AIRCRAFT ACCIDENT REPORT NO 2/89

REPORT ON THE INCIDENT INVOLVING BAC 1-11 G-AYWB AND BOEING 737 EI-BTZ ON 12 APRIL 1988 AT GATWICK AIRPORT

The Inspector's report on this incident was submitted to the Secretary of State for Transport on 4 April 1989. He has agreed to its publication and the report is now available from HMSO bookshops and accredited agents.

The incident occurred when a British Aerospace (BAC) One-Eleven G-AYWB (WB) landed on taxiway 2 at Gatwick Airport after making a night visual approach to runway 08L, and stopped 190 metres short of a Boeing B737 EI-BTZ (TZ). The commander of the Boeing B737 observed the landing lights of the aircraft touching down on the taxiway and attempted to turn off to the side. Immediately the aircraft's port main wheels left the paved surface it bogged down in the soft ground partially blocking the taxiway with its left wing and rear fuselage. There were no injuries.

The report concludes that there were a number of factors which enabled this incident to happen and these are listed below, not in order of importance:

- (i) The commander of G-AYWB changed from an accurate to an inaccurate interpretation of the cues provided to him by the visual scene on the approach to runway 08L, and consequently landed on taxiway 2 believing it to be runway 08L (the "emergency runway").
- (ii) The commander's misinterpretation of the visual cues was facilitated by:
 - a. The similar visual appearance at night of runway 08R with a green centreline to its left on the taxiway (runway 08L); and runway 08L with a green centreline to its left on taxiway 2.
 - b. The use of runway 08L both as a runway with edge lighting and as a taxiway with centreline lighting.
 - c. The red LIMA stop bar on taxiway 2, implying a threshold, and enabling the impression to be formed of taxiway 2 as a poorly lit runway to the left of the apparent main runway.
 - d. The failure of the crew to brief themselves on the lighting they were expecting to see on the approach to runway 08L.
- (iii) The commander's change of interpretation was occasioned by a well-intentioned query from the first officer in an attempt to resolve his personal uncertainty about which runway was being approached.

Nine safety recommendations were made during the course of this investigation.