PRESS RELEASE
28 January 2014

Air Accident Investigation Unit (AAIU)
Department of Transport, Tourism and Sport (DTTAS)

Publication of AAIU Final Report No. 2014-001
Accident to SA 227-BC Metro III EC-ITP at Cork Airport on 10 February 2011

The AAIU has published its Final Report into the fatal public transport accident that occurred at Cork Airport in February 2011. The AAIU recognises that this is a difficult time for those families who lost loved ones and the surviving passengers who suffered injuries in this tragic accident. Our deepest sympathies to all concerned.

This particular Investigation was the most challenging of the more than 500 Investigations that have been completed by the Unit since its formation in 1994. The complexity of the accident sequence, examination of components at overseas locations, the international dimension of the Operation including the intricate relationship between the various agencies and associated undertakings, translation of technical documents and natural justice obligations determined the time taken to finalise this Report. The AAIU wishes to acknowledge the patience and understanding shown by all affected families while the Unit fulfilled its legal obligation to complete a detailed and independent safety investigation.

The aircraft, a Fairchild SA 227-BC Metro III registered in Spain as EC-ITP, was operating a scheduled commercial air transport flight from Belfast City to Cork with two Flight Crew members and ten passengers on board. The flight involved three separate undertakings; the Operator which held a Spanish Air Operator Certificate (AOC), a Ticket Seller based in the Isle of Man, and a Spanish company which supplied the aircraft and flight crew under an agreement with the Ticket Seller.

At 09.50 hrs while on the third approach to Cork in low visibility conditions, control of the aircraft was lost during an attempted go-around. The aircraft impacted the runway surface, inverted and came to rest in soft ground to the right of the runway. Post impact fires occurred in both engines which were expeditiously extinguished by the Airport Fire Service. Six persons, including both pilots, were fatally injured. Four passengers were seriously injured and two received minor injuries.

The Investigation determined that the probable cause was 'Loss of control during an attempted go-around initiated below Decision Height (200 feet) in Instrument Meteorological Conditions'.

The Investigation identified the following factors as being significant:

- The approach was continued in conditions of poor visibility below those required.
- The descent was continued below the Decision Height without adequate visual reference being acquired.
- Uncoordinated operation of the flight and engine controls when go-around was attempted.

- The engine power-levers were retarded below the normal in-flight operational range, an action prohibited in flight.
- A power difference between the engines became significant when the engine power levers were retarded below the normal in-flight range.
- Tiredness and fatigue on the part of the Flight Crew members.
- Inadequate command training and checking.
- Inappropriate pairing of Flight Crew members, and
- Inadequate oversight of the remote Operation by the Operator and the State of the Operator.

Systemic deficiencies at the operational, organisational and regulatory levels were also identified by the Investigation. Such deficiencies included pilot training, scheduling of flight crews, maintenance and inadequate oversight of the operation by the Operator and the State of Registration.

In accordance with the Investigation's objective of preventing future accidents and incidents, a total of 11 Safety Recommendations have been made to various entities as follows:

- Four are made to the European Commission Directorate responsible for Commercial Air Transport regarding Flight Time Limitations, the role of the ticket seller, the improvement of safety oversight and the oversight of Operating Licences.
- Three are made to the European Aviation Safety Agency (EASA) regarding the number of successive instrument approaches that can be conducted to an aerodrome in certain meteorological conditions, the syllabus for appointment to Commander and the process by which Air Operator Certificate (AOC) variations are granted.
- Two are made to the Operator, Flightline S.L., regarding its operational policy and training.
- One is made to *Agencia Estatal de Seguridad Aérea* (AESA), the Spanish Civil Aviation Regulatory Authority, regarding oversight of air carriers.
- One is made to the International Civil Aviation Organization (ICAO), regarding the inclusion of the approach capability of aircraft/flight crew on flight plans.

The sole objective of AAIU investigations is the prevention of aviation accidents and serious incidents. It is not the purpose of any such investigation and the associated investigation report to apportion blame or liability. A safety recommendation shall in no case create a presumption of blame or liability for an occurrence.

The full text of the Final Report 2014-001 is available on the AAIU website at www.aaiu.ie

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