CIVIL AVIATION AUTHORITY OF NEW ZEALAND
Te Mana Rererangi Tūmatanui o Aotearoa

Safety Investigation Brief

Landing Accident on Waitemata Harbour

Summary of occurrence

The amphibious floatplane landed on the Auckland Harbour water aerodrome and tipped over during the landing. It remained afloat but inverted, supported only by its floats (refer Figure 1). The pilot in command was the only person on board.

The aircraft was being re-positioned from Ardmore Aerodrome. Observers on the ground at the aerodrome noticed that the aircraft's wheels were not retracted after take-off.

Observers in the vicinity of the Auckland Harbour water aerodrome also noted that the aircraft's wheels were down during its approach and landing.

The pilot in command had extensive float plane experience from Canada and was working in New Zealand during the Canadian winter season.

The pilot omitted to raise the wheels after take-off from Ardmore Aerodrome and did not use the required cockpit checklist when executing the flight. He instead relied on his memory to carry out the various checks.

Aircraft checklists are designed to ensure pilots and aircrew safely manage their flights. Civil Aviation Rule 135.63 below details those requirements.

135.63 Cockpit check

(a) Each holder of an air operator certificate shall, for each air operation, ensure that flight crew members have available for use a cockpit checklist covering the procedures, including emergency procedures, for the operation.

(b) Each person performing an air operation shall establish and use an appropriate practice for cockpit checks covering the procedures, including emergency procedures, for the operation of the aircraft in accordance with the aircraft flight manual.

Figure 1. Inverted floatplane showing wheels extended.

Administrative information

<table>
<tr><td colspan="2">Aircraft manufacturer and model</td><td>De Havilland Canada – DH-2 Beaver Mk 1</td></tr>
<tr><td colspan="2">Engine manufacturer and model</td><td>Pratt and Whitney R-985</td></tr>
<tr><td colspan="2">Registration</td><td>ZK-WKA</td></tr>
<tr><td colspan="2">Location of incident</td><td>Waitemata Harbour, near Westhaven Marina Auckland</td></tr>
<tr><td colspan="2">Date and time of incident</td><td>1 March 2019 10:48 NZDT</td></tr>
<tr><td colspan="2" rowspan="2">Flight rules applying</td><td>Commercial ☒</td></tr>
<tr><td>Visual (VFR) ☒</td></tr>
<tr><td colspan="2">Occurrence number</td><td>19/1307</td></tr>
<tr><td rowspan="3">Injuries</td><td>Crew</td><td>0</td></tr>
<tr><td>Passengers</td><td>0</td></tr>
<tr><td>Others</td><td>0</td></tr>
</table>

Pilot information

Age and gender		31, Male
Pilot licences		CPL (A). Issued in Canada
Pilot ratings		DHC-2 Float plane and Amphibian, Cessna 172
Flying experience (hours)	Total helicopter	n/a
	Total fixed wing (all)	1,189.20
	With this aircraft type	Pure Floats 872.50 Amphibian 122.70
	In last 7 days - DHC-2	Pure Floats 10.00 Amphibian 5.10
	In last 90 days - DHC-2	Pure Floats 134.30 Amphibian 46.7

Meteorological information and flight plan

Conditions at incident site	Wind (knots)	Estimated 8 knots South-Westerly
	Visibility (metres)	Unlimited
Departure point		Ardmore Aerodrome
Destination		Auckland Harbour Water Aerodrome

Wreckage and impact information

Aircraft damage	Major damage - due to salt water immersion	
Aircraft recovered?	Yes ☒	
Location	Approximately 36°50'1.56"S 174°45'26.12"E	

About the CAA

New Zealand's legislative mandate to investigate an accident or incident are prescribed in the Transport Accident Investigation Commission Act 1990 (the TAIC Act) and Civil Aviation Act 1990 (the Act).

Following notification of an accident or incident, TAIC may conduct an investigation. CAA may also investigate subject to Section 72B(2)(d) of the Act which prescribes the following:

> **72B Functions of Authority**
>
> (2) The Authority has the following functions:
>
> (d) To investigate and review civil aviation accidents and incidents in its capacity as the responsible safety and security authority, subject to the limitations set out in section 14(3) of the Transport Accident Investigation Commission Act 1990

A CAA safety investigation seeks to provide the Director of the CAA with the information required to assess which, if any, risk-based regulatory intervention tools may be required to attain CAA safety objectives.

About this safety investigation brief

The purpose of this brief is to identify to the aviation community:

- what happened
- factors contributing to the accident
- any relevant safety messages.

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