



## OFFICE OF THE CHIEF COMMISSIONER

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**Safety recommendation: AIC 19-R19/18-1002**

**Addressed to: Avions de Transport Regional (ATR) Limited**

**Date issued: 27<sup>th</sup> July 2019**

**Investigation link: AIC 18-1002**

**Action status: Issued**

### Introduction

On 28<sup>th</sup> July 2018, at 23:37 UTC<sup>1</sup> (10:37 local time) an Avions de Transport Regional, ATR72-500 registered YJ-AV71 (AV71), operated by Air Vanuatu Operations Limited was on a scheduled flight from Whitegrass Airport, Tanna to Bauerfield Airport, Port Vila. During its landing roll, the aircraft lost directional control and veered off, towards the left of runway 29, and collided with two unoccupied Britten-Norman Islander Aircraft. The ATR had 39 passengers and four crew; two pilots and two Cabin Crew. No injuries were reported.

This occurrence was formally notified to the PNG Accident Investigation Commission (AIC) on 28<sup>th</sup> July 2018 with the request from the Director Civil Aviation Authority of Vanuatu (CAAV) for the PNG AIC to conduct the investigation. The CAAV delegated the whole of the investigation to the PNG AIC in accordance with *Annex 13 Paragraph 5.1*.

The PNG Minister for Civil Aviation approved the Commission to accept the delegated investigation and dispatch a team of investigators to Vanuatu as soon as possible. Investigators arrived at the accident site on Sunday afternoon 29<sup>th</sup> July 2018 and immediately commenced the on-site investigation. The investigation was fully supported by AIC staff in Port Moresby including the resources of the AIC's flight recorder laboratory.

Both the States of Manufacture of the Aircraft and the Engine participated as accredited representatives to the investigation. The manufacturer of the aircraft, ATR, and the engine, Pratt & Whitney Canada (P&WC) were involved as advisors to their respective accredited representatives.

In the absence of an independent investigation authority, the Director of the CAAV, represented the State of Operator, Registry and Occurrence undertook to provide guidelines on applicable Republic of Vanuatu Civil Aviation Occurrence Investigation Legislation. However, where possible the conduct of the investigation was to be in accordance with the PNG legislation, the *AIC Policy and Procedures*, and at all times in accordance with *ICAO Annex 13*.

### Occurrence

While enroute at 16,000 ft and about 60 nm from Port Vila, the flight crew noticed the No. 2 engine (right engine) *Interstage Turbine Temperature (ITT)* gauge increase rapidly and subsequently exceed its normal operating limits with the Master Caution visual and aural warnings being triggered.

Both the crew and passengers reported hearing loud banging noises from the right side of the aircraft. Some passengers reported seeing white flashes in the cabin. The investigation determined that the noises were as a result of the No. 2 engine compressor stalling.

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<sup>1</sup> The 24-hour clock, in Coordinated Universal Time (UTC), is used in this report to describe the local time as specific events occurred. Local time in the area of the accident, Vanuatu Time (VUT) is UTC + 11 hours.

At 23:20:54, the Senior Cabin Crew (SCC) was notified of the engine abnormality by the PIC via the crew interphone system. The SCC subsequently notified the flight crew that there was smoke entering the cabin from the right side of the cabin. The PIC broadcasted a *MAYDAY* and notified Vila Air Traffic Control (ATC) of their descent intentions. The pilots commenced the descent and proceeded to complete their checklist.

About 6 minutes after the first abnormal engine event, the No. 2 engine *oil low pressure warning* alert activated on the *Crew Alert Panel*. The pilots referred to the '*QRH<sup>2</sup> Engine Oil Low pressure*' checklist and subsequently shut down the No. 2 engine. The rest of the descent and the landing was conducted with the No. 2 engine inoperative.

Recorded data showed that one second after touchdown, both power levers were set to maximum reverse thrust. They were subsequently advanced back to Ground Idle after one second then after a further ground roll of about 200 metres the power levers were returned to reverse thrust.

The aircraft did not have hydraulically powered nosewheel steering and main-wheel brakes. Rudder authority, for ground aerodynamic steering was substantially limited because the switch for manual operation was not set to the appropriate setting. Reverse thrust was applied during the landing roll, which induced a significant left yaw resulting in the subsequent runway excursion.

## Safety Deficiency description

### 'SMOKE' checklist

When the electrical smoke warning activated, the flight crew referred to the *ATR Quick Reference Handbook (QRH)* '*ELECTRICAL SMOKE*' checklist (See Attachment 1). The first action item on the checklist required them to refer to the '*SMOKE*' checklist (See attachment 2).

The electrical smoke warning had given the crew the impression that the source of the smoke was in the avionics/electrical compartment, leading them to hastily read through the memory action items of the '*SMOKE*' checklist that they had partially completed. With this pre-conception, the crew returned to the Electrical Smoke checklist as soon as they got to the action item, '*SMOKE SOURCE...IDENTIFY*' of the '*SMOKE*' checklist. The '*Note*' contained in the '*SMOKE*' checklist was not consulted. The checklists were carried out in a disjointed and incomplete manner.

At the very least, under time critical circumstances and/or with crew confirmation bias, it is quite possible for the '*Note*' to be overlooked or ignored due to its representation by a plain black word '*Note*' that does not appear as important as would be the case if listed as an amber '*CAUTION*'.

Furthermore, the AIC determined that while the content of the '*Note*' section of the '*SMOKE*' checklist meets the criteria for being classified as a '*CAUTION*', it is not represented as such on the checklist.

## Recommendation number *AIC 19-R19/18-1002* to Avions de Transport Regional (ATR) Limited

### 'SMOKE' checklist

The PNG Accident Investigation Commission (AIC) recommends that ATR should ensure that the word '*Note*' on the '*SMOKE*' checklist is reclassified to, and represented by, an amber '*CAUTION*' that is ergonomically able to draw the attention of flight crews to the ambiguity presented by the electrical smoke warning.

## Action requested

The AIC requests that ATR note recommendation *AIC 18-R19/18-1002*, and provide a response to the AIC within 90 days of the issue date, and explain (including with evidence) how ATR has addressed the safety deficiency identified in the safety recommendation. Status **ACTIVE**.

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<sup>2</sup> QRH: *Quick Reference Handbook* checklist

**ATTACHMENT 1: ATR QUICK REFERENCE HANDBOOK, E26.05 ELECTRICAL SMOKE CHECKLIST**

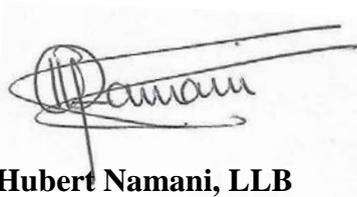
50eded2b-d359-4f7f-b1eb-1f4e07b3d10e		2.1
		ALL
<b>E26.05</b>	<b>ELECTRICAL SMOKE</b>	
23:23:48	▶ SMOKE procedure ( E26.01 ) ..... APPLY	
	▶ AVIONICS VENT EXHAUST MODE..... OVBD	
	▶ AIR FLOW..... HIGH	
	▶ DC SVCE & UTLY BUS..... OFF	
	▶ DC BTC ..... ISOL	
	▶ ACW GEN 1 + 2..... OFF	
23:26:05	▶ SUSPECTED EQUIPMENT..... OFF	
	■ <b>If smoke source not identified</b>	
	▶ <b>LAND ASAP</b>	
	▶ ACW GEN 1+2 LOSS procedure ( A24.07 ) ..... APPLY	
	■ <b>If smoke source identified</b>	
	▶ OPERATING EQUIPMENT..... RESTORE	
	● <b>When ΔP below 1 psi</b>	
	▶ OVBD VALVE ..... FULL OPEN	
	▶ AVIONICS VENT EXHAUST MODE..... NORM	

**AIC Note:** Pale green highlighting added by the AIC to identify the area of checklist completed.

**ATTACHMENT 2: ATR QUICK REFERENCE HANDBOOK, E26.01 SMOKE CHECKLIST (EMERGENCY)**

7d2c74a9-e6e1-4855-8fb5-15c18e9b8b95	3.2
ALL	
<b>SMOKE</b>	<b>E26.01</b>
<p>■ <b>If smoke/fumes in the cockpit</b></p> <ul style="list-style-type: none"> <li>▶ CREW OXY MASKS..... DON / 100 %</li> <li>▶ GOGGLES..... SET</li> <li>▶ CREW COMMUNICATIONS..... ESTABLISH</li> <li>▶ RECIRC FANS 1+2..... OFF</li> <li>▶ AP ..... ON</li> </ul>	
▶ SMOKE SOURCE..... IDENTIFY	
<p>■ <b>If source not identified or electrical smoke suspected</b></p> <div style="border: 2px solid red; padding: 5px; margin: 5px 0;"> <p><b>Note</b>  <i>ELEC SMK may be activated by an air conditioning smoke source</i></p> </div> <ul style="list-style-type: none"> <li>▶ ELECTRICAL SMOKE procedure ( <a href="#">E26.05</a> ) ..... APPLY</li> </ul>	
<p>■ <b>If air conditioning smoke identified</b></p> <ul style="list-style-type: none"> <li>▶ AIR COND SMOKE procedure ( <a href="#">E26.03</a> ) ..... APPLY</li> </ul>	
<p>■ <b>If FWD SMK comes on or smoke in FWD zone of aircraft</b></p> <ul style="list-style-type: none"> <li>▶ FWD SMOKE procedure ( <a href="#">E26.06</a> ) ..... APPLY</li> </ul>	
<p>■ <b>If AFT SMK comes on or smoke in aft zone of aircraft</b></p> <ul style="list-style-type: none"> <li>▶ AFT SMOKE procedure ( <a href="#">E26.02</a> ) ..... APPLY</li> </ul>	

**AIC Notes:** Memory items identified by bold border commencing at 'If smoke/fumes in the cockpit'  
 Pale green highlighting added by the AIC to identify the areas of checklist completed.  
 Red border around **Note** added by the AIC to highlight the area of safety deficiency concern.



**Hubert Namani, LLB**

Chief Commissioner

27<sup>th</sup> July 2019