

Serious incident

Air Accidents Investigation Branch

Aircraft Accident Report No: 6/2008 (EW/C2006/03/06)

Registered Owner and Operator: Emerald Airways Limited

Aircraft Type and Model: Hawker Siddeley HS 748 Series 2A

Nationality: United Kingdom

Registration: G-BVOV

Place of Incident: Guernsey Airport, Channel Islands
Latitude: 49°26'N Longitude: 002°36'W

Date and Time: 8 March 2006 at 1157 hrs
All times in this report are UTC

Synopsis

This serious incident was notified to the Air Accidents Investigation Branch (AAIB) by ATC at Guernsey Airport shortly after the occurrence. Inspectors from the AAIB travelled to Guernsey and commenced the investigation later that day.

The following Inspectors participated in the investigation:

Mr R D G Carter	Investigator-in-charge
Mr P Taylor	Operations
Mr R J McMillan	Engineering
Mr P Wivell	Flight Recorders

The aircraft was landing at Guernsey at the end of a two-sector cargo service from Coventry and Jersey. The Category I ILS approach on Runway 27 at Guernsey was flown in weather conditions that were poor but acceptable for making the approach and there was ample fuel on board for a diversion. The aircraft was seen to touch down between 400 and 550 metres from the 'stop' end of the runway and overran by some 145 metres onto the grass beyond the paved surface. There were no injuries.

Investigation by the AAIB revealed no aircraft or runway deficiencies to account for the overrun. During the final approach and landing there were substantial divergences from the company Operations Manual.

This operator had previously been the subject of close monitoring by the CAA over a sustained period and its Air Operator's Certificate (AOC) was later suspended.

The investigation identified the following causal factors:

- (i) The flight crew did not comply with the Standard Operating Procedures for a Category I ILS.
- (ii) The commander's decision to land or go around was delayed significantly beyond the intersection of the Decision Altitude and the ILS glideslope.
- (iii) After landing, the crew did not immediately apply maximum braking or withdraw the flight fine pitch stops, as advised in the Operations Manual.
- (iv) The operator's training staff lacked knowledge of the Standard Operating Procedures.

The investigation identified the following contributory factor:

- (i) Close monitoring by the CAA had not revealed the depth of the lack of knowledge of Standard Operating Procedures within the operator's flight operations department until after this incident.

One Safety Recommendation is made to the CAA.