



Australian Government

Australian Transport Safety Bureau

Wheels up landing involving a Cessna 337F, VH-JUP

Exmouth (ALA), Western Australia, 25 February 2013

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Addendum

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Wheels up landing involving a Cessna 337F, VH-JUP

What happened

On 25 February 2013, a Cessna 337F (337) aircraft, registered VH-JUP (JUP), was chartered to fly three passengers from the Exmouth aeroplane landing area (ALA) to Onslow, Western Australia in the morning and back to Exmouth in the late afternoon. The flight to Onslow was without incident.

At about 1730 Western Standard Time,¹ JUP departed Onslow for the 30 minute flight to Exmouth. The front seat passenger and the pilot conversed for most of the flight.

When on a 5 NM final for runway 20, the pilot of JUP commenced pre-landing actions by extending the first stage of flap. The pilot later reported that this was where she normally lowered the landing gear, but could not recall why this action was missed.

About 1 NM from landing, as the pilot was about to commence the final pre-landing checks, she asked the front seat passenger to assist by scanning the airstrip for animals that might pose a problem for the landing. Again, the pilot could not recall why she had not checked that the landing gear was down, as part of the final pre-landing checks.

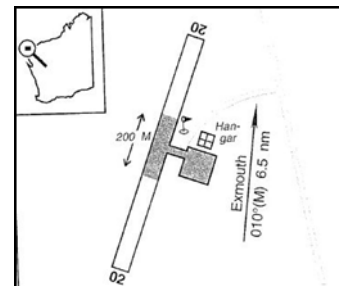
At 1800, the pilot commenced the flare² about 3 ft above the runway and as the aircraft touched down, the pilot realised that the landing gear had not been selected down. The pilot reported that the landing gear warning horn did not sound until the aircraft had come to a stop, about 200 m from where JUP first made contact with the runway.

The passengers and pilot exited the aircraft without injury. The fiberglass cargo pod (Figure 1) fitted to the aircraft was damaged. The aircraft hull was undamaged; however, the rear propeller contacted the ground.

The pilot noted that she regularly flew a number of different aircraft types, some with fixed and some with retractable landing gear.

As a result of this occurrence, the pilot advised that when at least 5 NM on final, she will ask the passengers not to speak to her, except to alert her to the presence of animals on the runway.

Exmouth (ALA)



Source: FlightAce

¹ Western Standard Time (WST) was Coordinated Universal Time (UTC) + 8 hours.

² Flare: Final nose-up pitch of a landing aircraft to reduce the rate of descent close to zero at touch-down.

Figure 1: A Cessna 337 with cargo pod fitted



Source: Operator

Safety message

The sterile cockpit rule, where pilots refrain from performing non-essential activities and conversations during critical phases of flight, including taxiing, takeoff and landing, assists in ensuring that crucial information is not missed or misinterpreted. By explaining the sterile cockpit rule in their pre-flight brief, pilots can give passengers an awareness of the importance of minimising discussions, questions, and conversation during these phases of flight. The following websites provide additional information on sterile cockpits:

- www.aopa.org/asf/asfarticles/sp0006.html
- [www.skybrary.aero/index.php/Sterile_Flight_Deck_\(OGHFA_BN\)](http://www.skybrary.aero/index.php/Sterile_Flight_Deck_(OGHFA_BN))

Civil Aviation Safety Authority (CASA) Civil Aviation Advisory Publication (CAAP) 215-1 (1) *Guide to the preparation of Operations Manuals* provides guidance on the preparation and contents of an Operations Manual for flight operations, including advice on where to include the company policy on the phases of flight that require a sterile cockpit. The CAAP is available at:

www.casa.gov.au/scripts/nc.dll?WCMS:STANDARD::pc=PC_91054

General details

Manufacturer and model:	Cessna Aircraft Company 337F	
Registration:	VH-JUP	
Type of operation:	Charter	
Occurrence category:	Serious incident	
Primary occurrence type:	Wheels up landing	
Location:	Exmouth ALA, Western Australia	
	Latitude: 22° 02.48' S	Longitude: 114° 06.13' E
Persons on board:	Crew – 1	Passengers – 3
Injuries:	Crew – Nil	Passengers – Nil
Damage:	Minor	

About the ATSB

The Australian Transport Safety Bureau (ATSB) is an independent Commonwealth Government statutory agency. The Bureau is governed by a Commission and is entirely separate from transport regulators, policy makers and service providers. The ATSB's function is to improve safety and public confidence in the aviation, marine and rail modes of transport through excellence in: independent investigation of transport accidents and other safety occurrences; safety data recording, analysis and research; and fostering safety awareness, knowledge and action.

The ATSB is responsible for investigating accidents and other transport safety matters involving civil aviation, marine and rail operations in Australia that fall within Commonwealth jurisdiction, as well as participating in overseas investigations involving Australian registered aircraft and ships. A primary concern is the safety of commercial transport, with particular regard to fare-paying passenger operations.

The ATSB performs its functions in accordance with the provisions of the *Transport Safety Investigation Act 2003* and Regulations and, where applicable, relevant international agreements.

The object of a safety investigation is to identify and reduce safety-related risk. ATSB investigations determine and communicate the safety factors related to the transport safety matter being investigated.

It is not a function of the ATSB to apportion blame or determine liability. At the same time, an investigation report must include factual material of sufficient weight to support the analysis and findings. At all times the ATSB endeavours to balance the use of material that could imply adverse comment with the need to properly explain what happened, and why, in a fair and unbiased manner.

About this report

Decisions regarding whether to conduct an investigation, and the scope of an investigation, are based on many factors, including the level of safety benefit likely to be obtained from an investigation. For this occurrence, a limited-scope, fact-gathering investigation was conducted in order to produce a short summary report, and allow for greater industry awareness of potential safety issues and possible safety actions.