



Accident to the PILATUS PC-6/B2-H4
registered **D-FIPS**
on Sunday 28 June 2026
at Tomblaine

Time	Around 11:00 ¹
Operator	Tandemotion Parachutisme
Type of flight	Parachute dropping
Persons on board	Pilot, ten parachutists
Consequences and damage	Occupants fatally injured, aeroplane destroyed
This is a courtesy translation by the BEA of the preliminary report on the safety investigation. As accurate as the translation may be, the original text in French is the work of reference.	

**Loss of control just after take-off, collision with ground,
during a parachute dropping flight**

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¹ Except where otherwise indicated, the times in this report are given in local time.

1 HISTORY OF THE FLIGHT

Note: the following information is principally based on the aeroplane's Garmin GI-275 electronic flight instrument and the GoPro cameras worn by the parachutists.

From taxiway B², the pilot lined up on runway 21 at Nancy-Essey airport and then took off for the sixth dropping flight since the beginning of the day with ten parachutists on board. During the take-off rotation, an instructor situated at the rear of the aeroplane shouted out, “Ça fume” (there’s smoke)³, pointing to the front right of the cabin with his finger. The pilot, who seemed not to have heard this shout, continued the take-off. Another instructor situated in the middle of the cabin also shouted out, “Ça fume!” pointing to the floor in the same area. The instructors agreed to slightly open the side door to air the cabin.

A short time later, the gas generator speed (Ng) of the turboprop engine decreased by around 10%. At the same time, the propeller speed (Np) briefly fluctuated before returning to its nominal value of 2,000 rpm⁴. Soon after, the pitch attitude of the aeroplane increased and the stall warning was briefly activated three times. The pilot turned left with a high pitch attitude and the stall warning continuously sounded. The aeroplane entered an asymmetric stall and collided with the ground.

² Remaining distance to end of runway: 700 m.

³ No smoke was visible on the videos read out by the BEA.

⁴ The glossary of abbreviations and acronyms frequently used by the BEA can be found on its [web site](#).

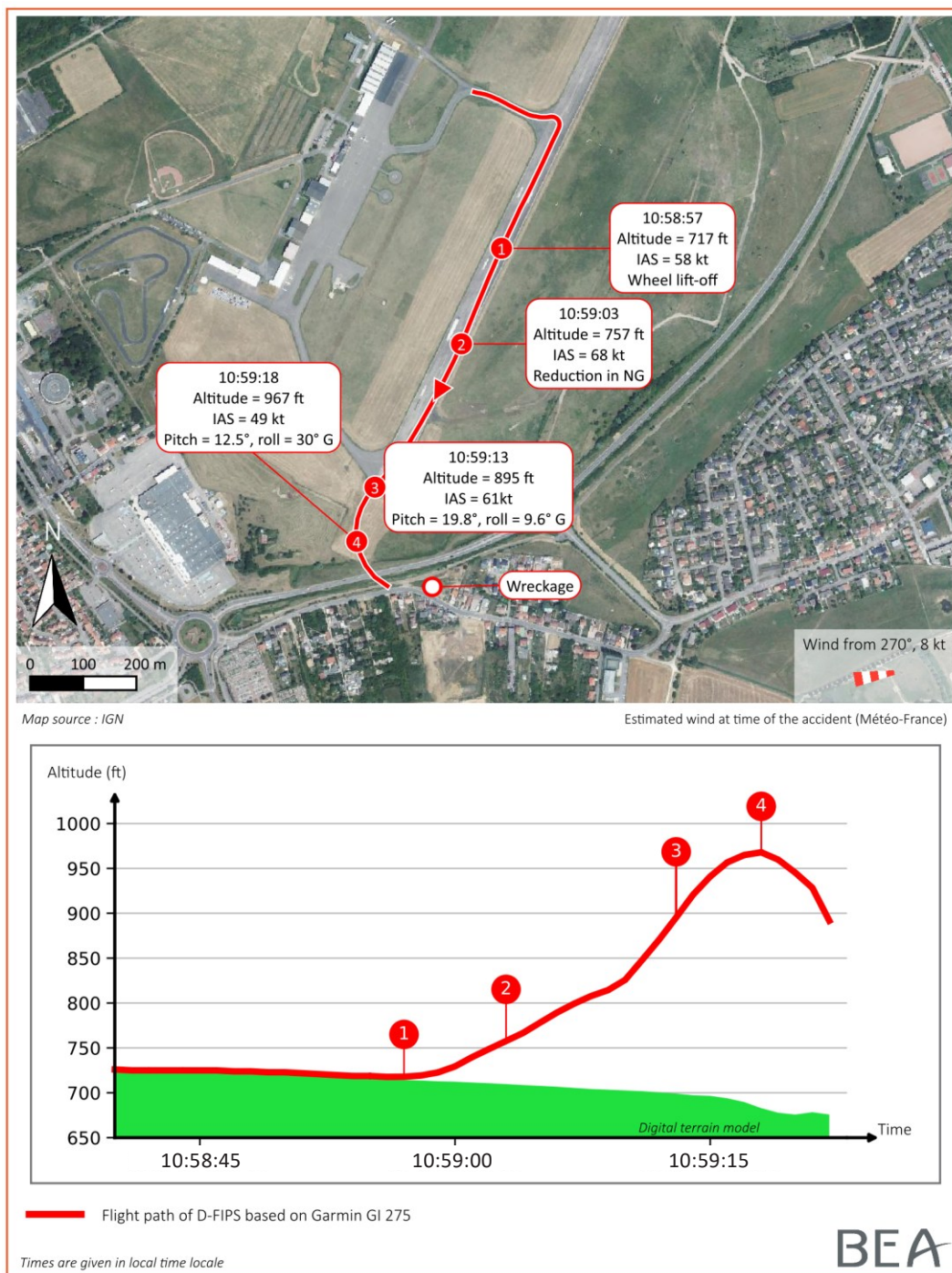


Figure 1: flight path of D-FIPS based on on-board Garmin GI-275 equipment

2 CONTEXT

2.1 Meteorological information

Météo-France's analysis of the weather conditions indicated a very hot air mass and a general south-westerly flow.

The aerodrome's 11:00 METAR indicated:

- wind from 260° at 8 kt varying between 200° and 310;
- CAVOK;
- temperature 33°C and dew point temperature 18°C.

The weather station recorded the following wind and temperature data:

Local time	Two-minute mean wind direction	Two-minute mean wind speed	Maximum wind speed	Temperature in shade	OAT 50 cm above ground	OAT 10 cm above ground
10:56	260°	9.9 kt	13.0 kt	33.0 °C	36.3 °C	40.1 °C
10:57	270°	8.2 kt	13.0 kt	32.9 °C	36.3 °C	40.2 °C
10:58	270°	6.6 kt	13.0 kt	32.9 °C	36.3 °C	40.5 °C
10:59	270°	6.8 kt	13.0 kt	32.9 °C	37.2 °C	41.1 °C
11:00	280°	6.6 kt	13.0 kt	32.8 °C	36.7 °C	40.6 °C

Figure 2: data recorded by airport weather station

The AFIS officer informed the pilot of a wind from 270° at 8 kt before take-off.

2.2 Aerodrome information

Nancy-Essey airport, situated at an altitude of 757 ft, has a paved runway 03/21 measuring 1,600 m x 40 m. When lining up from taxiway B, the take-off distance on runway 21 is 700 m.

A NOTAM covering the period Friday 26 to Sunday 28 June, informed users of the parachute dropping activity overhead the airport.

No particular observations were made during the runway inspection by the airport's multi-function officer in the morning of 28 June and the morning of 29 June.

3 OPERATIONAL INFORMATION

3.1 Tandemotion Parachutisme

Tandemotion Parachutisme was founded in 2011. The company's main activity is the organization of commercial introductory tandem parachute jumps. In this context, the company must comply with Annex III (Part ORO) regarding the requirements to be followed by organizations and Annex VIII (Part SPO) regarding the specialized operations of Regulation (EU) No 965/2012 setting out the technical requirements and administrative procedures applicable to air operations.

The company carries out introductory tandem parachute jumps at several aerodromes in France and abroad, including Nancy-Essey.

Tandemotion Parachutisme's accountable manager indicated that he used self-employed professional instructors for the introductory tandem parachute jumps. As the company does not own an aeroplane, it takes out dry lease contracts. As the Tandemotion Parachutisme pilot was not available the weekend of 27-28 June, Tandemotion Parachutisme's accountable manager asked the company from which he leased D-FIPS to also provide him with a pilot.

The accountable manager added that given the extremely hot temperatures forecast for the weekend, a pause in operations was scheduled between 14:00 and 18:00. The day before the accident, fifteen dropping flights had been carried out which was significantly less than the usual number. The day of the accident, fifteen dropping flights were also planned. He added that the dropping flights were carried out in blocks of three with the aircraft being refuelled between each block.

3.2 Pilot information

Age	44 years
Licence	CPL(A) issued in September 2006
Ratings	Valid FI, IR-ME, MEP and SET
Medical certificate	Class 1 issued in October 2025

The pilot had logged around 10,500 flight hours. The last flight recorded in his log book was 8 June⁵. Based on this log book, the pilot had carried out 11 flight hours under instrument flight rules in the previous 30 days and his previous flight on the PC-6 was on 10 May.

The pilot obtained his Cessna SET⁶ class rating in 2009 and his Pilatus PC-6 SET rating in 2015. He revalidated his Pilatus SET rating every year up until 2025, at which time his Pilatus PC-6 SET and Cessna SET ratings were grouped into a single SET class rating. According to the statements collected, the pilot had logged around 4,000 h on the PC-6. The day before the accident, he had carried out fifteen dropping flights for Tandemotion Parachutisme on D-FIPS from Nancy-Essey airport. The day of the accident, he had carried out a first block of three dropping flights, the accident occurred during the third dropping flight of the second block.

The pilot was employed by the company which owned D-FIPS and regularly flew on this aeroplane.

3.3 Weight, balance and performance

Based on the information collected during the investigation, the aeroplane's take-off weight, calculated using the actual weights of the occupants, was 2,590 kg for a maximum weight of 2,800 kg. The centre of gravity at take-off was calculated as being 31.5%⁷ taking into account the observed position of the parachutists. The weight and balance of the aeroplane were within the envelope recommended by the manufacturer. In flight, no occupant was seen to move before the loss of control.

According to the flight manual, in the conditions of the day, the take-off run (TOR) distance was 200 m, the take-off distance (TOD) was 400 m, the acceleration-stop distance (ASD) was 300 m and the landing distance (LD) was 320 m.

⁵ It is probable that the log book was not up to date.

⁶ Single-engine turbine class rating.

⁷ The flight envelope for a weight of 2,600 kg gives a centre of gravity between 29 and 38% of MAC.

The analysis of the flight path confirmed the consistency of the theoretical TOR and TOD distances with the actual distances.

According to the flight manual, the stall speed at the maximum weight of 2,800 kg, with the flaps in the take-off configuration, is 53 kt with zero bank, 57 kt with a bank angle of 30° and 75 kt with a bank angle of 60°.

4 SITE AND WRECKAGE

The aeroplane collided with the ground at around 200 m from the end of runway 21 and around 150 m to the left of the runway extended centreline.

The wreckage was found close to small bushes and street lights. No damage showing that the aeroplane had collided with these objects was observed.



Wreckage

Figure 3: accident site (source: BEA)

The observation of the site and wreckage found that the aeroplane had struck the ground on a near-vertical flight path, with a steep nose-down attitude and left bank.

The wreckage was complete and grouped together. The flight controls were continuous at the time of the collision with the ground.

The wreckage was then transported to the BEA for additional examinations; these are described in paragraph 6.3

5 ANALYSIS OF RECORDED DATA

Several videos taken by an eyewitness on the ground, a security camera and a passing vehicle were collected. No smoke escaping from the aeroplane was visible on these videos.

The five GoPro cameras worn by the instructors were analysed. The five recordings stopped before the collision with the ground. The videos start when the aeroplane begins taxiing on taxiway B and the last one stops at the time of the loss of control. The videos show alternately the inside of the aeroplane and outside. No smoke was visible.

The spectrum analysis of the audio content of these videos made it possible to determine the propeller speed (Np) and the gas generator speed (Ng). When power was applied for take-off, the Ng stabilized at around 96%⁸ of the maximum speed as in the previous five flights. A 10% reduction in the Ng was then identified. This reduction had not been observed during the take-offs of the previous five flights. The Ng value then remained stable until the end of the recording. At this stage of the investigation, it has not been determined if this reduction was controlled by the pilot or not.

The Garmin GI-275 equipment recorded the parameters of the accident flight together with those from several previous flights. A first analysis shows that the acceleration, rotation and initial gain in altitude were similar to the two previous flights. The rotation took place at a speed of around 60 kt; the speed then reached a maximum value of 73 kt two seconds after the reduction in Ng, the pitch attitude at this point was around 9° and the altitude AMSL was 780 ft. The parameters then diverged from those observed during the previous two flights. The speed decreased while the pitch attitude substantially increased along with the roll, initially to the right and then to the left. The pitch attitude reached a value of 19° with a left-hand roll of more than 20° and increasing. At this point, the indicated airspeed was around 55 kt. Control of the aeroplane was lost a short time later.

6 AIRCRAFT INFORMATION

6.1 Description

D-FIPS was a Pilatus PC-6/B2-H4 equipped with a Pratt & Whitney PT6A-27 turboprop engine and a Hartzell Propeller HC-B3TN-3D three-blade variable-pitch constant-speed propeller. The aeroplane had electrical trims on the three axes and manual flaps. The maximum take-off weight was 2,800 kg.



Figure 4: photo taken in May 2026 (source: pilot who had flown D-FIPS)

6.2 Continuing airworthiness and maintenance

At the time of the accident, D-FIPS had logged around 12,560 flight hours and around 22,640 cycles. The turboprop engine had totalled approximately 7,540 operating hours and approximately 3,785 hours since its last general overhaul.

⁸ This value is nominal during take-off.

The continuing airworthiness was managed by a CAMO⁹ in Germany. The last scheduled maintenance inspection, a 100-h airframe and engine inspection, was carried out in April 2026 in Switzerland in a Part-145 workshop. The certificate of airworthiness was valid until 31 July 2026.

6.3 Technical examinations carried out on the aeroplane

The aeroplane components underwent the examinations typically carried out in a safety investigation. These included disassembling the various assemblies and visually inspecting them. When it was possible, functional tests were carried out along with a search for faults, anomalies or failures which might have contributed to the accident. These examinations were supplemented by a systematic search for any evidence likely to attest to the presence of smoke on board the aeroplane. Particular attention was paid to the identification of traces of soot, overheating or any other sign compatible with the presence of smoke.

6.3.1 Flaps

The flaps were in place on each wing and the control linkages continuous. No anomaly which could have contributed to the accident was observed. The measurements taken of the control actuators indicate that the flaps were extended symmetrically in an intermediate position. The precise position is still being determined.

6.3.2 Trims

The elevator control system is composed of:

- a trimmable horizontal stabilizer (THS) pivoting around axis #1 with respect to the fuselage and moved by an electric actuator situated on the lower surface in the fuselage;
- an elevator pivoting around axis #2 with respect to the THS and moved by cables connected to the stick via a set of rods and bellcranks;
- a tab pivoting around axis #3 with respect to the elevator. Its deflection is automatically combined with the elevator's deflection (it is not controlled by the pilot from the cockpit).

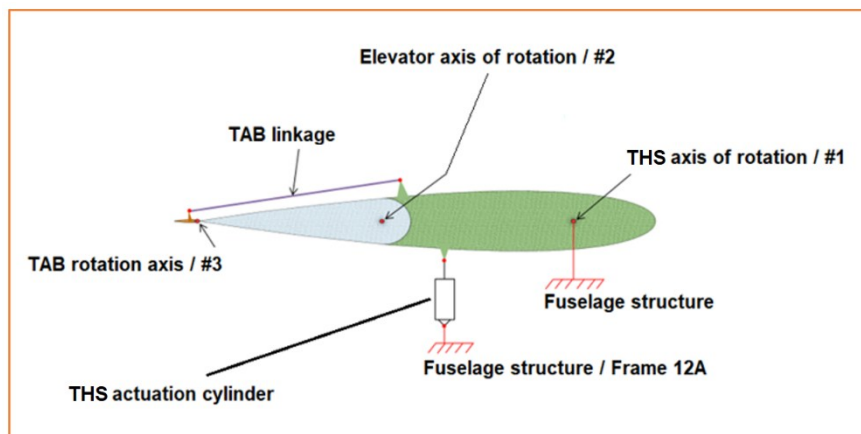


Figure 5: diagram of elevator control system (source: BEA)

⁹ Continuing Airworthiness Management Organization.

The electrical actuator controlling the THS was nominally installed on the aeroplane structure (lower attachment of actuator) and on the THS (upper attachment of actuator). No anomaly was observed during its disassembly. An X-ray radioscopic examination was also carried out which did not reveal any particularity. The actuator is operated by an irreversible screw-nut system. The position in which the actuator was found on the wreckage is therefore representative of its position during the collision with the ground. The measurement of this position indicates that the THS was in a position consistent with the manufacturer's recommendations for take-off.

The rudder and roll trims were examined using the same methodology:

- the actuators were correctly installed on the aeroplane structure;
- no anomaly was observed when they were disassembled and underwent a tomographic examination;
- measurements of the screw-nut systems indicated that both trims were in positions consistent with the manufacturer's recommendations for take-off.



Figure 6: recreation of display in cockpit of trim positions at time of collision with ground (source: BEA)

6.3.3 Fuel system

The PC-6 is equipped with two structural fuel tanks built into each wing with a capacity of around 320 l each. The two fuel tanks feed a collector tank situated in the fuselage. A shut-off valve is situated on the engine feed line, level with the firewall. This valve is manually operated from the cockpit to isolate the system in the event of an emergency for example. There is no fuel tank selector on this aeroplane.

The system had been very badly damaged. It was nevertheless possible to reconstruct it and it is currently being examined. On disassembly, fuel was found in all of the system.

The BEA took a fuel sample from the left-hand tank to carry out physico-chemical analyses. The BEA is waiting for the results. The right-hand fuel tank was found ripped open, there was very little remaining fuel.

A 200 l top-up (to supplement the quantity already present) was carried out at the end of the first block of three dropping flights, i.e. two dropping flights before the accident flight. It was estimated that the aeroplane was carrying around 200 l of fuel when it took off for the accident flight.

The airport fuel supplier had a fuel sample taken from the refuelling tanker and the refuelling station tank analysed by an independent laboratory. The analysis reports did not indicate any particularity.

6.3.4 Annunciator panel

The PC-6 is equipped with an annunciator panel with lights displaying the warnings (red), cautions (amber) and advisory information (green).

Each light is equipped with two filament bulbs. When a bulb is electrically powered (lit), its tungsten filament is heated to incandescence and becomes ductile. According to the pitch attitude of the aeroplane and its deceleration on impact, the filament may undergo characteristic plastic deformation such as elongation or uncoiling or break with deformation. Conversely, a filament that is not powered and at ambient temperature, will generally show no deformation and may break in a brittle manner.

All of the lights on the annunciator panel underwent an X-ray radioscopic examination. Three lights had bulbs with a filament deformed in a more or less homogeneous manner and which had uncoiled. These were the PROP LOW P, CHIP and F-FILTER lights. The filaments of the other bulbs showed no uncoiling. Some of them had broken without deformation, other were intact. It is therefore very likely that the PROP LOW P, CHIP and F-FILTER lights were lit at the time of the collision with the ground.

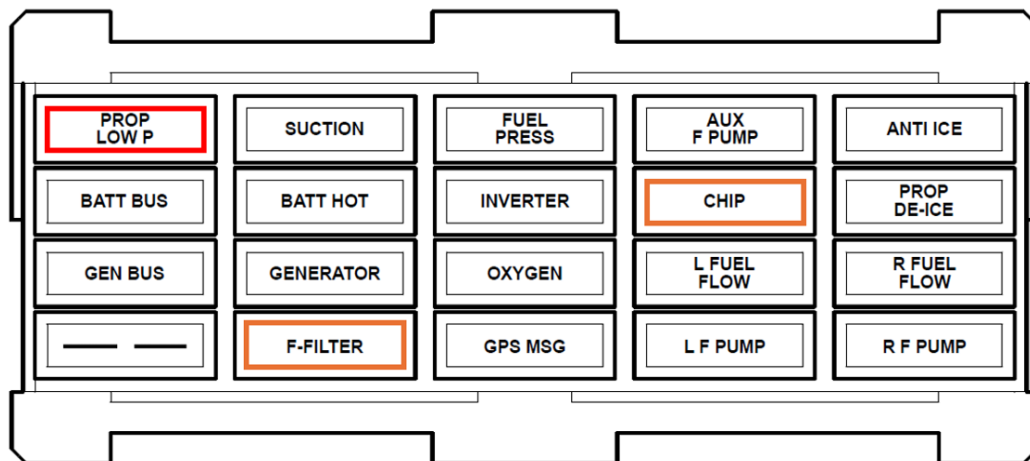


Figure 7: annunciator panel (source: Pilatus, annotations BEA)

The meaning of these three indications is the following:

- **PROP LOW P**: warning indicating that the propeller has reached a low pitch in flight;
- **CHIP**: caution indicating that the contamination of the turboprop engine oil by metal particles has been detected;
- **F-FILTER**: caution indicating that the fuel filter is clogged.

The analysis is continuing to determine if these lights were activated before or after the loss of control.

6.3.5 Examinations in connection with smoke indicated by two instructors

Devices carried by passengers

In accordance with the operator's procedures, the parachutists had not boarded with their telephone. A single telephone was found in the wreckage, very probably belonging to the pilot¹⁰. The telephone was very damaged. No signs of overheating or thermal runaway of the battery were observed.

¹⁰ The pilot did not use it during the flight.

The tandem parachutes showed no signs of an untimely activation of their automatic deployment system. In particular, no sign of the activation of a pyrotechnic charge was observed. The parachutists were not equipped with smoke canisters.

Electrical system

All of the aeroplane's electrical system was separated from the structure and then placed on an examination table in order to obtain an overall view of its architecture and the general condition of the various parts of the system.

No sign of overheating, damaged insulation or any other anomaly likely to have generated smoke was observed.

Air conditioning system

All of the system was separated from the aeroplane structure for examination. No area of overheating or soot deposit that could indicate the presence of smoke was observed.

Flames observed on accident site

A witness travelling in a road vehicle saw the aeroplane take-off and the loss of control. The latter immediately went to the accident site. On arriving at the scene, he observed flames on the front left-hand side, 30 cm to 40 cm aft of the propeller. He used the powder fire extinguisher he had in his vehicle and rapidly put out the flames. He specified that he used around half of the 2 kg fire extinguisher. Additional examinations are in progress to determine if this fire was the consequence or not of the impact with the ground.

7 CONTINUATION OF SAFETY INVESTIGATION

The collection and analysis of data is continuing. These include the examination of the turboprop engine in Canada on the Pratt & Whitney premises in the presence of the BEA, the examination of the fuel system, the analysis of the recorded videos and the analysis of the data recorded by the Garmin GI-275 equipment.

The BEA will publish a final report setting out its conclusions.

The BEA investigations are conducted with the sole objective of improving aviation safety and are not intended to apportion blame or liabilities.