Discus' pilot first flew straight ahead and then started to spiral clockwise. The pilot of the G102 saw the Discus turning into a thermal and decided to join into it also. When it arrived at the thermal, the G102 came out behind the Discus. The pilot stated that he did not think that it was an ideal place to join in and he had decided to fly on and then turn 180 degrees and make

another attempt. When the G102 commenced the turn, the pilot had lost sight of the Discus. Therefore, he assumed he had not yet turned sufficiently and continued the turn. Shortly after, the G102 and the Discus found themselves heading straight towards one another. The pilot of the G102 then attempted to increase the distance by steering downwards and further in so as to make the turn shorter. His doing so could, however, not prevent the G102 from passing over the Discus in the opposite direction at close range. At that point, the minimum vertical separation was about 30 feet and the minimum horizontal separation was 8 metres. Both aircraft continued their flight.

▼ *The flightpaths of the two gliders. (Source of data: gliders' data loggers, source of map: OpenStreetMaps)*



The pilot of the Discus stated that there had been little thermal activity that day. Both pilots also stated that there had been a stiff wind. The METAR data from Groningen Airport Eelde – which is at a straight-line distance of about 17 km from Veendam glider airfield – shows that around the time of the incident, the wind was from the southwest with a strength of 14 knots.

The glider club's safety manager conducted a safety investigation. The final report notes that joining into a thermal can lead to dangerous situations. It is therefore important to consider whether or not it is safe and prudent to join into a thermal along with another glider. The report also contains a number of recommendations regarding thermals:

- Do not join in if that cannot be done safely.
- Joining in at the same altitude as the other aircraft is particularly dangerous. It is safer to join in at a lower or higher altitude than the other glider. Ensure sufficient (>50 metres) vertical separation.
- Make sure you are spiralling in the opposite direction to the other glider so that the two pilots can see each other.
- Wave to each other to show that you are aware of each other's position.
- Keep looking outside.

The Dutch Safety Board did not investigate the occurrence any further. The above report is based on flight data, statements made by the pilots, and the glider club's investigation.

**Classification:** Serious incident

**Reference:** 2024042

## Wingtip touches ground during winch launch, Rolladen-Schneider LS 4-b, PH-1484

Nistelrode glider airfield, 13 April 2024

The LS 4-b glider was ready for a winch launch on Runway 29. As it rolled along the ground, its right wingtip touched the ground. The glider then made a movement of about 30 to 40 degrees to the right, with the wingtip still on the ground, after which it became airborne. The aircraft was then pulled straight by the winch cable and jerked to the left, after which the winch take-off continued without anything unusual happening. After the flight, it became apparent that the pilot had not realised that the wingtip had moved across the ground. Bystanders reported that the wing runner had held the left wing – the side from which the wind was coming – in the neutral position, or slightly higher. The wind was moderate to fairly strong and was coming from the southwest.

The pilot's total flying experience amounted to 318 takeoffs (77 hours flying), of which 7 takeoffs (and approximately 3 hours) were in the aircraft type concerned.

If a wingtip touches the ground during a winch take-off, the glider can rotate around the wingtip and it can cartwheel. This can happen so quickly that recovery – for example by unhooking the winch cable – is no longer possible. It is important to anticipate this danger and to always keep one hand near the release hook. If it is not possible to keep the wings horizontal, the cable should be unhooked immediately, even before a wing touches the ground.

**Classification:** Serious incident

**Reference:** 2024044



## Flight over paragliding winch field, Piper PA-19, PH-FLG

at Ameide, 11 May 2024

The PA-19, with a single occupant, was carrying out a VFR flight from Antwerp Airport in Belgium (EBAW) to Hilversum Airport (EHHV) at heights varying between 800 and 1,200 feet. At about 16.27 hours, the aircraft flew over the winch field at Ameide where a paraglider had just been winched aloft. The paraglider had disconnected the winch cable at a height of approximately 820 feet. According to witnesses on the ground, the powered aircraft was flying lower than the disconnection height. There was no direct risk of collision between the two aircraft, however. With the aid of the thermals that were active, the paragliders reached a height of about 1,800 feet that afternoon.

The pilot of the PA-19 was not familiar with the Ameide winch field. He had not observed any paraglider activity while preparing for and carrying out the flight. While preparing for the flight, the pilot had used the EasyVFR application, specifically to check for NOTAMs. He had not used this application during the actual flight.

▲ A paraglider. (Source: Maurik Paragliding)

The Ameide winch field, together with two other winch fields, is located between Gorinchem and Lopik on the western side of the A27 motorway. The AIP<sup>3</sup> states that paragliders can be winched up to a height of 1,500 feet AMSL and that the winch cable forms a virtually invisible obstacle at a distance of approximately 1 NM around the geographical position of Ameide.<sup>4</sup> On the *Aeronautical Chart The Netherlands*, a paraglider field is represented by a dark blue circle containing an S. At the bottom right of the circle is a number (for example 15) indicating the maximum height in hundreds of feet to which the winch cable can reach. See the figure below, which shows the three winch fields that are situated close to one another. The field at Ameide<sup>5</sup> is below the Schiphol

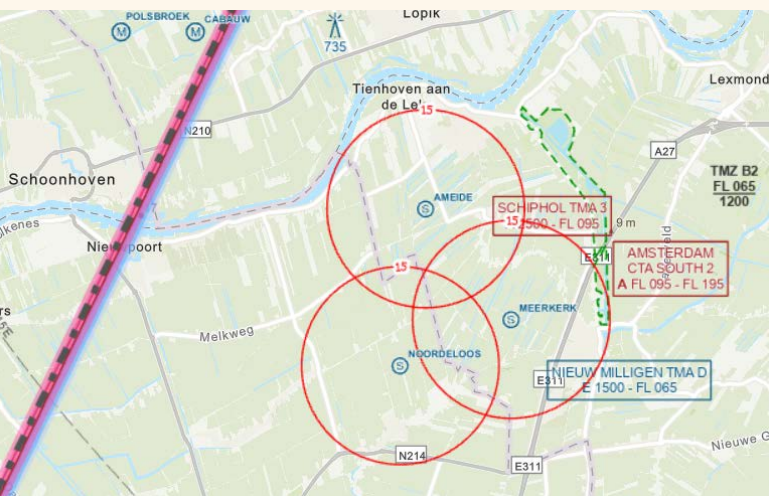
3 ENR 5.5 AERIAL SPORTING AND RECREATIONAL ACTIVITIES, 3 HANG- OR PARAGLIDER ACTIVITIES.

4 51° 56' 29" N 04° 57' 03" E.

5 The winch field at Ameide is the northernmost field in the figure above.

TMA 3, which has a lower limit of 2,500 feet. The <https://www.maurikparagliding.nl> website states – under ‘Actuele vliegverwachting’ [Current flying forecast] – whether the flying school is operational. The flying school also flies from a winch field at Noordeloos, the southernmost winch field in the figure below.<sup>6</sup>

**Classification:** Incident  
**Reference:** 2024070



▲ The three winch fields between Gorinchem and Lopik; the northernmost is located close to Ameide. (Source: VFR chart The Netherlands, LVNL)

<sup>6</sup> The easternmost winch field in the figure is used by Action Pilots Paragliding.

## Airprox, Alexander Schleicher ASK 21, PH-713 and Cessna C150, OO-FUN

Axel glider airfield, 12 May 2024

The Cessna C150, with two licensed pilots on board, was conducting a flight under visual flight rules (VFR<sup>7</sup>) from Midden Zeeland Airport (EHMZ) to Spa-La Sauvenière Airport (EBSP) in Belgium. There were visual meteorological conditions (VMC). At a certain point, the aircraft was flying at an altitude of 1,500 feet above Axel glider airfield. At the same time, the ASK 21, with a soloist<sup>8</sup> on board, was undertaking a winch launch. The pilot flying the C150 saw the glider flying from right to left in front of him at an estimated horizontal distance of about 100 metres away from him and 100 feet below him. He immediately performed an evasive manoeuvre to the right so as to avoid a mid-air collision, after which both aircraft continued their flight. The release height for winch launches that day was about 1,300 feet (400 metres).

The pilot flying the C150 stated that he had logged on to the frequency of Dutch Mil Info, but had not received any information about other traffic or specifically gliding activities in the area concerned. He therefore assumed that the area in which they were flying would be free of other conflicting traffic.

On the SKyDemon application – used by C150 pilots for flight preparation and during flight operations – they had observed three symbols for gliders in the area around Terneuzen and Axel, without any specific airfield symbol. They assumed that these symbols indicated that gliding activities could take place in the area, but not that glider airfields were present.

<sup>7</sup> Visual flight rules.

<sup>8</sup> An as-yet unlicensed pilot.

After the flight, the pilots saw a G symbol near Axel on their paper aeronautical map (scale 1:250,000); they did not know that this indicated a glider airfield. The pilots stated that in future, additional documents and maps would be important for them during flight preparation in order to determine whether the planned route avoided glider airfields. It was also important to increase their knowledge of the symbols used on aeronautical maps.

Glider airfields are marked differently on paper and digital VFR maps. On a paper VFR map, the location of a glider airfield is indicated by a blue circle containing a G, with a figure in hundreds of feet above the local terrain level up to which the winch cable can extend. On a digital VFR map, a glider symbol may be used to indicate the location, but the maximum winch cable height may not be visible without taking additional steps to make more details visible.

The Royal Dutch Aviation Association (KNVVl) has produced an animation explaining the dangers involved in flying over glider airfields. This is available [here](#).

**Classification:** Serious incident  
**Reference:** 2024066

## Airprox, Rolladen-Schneider Flugzeugbau GmbH LS8-a, PH-1348 and a drone

Zeist, 19 May 2024

The LS8-a glider had taken off from Soesterberg glider airfield for a local flight. The pilot stated that he had to avoid a drone at an altitude of approximately 800 metres above Zeist at around 11.35 hours. He estimated the mutual distance to be 30 to 50 metres.

The Command of the Royal Netherlands Air Force, which has a system for detecting drones, has not been able to trace the drone. This made it impossible to trace the drone operator. The Dutch Safety Board was therefore unable to investigate this incident further.

**Classification:** Serious incident  
**Reference:** 2024076



## Preliminary reports

### Preliminary report on crashed Blackshape S.p.A. BS 115

Zwarte Meer, 28 June 2022

The Dutch Safety Board is investigating the accident involving a Blackshape BS 115, in which the instructor and student pilot were killed. The accident occurred near the Zwarte Meer in the Netherlands on 28 June 2022. The aircraft was conducting a training flight at an altitude of approximately 5,000 feet, when it suddenly lost altitude and crashed into the Zwarte Meer. The investigation focuses on both operational and technical aspects.

The Dutch Safety Board published a preliminary report on 17 April 2024. This report is available on the [website](#). The investigation activities mentioned in that report are currently being carried out.

The preliminary report states that the European Union Aviation Safety Agency (EASA) issued an Airworthiness Directive suspending flights with Blackshape BS 115, BK 160, BK 160-200 and BK 160 TR aircraft (reference AD No. 2024-0074-E). EASA cancelled this airworthiness designation on 13 June 2024 based on additional information (reference AD No. [2024-0074-CN](#)).

**Classification:** Accident

**Reference:** 2022077

## Completed investigations (abroad)

### Descent below segment minimum safe altitude, Fokker F28 Mk 0100, VH-FGB near Adelaide Airport (Australia), 30 August 2023

During the standard instrument arrival route into Adelaide Airport (YPAD), with the auto-flight system engaged, the Fokker 100, with 96 occupants, descended below a segment minimum safe altitude of 3,800 feet.

Observing the deviation, the captain commanded the aircraft to hold its current altitude. However, the first officer observed that the aircraft continued to descend, and in response, disconnected the autopilot and initiated a climb.

The auto-flight system then captured the lateral track of the localiser and intercepted the instrument landing system (ILS) glideslope when the autopilot was subsequently reconnected. The aircraft continued the ILS approach and landed safely.

*The Australian Transport Safety Bureau (ATSB) published the [report](#) on 12 April 2024.*

**Classification:** Incident

**Reference:** 2023188

▼ Archive photo Fokker 100. (Source: P. Reading )





## Colofon

This is a publication of the Dutch Safety Board. This report is published in the Dutch and English languages. If there is a difference in interpretation between the Dutch and English versions, the Dutch text will prevail.

August 2024

### Photos

Photos in this edition, not provided with a source, are owned by the Dutch Safety Board.

## The Dutch Safety Board in three questions

### 1. What does the Dutch Safety Board do?

Living safely, working safely, safety. It seems obvious, but safety cannot be guaranteed. Despite all knowledge and technology, serious accidents happen and disasters sometimes occur. By carrying out investigations and drawing lessons from them, safety can be improved. In the Netherlands the Dutch Safety Board investigates incidents, safety issues and unsafe situations which develop gradually. The objective of these investigations is to improve safety, to learn and to issue recommendations to parties involved.

### 2. What is the Dutch Safety Board?

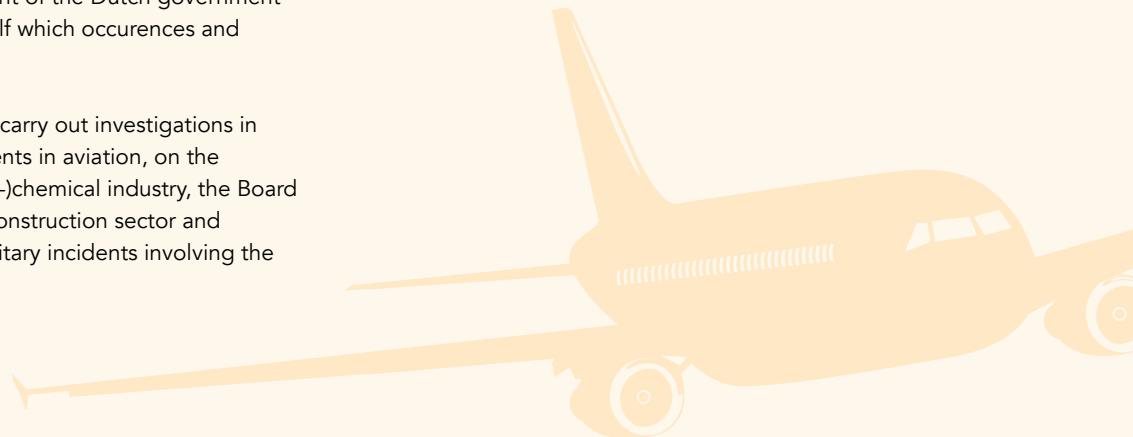
The Dutch Safety Board is independent of the Dutch government and other parties and decides for itself which occurrences and topics will be investigated.

The Dutch Safety Board is entitled to carry out investigations in virtually all areas. In addition to incidents in aviation, on the railways, in shipping and in the (petro-)chemical industry, the Board also investigates occurrences in the construction sector and healthcare, for example, as well as military incidents involving the armed forces.

### 3. Who works at the Dutch Safety Board?

The Board consists of permanent board members; the Chairperson is Chris van Dam MPA. The board members are the public face of the Dutch Safety Board. They have extensive knowledge of safety issues.

They also have extensive administrative and social experience in various roles. For specialist knowledge, the Board members can enlist the assistance of the associate members of the Board. The Safety Board's bureau has around 80 staff, two-thirds of whom are investigators.



Visit the website for more information [www.safetyboard.nl](http://www.safetyboard.nl).