AAIB Bulletin No: 8/94 **Ref: EW/G94/06/15** **Category: 1.1**

INCIDENT

Aircraft Type and Registration:	DC-9-83 (MD-83), G-GMJM
No & Type of Engines:	2 Pratt & Whitney JT8D-219 turbofan engines
Year of Manufacture:	1991
Date & Time (UTC):	17 June 1994 at 0433 hrs
Location:	Manchester International Airport
Type of Flight:	Public Transport
Persons on Board:	Crew - 7 Passengers - 172
Injuries:	Crew - 2 Minor Passengers - 2 Minor
Nature of Damage:	Major damage to flight deck door
Commander's Licence:	Airline Transport Pilot's Licence
Commander's Age:	43 years
Commander's Flying Experience:	11,100 hours (of which approx 500 were on type) Last 90 days - N/K Last 28 days - N/K
Information Source:	Accident report submitted by the Operator

The aircraft landed on Runway 24 at Manchester Airport after a flight from Malaga, Spain. At about the time the commander applied reverse thrust, a cart became detached from its stowage in the rear galley and moved into the aisle. It travelled the length of the aircraft and impacted the flight deck door; it was estimated that the aircraft was decelerating through about 110 kt at the time.

The cart made contact with two passengers during its progress, causing minor injuries to both; the cabin staff supervisor, who was positioned forward, received a slight injury to her foot. The 'kick out' panel in the door was thrown forward and it struck the first officer on his left arm.

When the cabin staff supervisor, aided by another cabin attendant removed the cart from its position, she noted that the brake was on. Subsequent examination of cart found no defect in the brake system which performed satisfactorily to the original design criteria. During the inspection, it was found that a longitudinal shift forward of the centre of gravity of the cart, along the line of the wheels, would remove sufficient friction from the braked wheels to allow it to travel forward even with the brake applied.

The incident was thoroughly investigated by the company flight safety officer and a frank and comprehensive report was submitted. Apart from the supervisor, the cabin staff were all of very low experience having only started flying at the beginning of 1994. The report highlighted this as a contributory factor; the rear cabin staff had allowed themselves to become overloaded during the preparations for landing and had omitted to lower the galley cart safety latches on the relevant stowage.

The following were among a number of recommendations made to the company in the report:

1. A policy should be established to ensure a minimum supervisory level of experience in the rear cabin of all flight.

2. Such cabin crew should be annotated within the airline information management system, to ensure compatible balanced rostering of crews.

3. A review of cabin training should be carried out to highlight the need to give safety related duties priority over cabin service at critical phases of flight.