



DUTCH  
SAFETY BOARD

# Quarterly Aviation Report

October - December 2024

# Q4 2024



# Table of contents

<b>01</b>	<b>Review of activities of the aviation sector .....</b>	<b>4</b>
<b>02</b>	<b>Occurrences into which an investigation has been launched.....</b>	<b>6</b>
	Fire warning for left engine, 15 October 2024.....	6
	Loss of control with uncontrolled loss of altitude, 29 October 2024.....	6
<b>03</b>	<b>Occurrences into which an investigation has been launched (abroad).....</b>	<b>7</b>
	Damage resulting from turbulence, 20 June 2024 .....	7
	Loss of control, 25 June 2024.....	7
	Runway excursion, 28 December 2024 .....	7
<b>04</b>	<b>Completed investigations.....</b>	<b>8</b>
	Near mid-air collision in the Rotterdam control zone, 15 June 2022 .....	8
	Touchdown before threshold, 12 January 2023 .....	9
	Landing with centre of gravity located aft, 11 October 2022.....	11
	Runway excursion, 31 May 2024 .....	12
	Glider strikes tree and fence on final, 9 June 2024 ....	13
	Runway excursion during take-off, 19 June 2024 .....	14
	Hard landing after engine failure exercise, 11 July 2024 .....	15
	Wing damage during outlanding, 15 July 2024.....	16
	Runway incursion, 15 July 2024 .....	17
	Injured by burner flame, 17 July 2024 .....	18
<b>05</b>	<b>Completed investigations (abroad).....</b>	<b>19</b>
	Runway excursion, 26 March 2024 .....	19
	Passenger dragged during landing, 28 April 2024.....	19

## Types of completed investigations.

### Statement of facts

A factual account of the occurrence.

### Summary

A summary of an investigation report that has already been published on the Dutch Safety Board's website.

### Report

A factual description of the occurrence with an analysis, conclusion and potential lessons learned.

### Discontinued investigation

An investigation that has been halted.

# 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.



## Investigations are an important part of aviation safety

If there's a technical defect in an aircraft or an in-flight operational disruption, then – fortunately – passengers usually hardly notice it, it they notice it at all. Technical problems are generally already detected and rectified during regular maintenance, before they can lead to any in-flight problems. Sometimes though, a malfunction only becomes apparent during a flight.

In 2024, the Dutch Safety Board published two reports about a technical defect and an operational disruption that occurred during commercial flights:

- a broken aileron flight control cable in a Boeing 737 on 8 July 2022 and
- an Airbus 330 that touched down before the runway threshold on 12 January 2023.

Crews are well trained in how to act if a technical defect or operational disruption occurs during a flight. They may then decide to return to the airport they departed from or divert to a different airport.

Most of the passengers probably noticed very little about these two incidents. The Safety Board nevertheless conducted an extensive investigation into each of them in order to determine the causes, risks, and safety lessons. Based on the investigation results, airlines can adopt any necessary measures to prevent major incidents in the future.

The Safety Board continues to promote aviation safety, allowing passengers to board without anxiety and rely on a high level of safety.

Chris van Dam  
*Chairman of the Dutch Safety Board*

## Review of activities of the aviation sector

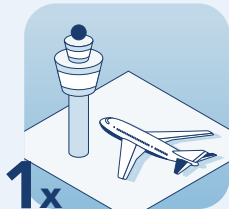
# 2024



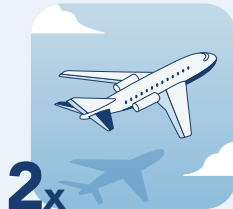
In 2024, the Dutch Safety Board received a **total of 218 notifications in the aviation sector**. This led to investigations into:



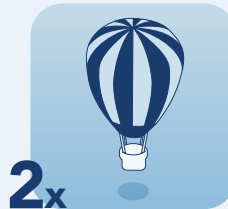
**Commercial air transport** The Dutch Safety Board started six investigations into occurrences within commercial air transport with:



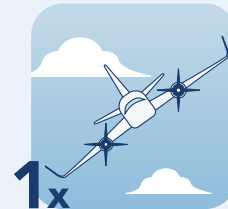
A commercial passenger aircraft at Schiphol



A business jet



A hot air balloon



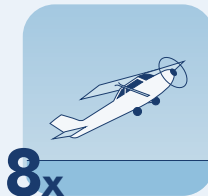
A turbopropeller aircraft on Bonaire

### General aviation

In general aviation in the Netherlands, 13 serious incidents and 15 accidents took place. For an airprox, two flight phases apply.



During engine start up



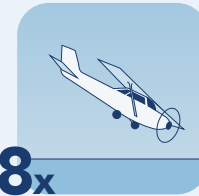
During takeoff



En route



In the traffic circuit



During landing

## Foreign investigations



The Dutch Safety Board has offered assistance 19 times to foreign investigation authorities. We do that in case of occurrences with Dutch involvement (e.g. when the aircraft has been registered or manufactured in the Netherlands).

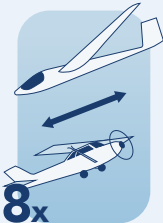
## Fatal accidents



1 person in the Netherlands died in an aviation accident. This involved a student pilot who flew with an A210 Aquila that crashed on a highway near Sint Willebrord.

1 Dutch person has died abroad due to an aviation accident. It concerned a pilot who crashed with his glider in Germany.






## Airproxes



The Dutch Safety Board started investigations into 8 airproxes. An airprox is a situation in which the distance between aircraft as well as their relative positions, direction and speed have been such that the safety of the aircraft involved may have been compromised. The Board also started a thematic investigation into airproxes.

## Aviation reports

The Dutch Safety Board published in 2024:

- 4<sub>x</sub>** A Quarterly Aviation Report
- 1<sub>x</sub>** Preliminary report on the crashed Blackshape S.p.A. BS 115 on 28 June 2022
- 5<sub>x</sub>** An aviation report
  -  Loss of control, Hélicoptères Guimbal Cabri G2 helicopter, Lelystad Airport, 18 March 2022
  -  Near mid-air collision in the Rotterdam Control Zone, 15 juni 2022
  -  Failure of aileron flight control cable, Boeing 737-804, Heraklion International Airport (Greece), 8 July 2022
  -  Touchdown before threshold, Airbus A330-300, Amsterdam Airport Schiphol, 12 January 2023
  -  Oven overheat in aft galley, Boeing 777-300, Mediterranean Sea (France), 9 February 2023

# Occurrences into which an investigation has been launched



▲ Archive photo. (Source: H. Chow)

## Fire warning for left engine, Bombardier Global 7500

Amsterdam Airport Schiphol, 15 October 2024

At FL80<sup>1</sup>, a fire warning for the left engine was generated in the cockpit. The crew responded by closing down the engine. They issued an emergency call and returned to Amsterdam Airport Schiphol (EHAM), where they made a safe landing. An inspection by the fire service revealed no abnormalities, after which the crew taxied to the general aviation apron.

**Classification:** Serious incident

**Reference:** 2024198

## Loss of control with uncontrolled loss of altitude, Eurocopter Deutschland GmbH EC135 P2+,

Zoetermeer, 29 October 2024

During a flight at 3,000 feet from Rotterdam The Hague Airport (EHRD) to Schiphol subject to instrument flight rules (IFR) and in instrument meteorological conditions, a malfunction occurred in the system that displays the artificial horizon to the pilot. Shortly after that, the helicopter entered an uncontrolled high-speed dive. It emerged below the clouds at an altitude of about 450 feet. The pilot then steered the helicopter out of the dive and entered horizontal flight just above some buildings on the ground. The pilot returned to EHRD, where he made a safe landing.

**Classification:** Serious incident

**Reference:** 2024212

<sup>1</sup> 8,000 feet above the standard isobaric reference plane (1013 hPa).

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

## Damage resulting from turbulence, Boeing 787-9

San Carlos (Argentina), 20 June 2024

After departing from Santiago International Airport (SCEL) in Chile, the aircraft experienced severe turbulence while climbing as it passed FL325. A number of cabin crew members lost their balance and most of them sustained minor injuries. The 257 passengers were unharmed. After the aircraft had landed at Ministro Pistarini International Airport (SAEZ) in Argentina, a severe turbulence inspection was carried out and some damage to the fuselage was identified.

*Argentina's Transport Safety Board [Junta de Seguridad en el Transporte] (JST) has commenced an investigation in response to this occurrence. The Dutch Safety Board has offered its assistance, given that a Dutch airline was involved in the occurrence and the aircraft is registered in the Netherlands.*

**Classification:** Incident

**Reference:** 2024130

## Loss of control, Jonker Sailplane JS1-B

Suhl (Germany), 25 June 2024

During a local flight from Suhl-Goldlauter Airport (EDQS), the pilot lost control of the glider. The aircraft crashed and the pilot succumbed to his injuries.

*In response to this occurrence, the German Federal Bureau of Aircraft Accident Investigation [Bundesstelle für Flugunfalluntersuchung] (BFU) has launched an investigation. The Dutch Safety Board has offered its assistance because the pilot of the aircraft was a Dutch national.*

**Classification:** Accident

**Reference:** 2024142

## Runway excursion, Boeing 737-800

TORP Sandefjord Airport (Norway), 28 December 2024

During the take-off run from Oslo Gardermoen Airport (ENGM), a tyre burst and there was a subsequent loss of hydraulic pressure. The crew decided to divert to TORP Sandefjord Airport (ENTO). At the end of the ground roll, the aircraft came to a standstill in the grass to the right of the runway. The 182 occupants were unharmed.

*The Norwegian Safety Investigation Authority (NSIA) has launched an investigation into this occurrence. The Dutch Safety Board has offered its assistance, given that a Dutch airline was involved in the occurrence and the aircraft is registered in the Netherlands.*

**Classification:** Incident

**Reference:** 2024224

# Completed investigations

## Summary

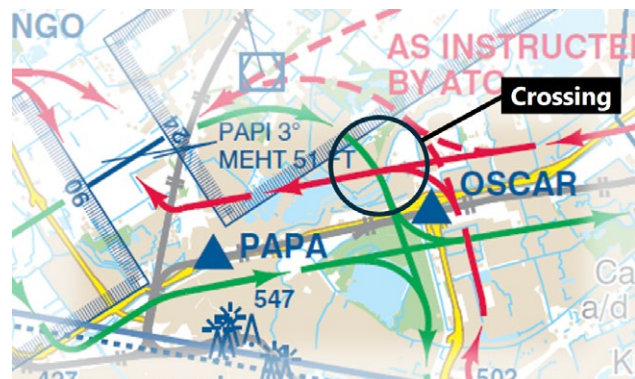
### Near mid-air collision in the Rotterdam control zone, Cessna 172S, D-EBTO and Cessna 172P, N98825

Rotterdam CTR, 15 June 2022

On 15 June 2022 a Cessna 172S, registered as D-EBTO with a pilot and passenger (a licensed aviator) on board, flew under visual flight rules (VFR) from Münster Osnabrück Airport, Germany (EDDG) to Rotterdam The Hague Airport (EHRD). The pilot followed the standard ROMEO arrival route in the Rotterdam control zone (CTR) at 1,500 feet on its way to Runway 06. Meanwhile another Cessna 172, registered as N98825, took off from Runway 06 under VFR following a standard ROMEO departure route in the Rotterdam CTR on 1,500 feet. The pilot, being the only occupant, flew to Frankfurt Egelsbach Airport (EDFE) in Germany.

When Runway 06 is in use, the ROMEO arrival route crosses the ROMEO departure route at 1,500 feet near the reporting point OSCAR. Both aircraft neared the crossing point at the same prescribed altitude and at the same moment. Although Air Traffic Control (ATC) had informed both pilots earlier that they had opposite traffic, both pilots did not have the other aircraft (conflicting traffic) in sight when nearing the crossing point. When D-EBTO was about to cross the ROMEO departure route, the pilot observed N98825 at a late stage on his right and initiated an evasive action (a dive) to increase the vertical distance. The Dutch Safety Board classified the event as a serious incident.

Two comparable events had previously occurred at or near the same crossing point when Runway 06 was in use. In 2014, one aircraft flew a standard Mike departure procedure at 1,000 feet and another aircraft flew a standard Mike arrival procedure at 1,000 feet. In 2020, one aircraft flew a Mike



▲ Near mid-air collision near point OSCAR.  
(Source: AIP the Netherlands)

departure procedure at 1,000 feet and an arriving aircraft cleared for a 'direct course' in opposite direction flew at or approximately at 1,000 feet. In both of these near mid-air collision events arriving and departing traffic had crossing routes at the same or almost at the same altitude. Similar to the event on 15 June 2022, these two events and studies addressing the limitations of 'see and avoid' show that 'see and avoid' is sensitive to failure and therefore an unreliable safety barrier. As demonstrated by the events, in particular when Runway 06 is in use, adherence to prescribed VFR procedures and instructions may perpetuate the risk for conflict instead of mitigating it.

To fulfill the responsibility for VFR pilots to prevent collisions, they need to have the other traffic in sight in time. As demonstrated in the event in 2022, despite the provision of traffic information by ATC visual contact between D-EBTO and N98825 remained uncertain and ATC did not additionally aid in solving the upcoming risk for a collision. The investigation revealed that Air Traffic Control the Netherlands (LVNL) considers separation between VFR traffic solely as a responsibility for VFR pilots. Strictly speaking, it is correct that ATC has no formal responsibility to separate VFR traffic from VFR traffic



and no references exist. However, this should not be confused with the overarching responsibility for preventing collisions. As laid down in the regulatory framework, Air Traffic Services Providers have a responsibility in preventing (mid-air) collisions in class C airspace. VFR traffic is not exempted from this. Therefore, the Dutch Safety Board has issued recommendations to LVNL.

#### Recommendations

To Air Traffic Control the Netherlands (LVNL):

1. Secure on short notice and in consultation with stakeholders that arriving VFR traffic and departing VFR traffic in the CTR of Rotterdam The Hague Airport, have under all circumstances no crossing flight paths at the same altitude.
2. Include the objectives of Commission Implementing Regulation (EU) 2017/373 ATS. TR.100 for VFR operations in class C and D airspace in LVNL policy for procedures and/or training in order to prevent collisions between VFR traffic.

To the International Civil Aviation Organisation and to the European Union Aviation Safety Agency:

3. For the purpose of accident and incident investigation, amend the retention period of background communication and aural environment recordings in air traffic services from 24 hours of operation to 30 days (ICAO annex 11, Commission Implementing Regulation (EU) 2020/469, ATS.OR.460).

The Dutch Safety Board published the [report](#) on 21 November 2024.

**Classification:** Serious incident

**Reference:** 2022070

## Touchdown before threshold, Airbus A330-300, N802NW

Amsterdam Airport Schiphol, 12 January 2023

On 12 January 2023, an Airbus A330-300, registered N802NW, encountered a complicated landing scenario at Amsterdam Airport Schiphol (EHAM). The aircraft, carrying 220 passengers, one captain, two first officers, and 10 flight attendants, faced a multitude of technical, environmental, and operational factors. The flight, which departed from Detroit Metropolitan Wayne County Airport (KDTW) on 11 January 2023 at 18.51 local time, ended up with the rear wheels of the main landing gear touching down on the grass 11 metres before the threshold of Runway 22 at 07.52 local time. The landing was executed under conditions of strong gale-force winds, with severe gusts, a light drizzle, and reduced visibility of 5,000 metres, one hour before sunrise.



▲ Tracks before the threshold of Runway 22.  
(Source: Amsterdam Airport Schiphol)

#### *Incident overview*

The Airbus A330, equipped with autopilot (AP) and autothrust (A/THR), followed a stabilized approach towards the Runway 22 touchdown zone, in adherence to the Instrument Landing System (ILS) glideslope. As the aircraft descended below the

clouds, the pilots observed the Precision Approach Path Indicator (PAPI), which signalled an accurate trajectory towards the touchdown zone. Despite Runway 22's sufficient length of 2,020 metres for an A330-300 landing, the flight crew perceived the runway length as short. This influenced their approach strategy. Additionally, the reduced threshold clearance for this type of aircraft was a challenge that the flight crew did not foresee.

### *Key factors leading to the incident*

**Manual control and trajectory alteration:** The captain manually controlled the aircraft's flight path after disengaging the autopilot at 240 ft radio altitude, allowing a descent below the ILS glide slope and PAPI glide path. This led to compromised safety margins intended to prevent undershoots.

**Flight crew's preoccupation with runway length:** The crew focused on speed management more than maintaining the glide path due to concerns about a potential overrun. This focus was further intensified by their limited experience on the Airbus A330 with short runways and their understanding of the Ground Speed Mini function of the A/THR.

**Environmental challenges:** The aircraft encountered a wind gust and downdraft at approximately 60 ft above ground level, altering its trajectory and leading to an early touchdown before the runway threshold.

**ILS and PAPI system limitations:** The ILS and PAPI system on Runway 22, designed for smaller aircraft, did not meet the International Civil Aviation Organisation (ICAO) and European Union Aviation Safety Agency (EASA) criteria for a minimum threshold crossing height for the A330-300's main landing gear, contributing to the reduced safety margin.

### *Human factors and operator's risk management*

The crew's collective judgment was shaped by their perception of the risks associated with a runway overrun, which overshadowed the risk of an undershoot. This may

have been further influenced by visual illusions, common during an approach under their circumstances.

Additionally, ambiguities in the operator's Standard Operating Procedures (SOPs) and a limited specific training for landing on short runways like Runway 22 led to deviations from intended procedures. Fatigue factors, analysed in Appendix F, suggest the captain and both first officers may have been affected. This may have impacted their cognitive functions and decision-making during the critical phases of flight, despite the operator's comprehensive fatigue risk management system.

The operator's risk management approach, including the provision of theoretical knowledge and operator's SOPs, did not fully address the specific risks associated with Runway 22 operations for larger aircraft. Furthermore, the incident brings to light the need for a comprehensive approach to safety risk analysis, particularly in considering the suitability of ILS and PAPI systems for wide-body operations, according to ICAO, FAA and EASA standards.

### *Conclusion*

The incident on 12 January 2023 highlighted a complex interplay of technical, environmental and human factors. While the Airbus A330-300 was capable of safely landing on Runway 22, the crew's skewed risk perception, influenced by environmental challenges, a lower than desired threshold crossing height following the PAPI, and operational decisions, led to the aircraft touching down before the runway threshold. This event underscores the necessity of comprehensive risk analysis, pilot training tailored to specific operational scenarios and a systemic review to ensure better awareness and decision-making regarding the suitability of runways for different types of aircraft. The incident highlights the importance of an integral approach to safety, encompassing both operational planning and runway suitability evaluation.

While Runway 22 at Amsterdam Airport Schiphol is structurally capable of accommodating the landing of an Airbus A330, the configuration of the instrument landing system (ILS) and precision approach path indicator (PAPI) system offers insufficient threshold crossing clearance for large and long aircraft. The ILS and PAPI do not meet ICAO and EASA standards for Eye-to-Wheel Height Category 4 aircraft. The minimum eye height over the threshold (MEHT) is published in the aeronautical information publication (AIP), giving operators the opportunity to assess whether the runway is suitable for landing with their aircraft. However, the continued use of the runway by Eye-to-Wheel Height Category 4 aircraft of other operators is evidence that the risk of crossing the runway threshold at a low altitude is not sufficiently mitigated.

The Dutch Safety Board therefore makes the following recommendation:

To Amsterdam Airport Schiphol:

Restrict the use of Runway 22 for Eye-to-Wheel Height Category 4 aircraft landings, until adjustments have been made to ensure the minimum threshold clearance for such aircraft can be achieved.

The Dutch Safety Board published the [report](#) on 21 November 2024.

**Classification:** Serious incident

**Reference:** 2023005

## Statement of facts

### Landing with centre of gravity located aft, Saab 340B, N417XJ

Bonaire International Airport, 11 October 2022

The aircraft, with 38 occupants, was flying from Curaçao International Airport (TNCC) to Bonaire International Airport (TNCB). Just before departure, extra baggage was loaded into the hold that was not included in the aircraft's weight and balance calculation. After touchdown, the nose of the aircraft would not lower; the pilot then braked hard to get the nose on the ground after all. Once the aircraft has come to a standstill on the apron, the thermal fuses of the tyres melted due to overheating of the brakes, after which the tyres deflated.

Analysis showed that the aircraft had had its centre of gravity located aft, just at the edge of the flight envelope. When landing at or near the aft centre of gravity limit, no upward movement of the aircraft's nose is introduced. A simulation showed that when the Beta range<sup>2</sup> is selected with the throttle levers before the nose wheel is on the ground, the nose of the aircraft will pitch up aggressively. This movement requires that the yoke be pushed forward forcefully together with prompt forward power application so as to lower the pitch attitude and bring the nose wheel back to the ground.

The Curaçao Civil Aviation Authority published the [report](#) on 18 December 2024.

**Classification:** Incident

**Reference:** 2022151

<sup>2</sup> In the Beta range, forward or backward movements of the throttle levers directly control the angle of the propeller via a mechanical clutch.

## Runway excursion, Groupe Daher Aerospace TB 9, PH-AIS

Lelystad Airport, 31 May 2024

The TB 9 left Lelystad Airport (EHLE) at 15.15 hours for a VFR cross-country flight. Upon its return, the aircraft experienced wind gusts during landing at around 16.35 hours. As a result, the pilot lost control of the aircraft and its right wing tip struck the runway. The aircraft ended up next to the runway and the wing tip was slightly damaged. The pilot and his passenger were unharmed.

At 16.00 hours, a trough<sup>3</sup> was situated from Zeeland to Overijssel, moving south over Lelystad Airport between 16.00 and 17.00 hours. There were clustered rain showers in the trough, sometimes with thunderstorms. At the time of the occurrence, the most active of these showers were 5 to 10 km south of the airport.

On his return, the pilot noticed that while flying an orbit at point X-RAY and on downwind for Runway 05, the wind speed increased, resulting in noticeable oscillation of the aircraft. After the aircraft turned on final, the air traffic controller gave the pilot clearance for landing, also providing the current wind readings. The wind was from 350 degrees at a speed of 15 knots, with gusts of up to 26 knots. Because of the wind, the pilot flew the approach at a slightly higher speed.

According to the pilot, the crosswind on final required extra attention so as to keep the aircraft aligned with the centreline of the runway. A gust of wind just after landing threatened to tip the aircraft over, causing the right wing tip to strike the runway. To keep all the aircraft's wheels on the ground, the pilot then applied one of the brakes. The aircraft straightened up again but the pilot was unable to prevent it from leaving the runway. The runway excursion was only brief. The pilot was able to rejoin the runway and continue to the parking area via Taxiway S4 without any problems.

**Classification:** Serious incident

**Reference:** 2024109



▲ The damaged wing tip. (Source: flying school)

<sup>3</sup> A trough is an elongated region of low atmospheric pressure and is an extension of a low-pressure area. In a trough, the isobars (i.e. the lines of equal atmospheric pressure) are usually close together. The closer they are together, the stronger the wind.

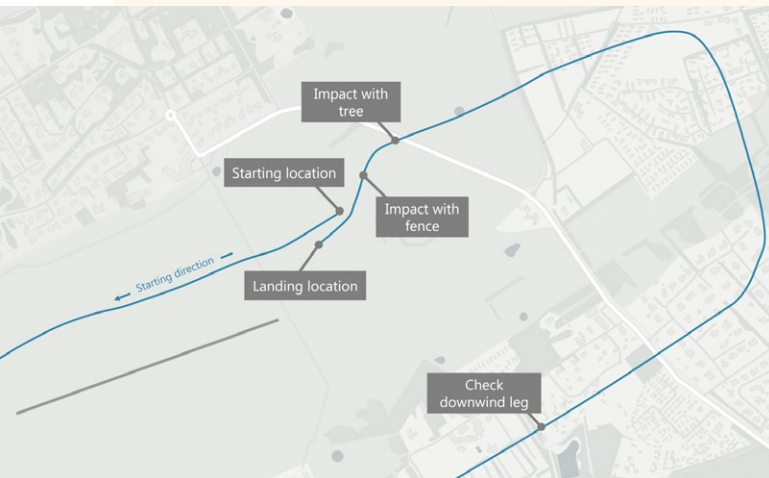
## Glider strikes tree and fence on final, Alexander Schleicher ASK 21, PH-1337

Haamstede glider airfield, 9 June 2024

On short final, the glider's left wing was badly damaged after striking a tree and a fence. The student pilot then landed the glider safely.

At 14.47 hours, a soloist took off in a two-seater glider, type Alexander Schleicher ASK 21, from Runway 24 by means of a winch launch. This was the student's first solo flight from Haamstede glider airfield. The club of which he was a member was a guest of the gliding club at Haamstede glider airfield that day. Two of his club's instructors were present, one of whom was designated to take charge of the host club. The wind on the ground was from the west at 17 knots, with gusts of up to 23 knots. Earlier that day, the student had performed a check start with an instructor in the ASK 21. Based on that flight, the instructor had given approval for the solo flight.

▼ *Flight path (Source: igc-data)*



After a short flight of about 5 minutes, the pilot flew a left-hand circuit. On final, he closed the airbrakes as far as the locking mechanism. The pilot felt he was continuing to descend fast and that the aircraft was starting to stall. At low altitude, he reduced the pitch attitude of the aircraft, after which the left wing struck the top of a tree. As a result, the glider yawed to the left and its left wing struck a wooden post that formed part of the glider airfield's barbed wire fence. The glider flew towards the take-off point and the gliders that were parked there. The pilot made a turn and landed the aircraft to the southwest of the take-off point. The left wing was badly damaged. The pilot was unharmed.

The student's total flying experience comprised 109 take-offs with an instructor (16 hours) and 7 solo flights (1 hour).

Below the final of Runway 24 there is a public road with a number of trees on both its west and east sides. During the morning briefing on the day prior to the accident, the duty instructor had explicitly pointed this out; he had advised flying on final with enough altitude and not coming in too flat. During the morning briefing on the day of the accident, the presence of the trees was not explicitly mentioned.

The Safety Team of the gliding club (which owns the ASK 21) investigated the occurrence and shared its investigation report with the Dutch Safety Board.

**Classification:** Accident

**Reference:** 2024097

## Runway excursion during take-off, APEX Aircraft DR 400/140 B, PH-SVT

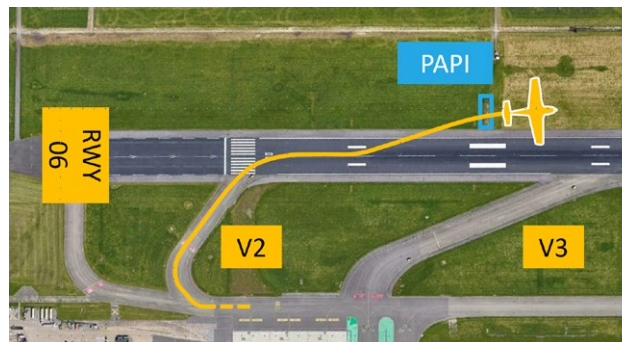
Rotterdam The Hague Airport, 19 June 2024

The pilot wanted to make a flight in the DR 400 from Rotterdam The Hague Airport (EHRD) to Breda International Airport (EHSE) to practice landings. During the take-off roll from Runway 06 on EHRD, the aircraft veered off the left side of the runway. This caused the aircraft to hit a Precision Approach Path Indicator (PAPI), resulting in damage to the left wing and the PAPI. The pilot was uninjured.

The pilot stated that after the run-up, he received permission to line up and wait on Runway 06 from holding point V2. The pilot taxied calmly to the runway, because a business jet took-off approximately 2 minutes earlier. During the taxi, the pilot received clearance for take-off. Together with the clearance, the pilot was informed about the wind: 360°, 14 knots and wind gusts till 19 knots. The pilot lined up on Runway 06 and stopped. The pilot did not feel wake turbulence from the business jet and he assumed that this would have been blown away by the crosswind.



▲ The PAPI after the runway excursion. (Source: Rotterdam The Hague Airport)



▲ Situation sketch. (Source: Google Earth edited by Dutch Safety Board)

The pilot repeated to himself 'Runway 06 identified, possible crosswind from the left, stick into the wind' and selected full power. The pilot stated that he expected to have to give a lot of right rudder, but it was not that bad. The airspeed increased and suddenly the pilot noticed that the aircraft was moving to the left side of the runway. The pilot did not remember any (roll) movement of the aircraft. He tried to correct the direction of the aircraft. The aircraft hit the PAPI and the aircraft stopped in the grass on the north side of the runway across the Taxiway V3.

The pilot stated after the occurrence that he did not remember the wind that was mentioned during the clearance and that he was surprised by the direction and speed of the wind.

**Classification:** Accident

**Reference:** 2024104

## Hard landing after engine failure exercise, Sportavia-Pützer GmbH & Co. KG SF 25 B, PH-826

Hilversum Airfield, 11 July 2024

A Touring Motor Glider (TMG) – with a student and an instructor on board – took off from Hilversum Airfield’s Runway 25 for a training flight at about 17.45 hours. Shortly after lift-off, the instructor simulated an engine failure (EFATO)<sup>4</sup> by returning engine power to idle. The instructor’s intention during the EFATO was for the student to land the aircraft on the remaining part of the runway. During the exercise, the aircraft stalled. Despite the nose down manoeuvre that the instructor performed, the aircraft failed to recover from the stall in time. It came down hard on the runway and was badly damaged. The two occupants remained unharmed.

During his flight training, the student had flown about 40 hours and had practised the EFATO exercise regularly. This was the first time that he was supposed to land the aircraft on the remaining part of the runway. During his training, the student had completed most of his flying hours and all his solo hours in a different TMG of the same type. That other TMG had better engine performance, enabling the post-take-off climb to be flown with a higher pitch attitude. During the accident flight, the student may have adopted the pitch attitude that he was used to in the other TMG. The aircraft stalled due to the combination of a high pitch attitude and the reduction in the power of its engine. The TMG was not equipped with a stall warning system.

▼ The damaged SF 25 B. (Source: student)



According to the *Pilot's Operating Handbook*, it is only a weight calculation that is required and not a centre of gravity calculation. The student had carried out a weight calculation prior to the flight, which had shown that the take-off weight was within the limits.

**Classification:** Accident

**Reference:** 2024124

<sup>4</sup> Engine Failure After Take-off.

## Wing damage during outlanding, Alexander Schleicher GmbH & Co ASW 28 B, PH-1692

Beemte Broekland, 15 July 2024

The glider took off from glider field Terlet (EHTL) for a cross-country flight to Smilde and back. On the return journey, the pilot found insufficient thermals to reach Terlet, so she decided to divert to Teuge Airport. The pilot unsuccessfully searched for this airport and subsequently found herself at such a low altitude that she was forced to make an outlanding in a field near Beemte Broekland.

The pilot flew over the outlanding field to assess its suitability. The field appeared suitable, so the pilot continued the circuit to land there. She stated that she turned onto final too quickly because she thought she was flying too low. On final approach, the pilot then felt she was flying too high and

initiated a slip approach. According to the pilot, the slip approach was not executed in a coordinated manner, causing the glider to drift and land on the left side of the field, near a ditch.

During the landing, the left wing struck a wooden pole, which was in the tall grass beside the ditch and had not been noticed by the pilot. The glider then ground-looped and came to a stop. The pilot was uninjured. The left wing was substantially damaged.

The licensed pilot had a total gliding experience of 341 launches, 26 of which were on the ASW 28 B, and 75 hours as pilot-in-command, of which approximately 15 hours were on the ASW 28 B.

**Classification:** Accident

**Reference:** 2024129

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





## Runway incursion, Robinson R44, F-HIBT

Hilversum Airfield, 15 July 2024

During a touch-and-go by a Katana DV 20, a Robinson R44 helicopter had entered the runway and started its take-off. The pilot of the DV 20 made an evasive manoeuvre at low altitude to avoid a collision with the R44.

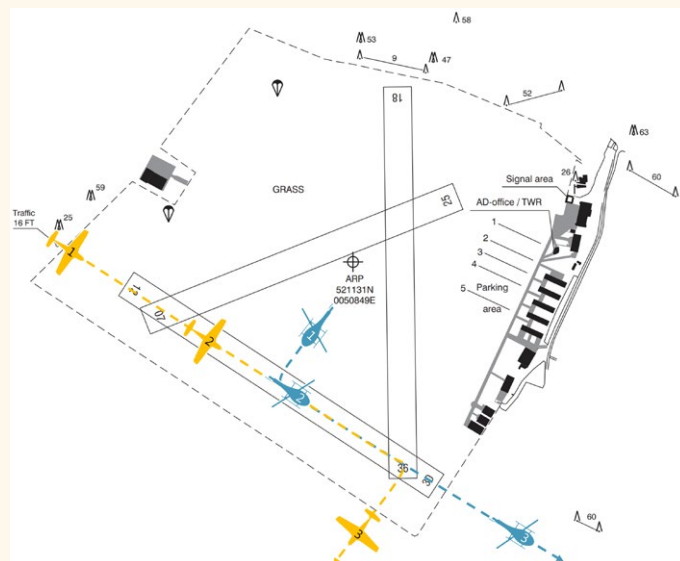
During a local flight from Hilversum airfield, the pilot of a Katana DV 20 flew several traffic circuits. The DV 20 was established on final for Runway 12; in front of it flew a Cessna 172. After the Cessna 172 had made a touch-and-go, the pilot of the DV 20 reported on the frequency of Hilversum radio that he is going to make a touch-and-go (situation 1 in figure). Due to the warm temperature (24 °C), a crosswind (160/08) and the presence of tall trees and lampposts aligned with Runway 12, the pilot of the DV 20 performed an immediate go-around after the initial touchdown. Directly thereafter, the R44 helicopter lined up for an immediate departure halfway down the runway, directly ahead of the DV 20 at approximately the same altitude. The pilot of the DV 20 then noticed the R44 and estimated the distance between the two aircraft to be about 200 metres (situation 2 in figure). Already airborne and with little runway remaining, the DV 20 pilot could not abort the go-around. The pilot of the DV 20 reported his position on the Hilversum radio frequency, after which the pilot of the R44 apologized and continued his take-off. Concerned about the trees ahead and potential rotor wash, the DV 20 pilot executed a 90-degree right turn with 60 knots at low altitude (situation 3 in figure). The pilot reported on the frequency that he was making an evasive manoeuvre. Both pilots continued their flight without further incident following another apology from the R44 pilot on the radio.

The R44 was performing a flight for the survey of gas pipelines. The pilot of it reported that he lined up in the middle of the runway at a speed of over 60 kts and increased speed to 80 kts and took off immediately. He had not heard the DV 20 on the radio, but had seen it and was of the opinion that the separation was sufficient to take off first. After take-off, he made a right turn and left the traffic pattern at the beginning of downwind to follow a pipeline.

**Classification:** Serious incident

**Reference:** 2024143

▼ *Situation sketch. (Source: AIP the Netherlands, modified by Dutch Safety Board)*



## Injured by burner flame, Balóny Kubicek spol. s r.o. BB100Z, PH-PAF

Woerden, 17 July 2024

Around 19.00 hours, passengers, pilot and crew gathered for a hot air balloon flight from the event location in Woerden. During the pre-flight preparations for this flight, the pilot became injured by a burner flame from one of the burners. This report is based on the statements of the pilot.

The pilot worked according a pre-flight checklist. The crew and the pilot, together with the passengers, offloaded the basket from the trailer and the pilot checked the gas bottles and brought them on board. After that, the pilot connected the tubes and verified that there was no leakage. The pilot set the navigation and altimeter and mounted these in the basket.

The pilot informed passengers and bystanders that he would test the burners so that they would not be startled by the noise and heat. After that, the pilot performed the burner test to verify if the burners were working correctly and to read the gas pressure on the pressure gauge. During the burner test, the pilot was standing in the basket, right under the red burners. The pilot ignited the pilot light of burner 1 and after that the main valve was opened and liquid gas ignited. However, the red transport cover was still over the burners, pushing some of the liquid gas down and igniting it. Due to the pressure of the gas, the transport cover flew off the burners. The pilot released the valve and dove away. Nevertheless, the pilot suffered first and possibly second degree burns to the face caused by the burner flame and received medical treatment.

The removal of the burner cover was not part of the pre-flight checklist. Normally the pilot or a crew member, dependent on who thinks of it first, removes the burner cover. The pilot stated that he asked for a transponder while performing his checks. A crew member brought this to him. As a result the pilot was distracted and therefore he performed the burner test without removing the burner cover.

The pilot states that the balloon company has the intention to change the burner cover, such that both the burners and valves are covered and to adjust the risk analysis at the end of the balloon season.

**Classification:** Accident

**Reference:** 2024131



▲ Red transport cover over the red burners.  
(Source: Pilot)



▲ Grey transport cover over red burners and valves.  
(Source: Pilot)

# Completed investigations (abroad)

## Runway excursion, Fokker F28 Mk 0070, 5Y-MMB

Wilson Airport (Kenya), 26 March 2024

After landing on Runway 07 at Wilson Airport (HKNW), the crew intended to turn the aircraft 180 degrees and then taxi to a taxiway. While turning, the Fokker 70 left the runway and came to a standstill with its nose wheel in the grass. The three occupants were unharmed. The width of the runway (24 metres) was sufficient to perform the planned manoeuvre; for the Fokker 70, the minimum required width for this is 18.87 metres.



▲ The Fokker 70 after the runway excursion. (Source: Aircraft Accident Investigation Department, Kenya)

The Safety Board received the investigation report from the Kenya Aircraft Accident Investigation Department on 28 November 2024.

**Classification:** Serious incident

**Reference:** 2024038

## Passenger dragged during landing, Balóny Kubicek spol. s r.o., BB85Z, PH-GVL

Mourão, Évora (Portugal), 28 April 2024

The Netherlands-registered hot-air balloon, with a pilot and 13 passengers on board, took off from a field near Monsaraz. After a flight of about an hour and a half, the pilot began the final descent with the intention of finding a suitable landing site. The pilot attempted to land the balloon before it reached the bank of a river. However, the balloon landed in shallow water. The pilot asked two or three men if they would leave the basket so as to pull it ashore. Two men prepared to do so, but ultimately only one of them left the basket and jumped into the water. Shortly after that, the balloon rose again. The pilot attempted, unsuccessfully, to land the balloon on the other side of the river. He finally succeeded in landing the balloon safely more than half an hour later. The passenger who had left the basket was later found dead in the water.

The Portuguese GPIAAF<sup>5</sup> published the [report](#) on 30 December 2024.

**Classification:** Incident

**Reference:** 2024201

▼ Archive photo PH-GVL. (Source: José António Martins © 2025)



5 Gabinete de Prevenção e Investigação de Acidentes com Aeronaves e de Acidentes Ferroviários.



## 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.

March 2025

### 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?

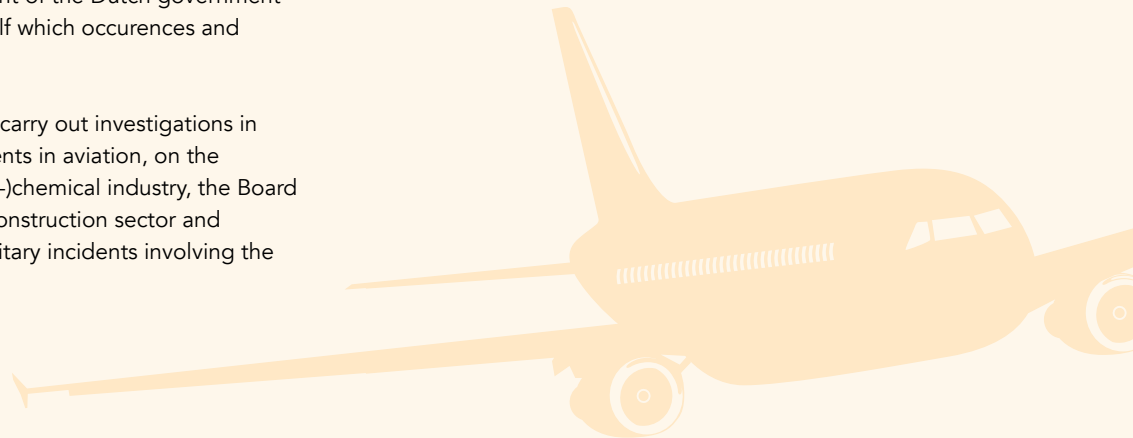
The Dutch Safety Board is independent of the Dutch government and other parties and decides for itself which occurrences and topics will be investigated.

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).