



AIRCRAFT ACCIDENT

FINAL REPORT

A 10/25

Air Accident Investigation Bureau (AAIB)

Ministry of Transport, Malaysia

Fixed Wing Aircraft PIPER PA28-181 Archer III, Registration 9M-SKR

at Sultan Abdul Aziz Shah Airport, Subang

on 18 November 2025



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FINAL REPORT A 10/25

AIR ACCIDENT INVESTIGATION BUREAU (AAIB) MALAYSIA

REPORT NO.: A 10/25

OPERATOR : MALAYSIAN FLYING ACADEMY
AIRCRAFT TYPE : PIPER PA 28-181 ARCHER III
AIRCRAFT NATIONALITY : MALAYSIA
REGISTRATION : 9M-SKR
**PLACE OF OCCURRENCE : SULTAN ABDUL AZIZ SHAH AIRPORT,
SUBANG**
DATE AND TIME : 18 NOVEMBER 2025 AT 1250LT

The sole objective of the investigation is the prevention of accidents and incidents. In accordance with Annex 13 to the Convention on International Civil Aviation, it is not the purpose of this investigation to apportion blame or liability.

All times in this report are Local Time (LT) unless stated otherwise. LT is UTC +8 hours.

FINAL REPORT A 10/25

INTRODUCTION

The Air Accident Investigation Bureau (AAIB) is the air accident and serious incident investigation authority in Malaysia and is responsible to the Minister of Transport. Its mission is to promote aviation safety through the conduct of independent and objective investigations into air accidents and serious incidents.

The AAIB conducts these investigations in accordance with Annex 13 to the Chicago Convention, the Civil Aviation Act of Malaysia 1969, and the Civil Aviation Regulations of Malaysia 2016.

It is inappropriate that AAIB reports should be used to assign fault or blame or determine liability since neither the investigations nor the reporting processes have been undertaken for that purpose.

In accordance with ICAO Annex 13 paragraph 4.1, notification of this accident was sent out on 20 November 2025 to the National Transportation Safety Board (NTSB) of the United States of America as the State of Design and Manufacture. A copy of the Preliminary Report was subsequently submitted to the NTSB, the Civil Aviation Authority of Malaysia (CAAM), and the aircraft operator on 18 December 2025.

In accordance with ICAO Annex 13 paragraph 6.3, a copy of the Draft Final Report was sent on 17 July 2026 to the NTSB, the CAAM, and the aircraft operator, inviting their significant and substantiated comments on the report.

Unless otherwise indicated, recommendations in this report are addressed to the investigating or regulatory authorities of the State having responsibility for the matters with which the recommendations are concerned. It is for those authorities to decide what action is to be taken.

TABLE OF CONTENTS

CHAPTER		TITLE	PAGE NO
		TABLE OF CONTENTS	iii
		ABBREVIATIONS	iv
		SYNOPSIS	1
1.0		FACTUAL INFORMATION	2
	1.1	History of the Flight	2
	1.2	Injuries to Persons	3
	1.3	Damage to Aircraft	3
	1.4	Other Damage	7
	1.5	Personal Information	8
	1.6	Aircraft Information	8
	1.7	Meteorological Information	11
	1.8	Aids to Navigation	11
	1.9	Communications	11
	1.10	Aerodrome Information	11
	1.11	Flight Recorders	12
	1.12	Wreckage and Impact Information	12
	1.13	Medical and Pathological Information	13
	1.14	Fire	13
	1.15	Survival Aspects	13
	1.16	Tests and Research	13
	1.17	Organisational and Management Information	13
	1.18	Additional Information	14
	1.19	Useful or Effective Investigation Techniques	15
2.0		ANALYSIS	16
	2.1	Aircraft and Mechanical Considerations	16
	2.2	Meteorological and Aerodrome Factors	16
	2.3	Landing Sequence and Technical Mechanism	17
	2.4	Human Performance Considerations	17
	2.5	Organisational Factors	18
3.0		CONCLUSIONS	18
	3.1	Findings	18
	3.2	Cause/Contributing Factor	19
4.0		SAFETY RECOMMENDATIONS	20
	4.1	Immediate Safety Actions of the Preliminary Report	20
	4.2	Safety Recommendations of this Report	20
5.0		COMMENTS TO THE REPORT AS REQUIRED BY ICAO ANNEX 13 PARAGRAPH 6.3	22

ABBREVIATIONS

A

AAIB	Air Accident Investigation Bureau
AFRS	Airport Fire and Rescue Services
AOC	Air Operator's Certificate
ATC	Air Traffic Controller
ATO	Approved Training Organisation
ATPL	Airline Transport Pilot Licence

C

CAAM	Civil Aviation Authority of Malaysia
CFI	Chief Flying Instructor
CoA	Certificate of Airworthiness
CoR	Certificate of Registration
CPL	Commercial Pilot Licence
CVR	Cockpit Voice Recorder

F

FDR	Flight Data Recorder
ft	feet

I

IR	Instrument Rating
----	-------------------

L

LDA	Landing Distance Available
LT	Local Time

M

METAR	Meteorological Aerodrome Report
MOR	Mandatory Occurrence Report

R

RA	Radio Altimeter
RPM	Revolutions Per Minute

S

STRIDE	Science and Technology Research Industry of Defence
SP	Student Pilot

U

UTC	Coordinated Universal Time
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W

WMKJ	Senai International Airport
WMKM	Malacca International Airport
WMSA	Sultan Abdul Aziz Shah Airport, Subang

FINAL REPORT A 10/25

SYNOPSIS

On 18 November 2025, a Piper PA-28-181 Archer III aircraft, registration 9M-SKR, operated by a student pilot on a solo long navigation training flight, was involved in an occurrence at Sultan Abdul Aziz Shah Airport, Subang (WMSA). The flight comprised multiple sectors, with the earlier sectors completed without incident.

During a touch-and-go landing on Runway 15 at WMSA, shortly after touchdown during a touch-and-go manoeuvre, the nose landing gear collapsed following a loud noise, consistent with excessive loading during the landing phase. The aircraft veered to the right and came to a stop on the runway edge. The student pilot was uninjured and exited the aircraft without assistance. The Airport Fire and Rescue Services attended the scene, and the pilot was later transported to the hospital as a precaution. The aircraft sustained damage to the nose landing gear and propeller.

The Aircraft Operator submitted a Mandatory Occurrence Report (MOR) to the Civil Aviation Authority of Malaysia (CAAM), followed by a notification of the occurrence submission to the Air Accident Investigation Bureau, Malaysia (AAIB), and an investigation team was dispatched to the crash site on the same day.

1.0 FACTUAL INFORMATION

1.1 History of the Flight

On 18 November 2025, a Piper PA-28-181 Archer III aircraft, registration 9M-SKR, operated with a student pilot (SP), was scheduled to conduct a solo long navigation flight of approximately five hours. The planned flight comprised four sectors. The first two sectors were from Malacca International Airport, Melaka (WMKM) to Senai International Airport, Johor Bahru (WMKJ), and return to WMKM. The remaining two sectors were from WMKM to Sultan Abdul Aziz Shah Airport, Subang (WMSA), and return to WMKM.

At approximately 0800 local time (LT), the SP departed WMKM for WMKJ. The flight proceeded uneventfully, and the aircraft landed back at WMKM at approximately 1045 LT, completing the first sortie without incident. Following the first sortie, the SP took a rest period of approximately 30 to 45 minutes, during which light refreshments consisting of bread and water were consumed.

The second sortie commenced at approximately 1130 LT with departure from WMKM to WMSA. According to the SP's statement, the flight proceeded as planned, and the aircraft arrived in the WMSA control zone approximately one hour later. Upon receiving clearance instructions, the air traffic controller (ATC) advised the SP that the aircraft was first in the landing sequence and was to conduct a touch-and-go, followed by a right turn at 1,000 feet, prior to receiving full landing clearance.

The approach to Runway 15 was conducted with flaps set to 25°, at an indicated airspeed of approximately 75 knots, and with engine power set between 1,500 and 1,600 RPM. Following touchdown, the SP reported that the aircraft initially tracked along the runway centreline. Shortly after touchdown and prior to initiating the take-off phase of the touch-and-go manoeuvre, specifically before flap retraction and application of take-off power, a loud noise was heard, originating from the nose landing gear area.

Immediately after the noise, the nose of the aircraft dropped, and the aircraft veered to the right. The SP initiated stopping actions and successfully brought the aircraft to a complete stop on the right edge of the runway. While stationary, the SP was contacted by WMSA Tower ATC to confirm the SP's condition. The SP reported being

FINAL REPORT A 10/25

uninjured and requested assistance. The after-landing and engine shutdown checklists were subsequently completed.

Prior to exiting the aircraft, the SP informed the Chief Flying Instructor (CFI) of the occurrence. The Airport Fire and Rescue Services (AFRS) arrived at the scene shortly thereafter. The SP exited the aircraft without injury. External observation of the aircraft revealed that it was resting in a nose-down attitude, the nose landing gear assembly was absent, and the propeller had sustained deformation.

As a precautionary measure, the SP was later transported by ambulance to a hospital for further medical examination.

1.2 Injuries to Persons

Injuries	Crew	Passengers	Others	Total
Fatal	NIL	NIL	NIL	NIL
Serious	NIL	NIL	NIL	NIL
Minor	NIL	NIL	NIL	NIL
None	01	NIL	NIL	01

1.3 Damage to Aircraft

Preliminary examination identified substantial damage to the propeller blades, as shown in Figure 1. Deformation and abrasion marks were observed on the lower fuselage area of the aircraft, as depicted in Figure 2.



Figure 1: Condition of the aircraft propeller blades

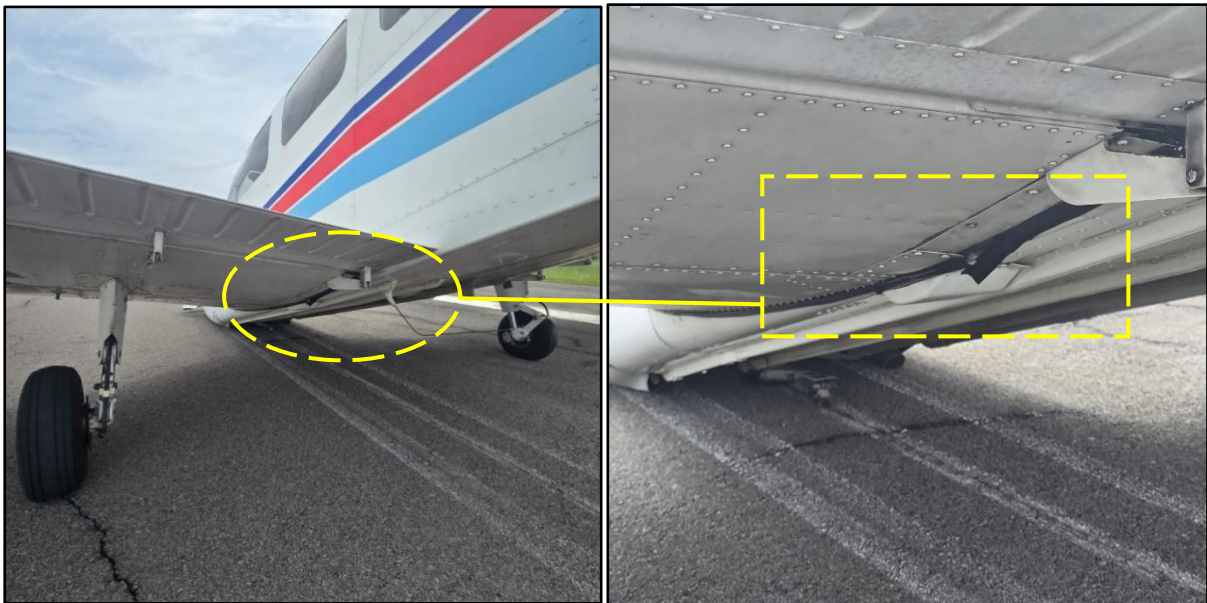


Figure 2: Deformation and abrasion marks on the lower fuselage area of the aircraft

1.3.1 Damage Assessment Inspection Report (DAIR)

The aircraft operator has produced a Damage Assessment Inspection Report (DAIR) which is a crucial follow-up phase after an aviation incident, conducted once the aircraft has been formally released by the AAIB and CAAM. Building upon the findings of the Initial Damage Assessment Report (IDAR), the DAIR involves a detailed physical inspection of affected aircraft components in accordance with the Aircraft/OEM Maintenance Manual. This comprehensive assessment, typically carried out by a team of qualified aircraft engineers and specialists, evaluates the extent of damage and the overall integrity of critical aircraft systems.

FINAL REPORT A 10/25

The findings from the DAIR form the basis for the Proposal Return to Service Report (PRSR), which outlines the required inspections, repairs, corrective actions, and regulatory compliance measures necessary to restore the aircraft to an airworthy condition. Together, the IDAR, DAIR, and PRSR provide a structured and systematic approach to damage assessment, repair planning, and return-to-service activities, ensuring the continued safety and integrity of aviation operations. Figures 3 to 7 below illustrate the findings from the DAIR.



Figure 3: Both blade tips twisted inward, causing serious damage to blade and hub



Figure 4: As specified in Lycoming's mandatory service bulletin SB533C, any sudden engine stoppage or propeller strike should be removed and engine shock load called for.



Figure 5: Both lower engine mount tubes bent inward as a result of the strong impact. Due to a hard impact, both centre engine mount tubes cracked, had completely broken off at the welding spot.

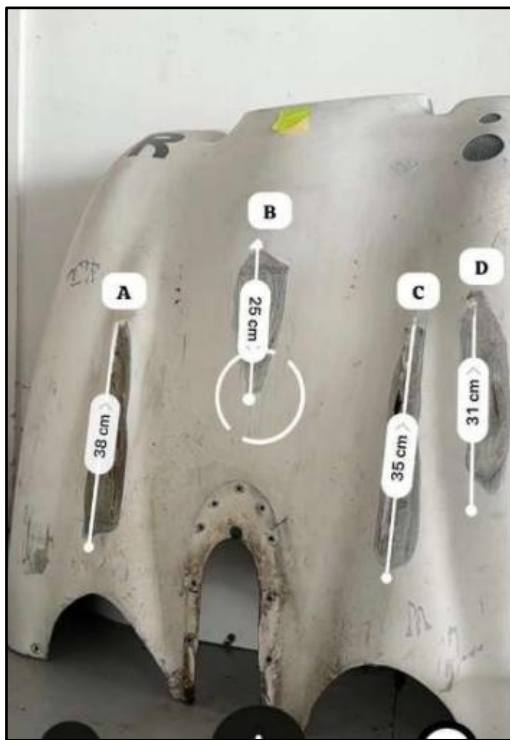


Figure 6: The lower engine cowling is heavily scratched in four places, and the length of the scratches is shown in the picture below. Scratch A and B were severely damaged, with holes appearing as a result of the propeller strike.



Figure 7: The box assembly was severely damaged, and a dent was observed

1.4 Other Damage

During the site investigation, scrape marks consistent with propeller blade contact were observed on the runway surface, as shown in Figure 8. Additionally, shallow potholes caused by the broken oleo from the nose landing gear were identified along the skid path.



Figure 8: Scrape marks on the Runway

FINAL REPORT A 10/25

1.5 Personnel Information

1.5.1 Pilot

Status	Pilot in Command (PIC)
Nationality	Malaysian
Age	24 years
Gender	Male
License Type	Student Pilot Licence (Aeroplane)
License Validity	31 July 2027
Total Hours on Type	110hrs
Total Flying Hours	110hrs
Rest Period Since Last Flight	Approx. 30mins
Medical Certificate Class	Class 1 VML – valid only with correction for defective distant, intermediate and near vision
Medical Expiry Date	31 July 2026

The SP was authorised to conduct the flight in accordance with existing regulations. Additionally, the SP was medically fit and sufficiently rested to operate the aircraft.

1.6 Aircraft Information

The Piper Archer III PA-28-181 is a single-engine aircraft designed and manufactured by Piper Aircraft, Inc. Florida, United States. The aircraft features a low-wing design, fixed landing gear, fixed-pitch propeller, and is powered by a 180-horsepower Lycoming O-360-A4M engine.

FINAL REPORT A 10/25

Aircraft General Information

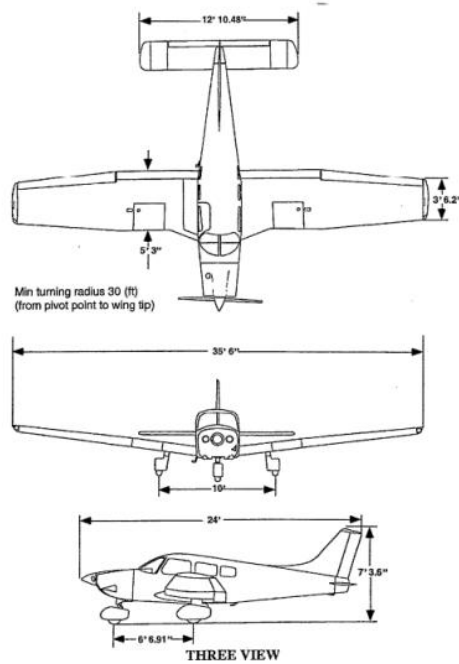


Figure 9: Three views of the aircraft

Aircraft Details			
Aircraft Type	PA 28-181 ARCHER III		
Manufacturer	PIPER AIRCRAFT		
Year of Manufacturer	2014		
Aircraft Owner	MALAYSIAN FLYING ACADEMY		
Aircraft Operator	MALAYSIAN FLYING ACADEMY		
Registration No.	9M-SKR		
Aircraft Serial No.	2843787		
TSN	6475:55		
Last Schedule Maintenance	Type Inspection	Airframe Hours	Date
	50 Hours	6468:30	13 Nov 2025
CoR Validity Period	21 December 2025		
CoA Validity Period	10 February 2026		

FINAL REPORT A 10/25

Engine Details	
Engine OEM	Lycoming
Model	O-360-A4M
Serial Number	RL-35306-36E
TSN/TSO	2080:05

Propeller Details	
Propeller OEM	Sensenich
Model	76EM8S14-0-62
Serial Number	105651K
TSN/TSO	478:35

The aircraft possessed valid Certificates of Registration (CoR) and Certificates of Airworthiness (CoA) and was maintained in compliance with the applicable civil aviation regulations and approved maintenance programmes. A review of the maintenance records confirmed that the aircraft was properly equipped and in an airworthy condition on the day of the occurrence.

1.6.1 Maintenance Examination and Findings (Previous Runway Excursion)

On 7 August 2025, the aircraft experienced a runway excursion on Runway 21 at WMKM. During the final approach in gusty wind conditions, the SP configured the aircraft for landing and touched down short of the intended aiming point but remained on the runway. During the flare, the aircraft bounced and deviated slightly to the left of the runway centreline.

The SP initiated a go-around; however, the aircraft did not achieve a positive rate of climb and subsequently began descending while yawing left. The SP was uncertain regarding the appropriate flap configuration and whether to allow the aircraft to settle back onto the runway. As a result, the aircraft departed the paved runway surface onto the adjacent grass area, where it was brought to a controlled stop. No obstacles were struck.

Following the runway excursion, an unscheduled rectification was carried out during the aircraft's 100-hour inspection on the same day. All landing gear assemblies were

FINAL REPORT A 10/25

inspected, including a dye penetrant inspection of the strut forks to detect any evidence of cracking. No defects were found. The port, starboard, and nose wheel tyres were reassembled and secured using new bolts, nuts, and washers. All inspection results were satisfactory.

The results of the dye penetrant inspection indicate that there was no evidence of cracking in the nose landing gear structure attributable to the runway excursion on 7 August 2025. Accordingly, the inspection findings rule out the possibility that the nose landing gear failure observed during the abnormal runway contact incident on 18 November 2025 was caused by pre-existing cracks originating from the earlier runway excursion.

1.7 Meteorological Information

The weather conditions were not considered to have contributed to the occurrence.

1.8 Aids to Navigation

Not applicable.

1.9 Communications

All communication frequencies were operating normally.

1.10 Aerodrome Information

Sultan Abdul Aziz Shah Airport Subang (WMSA), located at Latitude 03°07'52"N and Longitude 101°32'53"E, has an elevation of 89 feet and provides a Landing Distance Available (LDA) of 3,782 meters. Runways 15 and 33 were in use for landing operations at the time of the event, and no abnormalities were reported with respect to runway surface condition (refer to Figure 10).

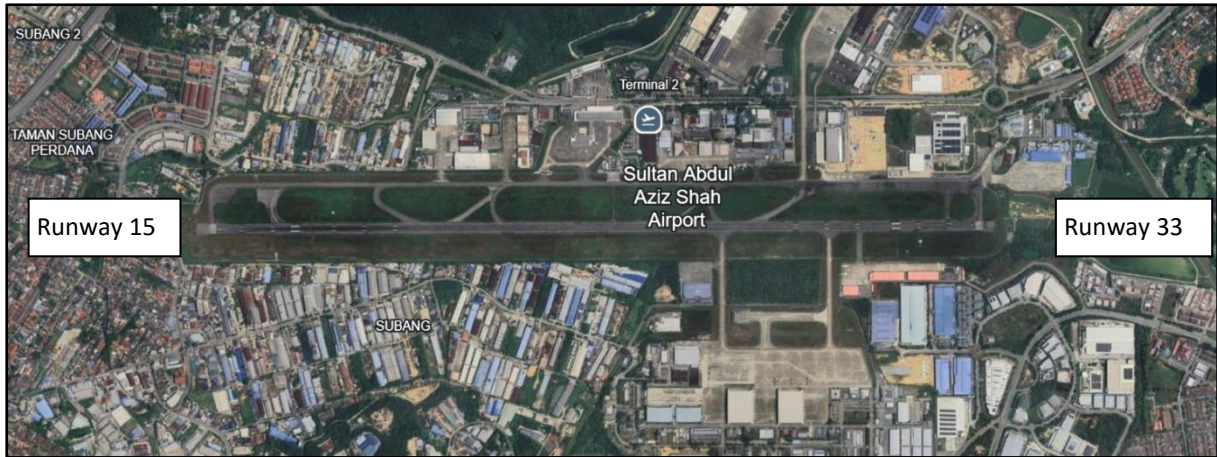


Figure 10: Sultan Abdul Aziz Shah Airport, Subang (WMSA)

1.11 Flight Recorders

The aircraft was not equipped with a Flight Data Recorder (FDR) or a Cockpit Voice Recorder (CVR).

1.12 Wreckage and Impact Information



Figure 11: 9M-SKR wreckage and impact information (WMSA)

Figure 11 depicts the wreckage and impact information of aircraft 9M-SKR at WMSA on the day of the occurrence. The yellow line represents the aircraft's inbound track toward Runway 15, while the red cross indicates the aircraft's final resting position.

1.13 Medical and Pathological Information

The SP underwent a urine drug screening test, the results of which were negative for prohibited substances.

1.14 Fire

No report on pre and post-impact fire.

1.15 Survival Aspects

After shutting down the engine, the student pilot exited the aircraft by opening the aircraft door. The AFRS attended the scene, and the SP was subsequently transported to the hospital as a precautionary measure.

1.16 Tests and Research

A fuel sample (AVGAS 100LL) was sent to the Materials Laboratory, Petroleum, Oil and Lubricant Unit, Human Performance Technology Division (HUMANCE), Science and Technology Research Institute for Defence (STRIDE) for laboratory analysis. The examination was conducted to exclude the possibility of fuel-related engine abnormalities contributing to the occurrence.

The results of the laboratory analysis indicated that the fuel sample complied with the applicable specification requirements. No fuel quality issues were identified.

1.17 Organisational and Management Information

Malaysian Flying Academy (MFA) is an organisation approved by the Civil Aviation Authority of Malaysia (CAAM) to conduct instructional flight training using single-engine Piper PA-28-181 Archer and twin-engine Piper PA-44 Seminole aircraft. Established in 1983 as part of the Royal Selangor Flying Club and originally based at the Sungai Besi Military Airbase, Kuala Lumpur, the academy was acquired by the Syed Kechik Group of Companies in 1985 and subsequently relocated to its present facility at Batu Berendam, Malacca, in 1987.

MFA's principal training programme is the Commercial Pilot Licence (CPL)(A) with Instrument Rating (IR), leading to a Frozen Airline Transport Pilot Licence (ATPL). Aircraft maintenance activities are carried out in-house under MFA's Approved Maintenance Organisation (AMO) authorisation, held under approval number AMO/2017/25. The current approval is valid from 5 June 2025 for the subsequent regulatory cycle.

1.18 Additional Information

1.18.1 Student Pilot Training Progress

A review of the SP's training progress report was conducted to determine whether any performance trends were relevant to the occurrence. The SP had accumulated approximately 110 total flying hours on type and had completed the required dual and solo training phases in accordance with the Approved Training Organisation (ATO) syllabus. The SP had been authorised to conduct the solo long navigation flight as part of the Commercial Pilot Licence (CPL) training programme.

FI's remarks within the progress report indicated that the SP demonstrated satisfactory knowledge of procedures and aircraft systems. However, landing performance was noted to require continued refinement, particularly in relation to flare judgement and touchdown consistency. There was no record of disciplinary action, repeated unsafe conduct, or non-compliance with training procedures. The available training records indicate that the SP met the minimum standard for progression, although landing technique remained under continued development.

1.18.2 Solo Release and Training Oversight

The SP was released for the solo long navigation flight in accordance with the organisation's training syllabus and internal authorisation procedures. The investigation reviewed the operator's procedures for solo release and found that the required dual checks and instructional endorsements had been completed prior to authorisation.

No evidence was identified indicating non-compliance with the regulatory requirements or the organisation's approved training manual in relation to the SP's release for the flight.

1.18.3 Absence of Recorded Data

The aircraft was not equipped with an FDR, CVR, or onboard video recording device. As such, the investigation relied upon:

- The SP's written statement;
- Air traffic control information;
- Physical evidence at the scene; and
- Maintenance examination findings.

In the absence of recorded flight data, the investigation was unable to determine the precise pitch attitudes, control inputs, or vertical acceleration loads during touchdown.

1.19 Useful or Effective Investigation Techniques

The investigation utilised conventional accident investigation techniques, including:

- Site examination and wreckage documentation
- Maintenance record review
- Laboratory fuel analysis conducted by STRIDE
- Review of training and authorisation records
- Interview and written statement from the SP and other witnesses

No specialised investigation techniques beyond standard procedures were required.

2.0 ANALYSIS

The analysis is based on the available evidence and information obtained during the investigation. Where evidence was limited, conclusions were drawn based on the balance of probabilities.

This analysis examines the operational, technical, and human performance factors relevant to the nose landing gear collapse during a touch-and-go manoeuvre at WMSA. The analysis considers:

- Aircraft mechanical condition
- Environmental factors
- Pilot performance and training progression
- Organisational oversight.

2.1 Aircraft and Mechanical Considerations

Maintenance records confirmed that the aircraft held valid CoR and CoA and had undergone a 50-hour inspection on 13 November 2025. Following a previous runway excursion on 7 August 2025, a dye penetrant inspection was conducted on the landing gear components. No cracking or structural defects were identified. The inspection findings rule out the presence of pre-existing structural cracks in the nose landing gear attributable to the earlier event.

Laboratory testing of the AVGAS 100LL fuel sample confirmed compliance with specification requirements. No fuel contamination or engine performance anomaly was identified.

There was no evidence of mechanical failure preceding the nose landing gear collapse. The damage pattern was consistent with overload resulting from runway contact.

2.2 Meteorological and Aerodrome Factors

Weather conditions at the time of the occurrence were reported as fine, and no adverse meteorological conditions were identified that would have directly contributed to the event.

Runway 15 at Sultan Abdul Aziz Shah Airport was serviceable, and no surface defects were reported prior to the occurrence.

Environmental factors were therefore not considered contributory.

2.3 Landing Sequence and Technical Mechanism

The aircraft was configured with 25° flaps at an indicated airspeed of approximately 75 knots during the approach. According to the student pilot's statement, shortly after touchdown and prior to flap retraction and application of take-off power, a loud noise was heard from the nose landing gear area, followed by the collapse of the nose landing gear.

In tricycle landing gear aircraft such as the Piper PA-28-181, nose landing gear collapse is typically associated with excessive forward loading during touchdown. This may occur when back pressure is insufficient during the flare, when the nose wheel contacts the runway prematurely, when a bounced landing is not adequately recovered, or when forward control input is applied during the touchdown transition.

In the absence of flight data or video evidence, the investigation was unable to determine whether sustained pilot-induced oscillation occurred. However, the available evidence does not indicate the presence of multiple oscillatory pitch cycles.

The observed damage pattern is consistent with a single excessive loading event on the nose landing gear rather than repeated oscillatory impacts. The evidence supports the conclusion that the nose landing gear collapse resulted from a single event involving excessive loading during the landing phase.

2.4 Human Performance Considerations

The SP had accumulated 110 total flying hours and was in the consolidation phase of landing skill development. Training records indicated that the SP's landing performance required further refinement, particularly in flare judgement and touchdown consistency.

Touch-and-go manoeuvres involve rapid configuration changes, continuous runway alignment monitoring, timely power application, and effective pitch control

coordination. These actions increase pilot workload, particularly during solo operations at a controlled aerodrome.

The investigation considers that the occurrence is consistent with a skill-based error during bounce recovery or the landing-to-go-around transition, resulting in excessive loading of the nose landing gear. Such performance is consistent with skill-based errors commonly observed during the consolidation phase of pilot training.

2.5 Organisational Factors

The SP was released for solo long navigation in accordance with the organisation's approved training syllabus.

The investigation found no evidence of regulatory non-compliance by the operator in authorising the flight.

However, the training record indicated that landing consistency remained under development at the time of solo release. While within minimum standards, the limited margin during dynamic landing scenarios may have increased exposure to risk.

No systemic training deficiency was identified.

3.0 CONCLUSION

3.1 Findings

3.1.1 Pilot

- i) The SP was properly licensed to fly the training flight.
- ii) The SP had accumulated 110 hours total time.
- iii) The SP was conducting a solo long navigation flight of approximately five hours.
- iv) Training records indicated that the student pilot's landing performance required further refinement.

3.1.2 Aircraft

- i) The aircraft is equipped and maintained in accordance with existing regulations and approved procedures.
- ii) The aircraft held a valid CoR and CoA and has been maintained in compliance with the regulations.
- iii) The aircraft was not equipped with an FDR or a CVR.
- iv) Fuel testing confirmed compliance with specifications.
- v) No pre-existing crack or structural defect was identified in the nose landing gear.
- vi) The aircraft sustained substantial damage to the propeller blades, and deformation and abrasion marks were observed on the lower fuselage area of the aircraft.

3.1.3 Environment

- i) Weather conditions were not contributory.
- ii) No pre-existing runway surface defects were reported.

3.2 Cause/Contributing Factor

The probable cause of the accident was excessive loading of the nose landing gear during abnormal runway contact following a touch-and-go manoeuvre, resulting from an improper landing technique and subsequent collapse of the nose landing gear. The accident is categorised as **Abnormal Runway Contact (ARC)**.¹

A contributing factor was the student pilot's developing landing proficiency under increased workload during the touch-and-go operation.

¹ **ARC: Abnormal Runway Contact** – Any landing or take off involving abnormal runway or landing surface contact.

4.0 SAFETY RECOMMENDATIONS (SR)

4.1 Immediate Safety Actions of the Preliminary Report

The Preliminary Report for this accident issued on 18 December 2025 contained the following recommendation for immediate safety actions to the aircraft operator:

“The operator is recommended to conduct a competency review flight with the SP before authorising any further solo flight operations.”

(AAIB Recommendation SR A10/25-1)

In line with the proposed immediate safety actions, the aircraft operator addressed AAIB Recommendation SR A10/25-1 immediately following the occurrence by implementing appropriate remedial measures before authorising the SP to undertake any further solo flight operations.

4.2 Safety Recommendations of this Report

The Aircraft Operator is recommended to:

4.2.1 Review and reinforce training guidance on:

- Bounce recovery techniques
- Touch-and-go execution procedures
- Go-Around Procedures

(AAIB Recommendation SR A10/25-2)

4.2.2 Review its solo release assessment criteria to ensure adequate consolidation of landing performance prior to authorisation for long navigation flights involving operations at controlled aerodromes.

(AAIB Recommendation SR A10/25-3)

The CAAM is recommended to:

4.2.3 Ensure that ATO surveillance activities include assessment of training effectiveness in bounce recovery techniques, touch-and-go procedures, and solo release standards.

(AAIB Recommendation SR A10/25-4)

**5.0 COMMENTS TO THE REPORT AS REQUIRED BY ICAO ANNEX 13
PARAGRAPH 6.3**

As required by ICAO Annex 13, paragraph 6.3, the draft Final Report was sent to the State of Occurrence/Registry/Operator (CAAM), State of Design and Manufacture (NTSB), and the Aircraft Operator inviting their significant and substantiated comments on the report. The following is the status of the comments received: -

States/Organisations	Status of Significant and Substantiated Comments
Civil Aviation Authority of Malaysia (CAAM)	Report received and no comments.
National Transport Safety Board (NTSB)	Report received and no comments.
Aircraft Operator	Comments received and amended accordingly in this report.

CONCLUDING STATEMENT

This investigation identified several instances of operational deficiencies. However, in accordance with the principles of ICAO Annex 13, it is emphasised that these findings are not intended to apportion blame or liability, but rather to identify safety issues and facilitate the prevention of future accidents and incidents. The implementation of the recommended safety measures will help address the identified shortcomings, strengthen the aviation safety framework, and mitigate risks arising from operational deficiencies and regulatory gaps. All relevant stakeholders are encouraged to prioritise aviation safety and collaborate in implementing the necessary measures to prevent recurrence and enhance the overall level of aviation safety.

Investigator-in-charge
AAIB
Ministry of Transport, Malaysia