Safety Regulation Group
Safety Investigation and Data Department

Follow-up Action on Occurrence Report

INCIDENT INVOLVING FOKKER F27-500, G-CEXG, AT BOURNEMOUTH AIRPORT ON 7 MAY 2004
(AIRCRAFT LOST DIRECTIONAL CONTROL DURING TAXY OUT AND LEFT TAXIWAY)

CAA FACTOR NUMBER	:	F45/2004
FACTOR PUBLICATION DATE	:	10 November 2004
OPERATOR	:	Channel Express
CAA OCCURRENCE NUMBER	:	2004/02819
AAIB REPORT	:	Bulletin 10/2004

SYNOPSIS

(From AAIB Report)

The crew reported for duty at 0300 hrs expecting to operate a two-sector return freight flight to Jersey. As they approached the aircraft they noticed that the aircraft's pneumatic system was being charged; this was not the normal procedure. The engineers present explained to the commander, whilst outside the aircraft, that this was a fleet wide procedure following pneumatic problems on another aircraft. Meanwhile, the first officer entered the flight deck and asked the engineer there if there was a pneumatic leak. Although he was told there was not, he noted that the brake bottle pressure, though within limits, was slightly lower than normal. Suspecting the integrity of the pneumatic system, he decided to pull out the pneumatic isolating valve pin, contrary to the checklist requirement that was to push it in.

When the commander entered the cockpit, the first officer drew his attention to the brake pressure but did not inform him that the isolation pin had been pulled out. The engines were then started but although the after start checklist required a check of pneumatics, the isolation pin remained out. During the taxi, the crew noticed that the pneumatic pressures were abnormally low but still in the green acceptable band. Shortly afterwards, the aircraft veered to the left and, although full right steering wheel was used and right brake was applied, directional control was lost. At this stage, realising that the pneumatic isolating valve pin was out, the commander pushed it back in but was unable to prevent the aircraft leaving the taxiway and travelling 50 metres along the grass before coming to a stop. There was no attempt to activate the emergency braking system. The commander commented that his left hand was fully engaged holding the steering wheel in an attempt to recover the loss of directional control and it would have been necessary to remove this hand to operate the emergency brakes.

The engines were shut down and engineering assistance obtained. An emergency was not declared but ATC subsequently alerted the emergency services who attended the aircraft. An unsuccessful attempt was made to tow the aircraft forwards with the engines running. This however, is not recommended due to possibility of nose landing gear damage. The aircraft was eventually recovered from the grass tail first.

FOLLOW UP ACTION

The two Safety Recommendations, made by the AAIB following their investigation, are reproduced overleaf, together with the CAA's responses.

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Recommendation 2004-78

It is recommended that the UK Civil Aviation Authority consider bringing the circumstances of this incident to the attention of all UK operators of F27 aircraft.

CAA Response

The CAA accepts this Recommendation.

The CAA has fully discussed the circumstances of this incident with the only UK operator of F27 aircraft. The operator has now modified the F27 checklists and pilot training, such that the functionality and purpose of the pneumatic isolating pin should now be fully understood.

CAA Status - Closed

Recommendation 2004-79

It is recommended that the Director General of Civil Aviation of the Netherlands and the type certificate holders, Stork B.V., consider bringing the circumstances of this incident to the attention of all other operators of F27 aircraft.

CAA Response

This recommendation is not addressed to the UK Civil Aviation Authority.

CAA Status - Closed