Aviation Safety Investigation Report 199403198

Fokker B.V. Fellowship

29 October 1994

Aviation Safety Investigation Report 199403198

Readers are advised that the Australian Transport Safety Bureau investigates for the sole purpose of enhancing transport safety. Consequently, Bureau reports are confined to matters of safety significance and may be misleading if used for any other purposes.

Investigations commenced on or before 30 June 2003, including the publication of reports as a result of those investigations, are authorised by the Executive Director of the Bureau in accordance with Part 2A of the Air Navigation Act 1920.

Investigations commenced after 1 July 2003, including the publication of reports as a result of those investigations, are authorised by the Executive Director of the Bureau in accordance with the Transport Safety Investigation Act 2003 (TSI Act). Reports released under the TSI Act are not admissible as evidence in any civil or criminal proceedings.

NOTE: All air safety occurrences reported to the ATSB are categorised and recorded. For a detailed explanation on Category definitions please refer to the ATSB website at www.atsb.gov.au.

The Bureau did not conduct an on scene investigation of this occurrence. The information presented below was obtained from information supplied to the Bureau.

Occurrence Number: 199403198 Occurrence Type: Incident

Location: Norfolk Island

State: NSW Inv Category: 4

Date: Saturday 29 October 1994

Time: 1038 hours Time Zone UTC

Highest Injury Level: None

Aircraft Fokker B.V.

Manufacturer:

Aircraft Model: F28 MK 3000

Aircraft Registration: VH-EWF Serial 11143

Number:

Type of Operation: Air Transport High Capacity International Passenger

Scheduled

Damage to Aircraft: Nil

Departure Point: Norfolk Island NSW

Departure Time: 1038 UTC **Destination:** Sydney Qld

Approved for Release: Monday, May 8, 1995

The No. 1 hydraulic system failed soon after take off. The flaps retracted to 6 degrees and the right main landing gear warning light illuminated. The pilot declared an emergency and the aircraft was held until emergency services were in place. Emergency landing gear extension was successful and a normal landing followed, but without nosewheel steering, requiring the pilot to use asymmetric braking.

Subsequent investigation revealed the No. 1 engine hydraulic pump pressure outlet elbow had failed, allowing a complete loss of fluid from the No. 1 system. The operator has consequently revised the inspection criteria for all hydraulic system elbows fleetwide.