

ACCIDENT B737-300 PK-MDE MANOKWARI – PAPUA INDONESIA

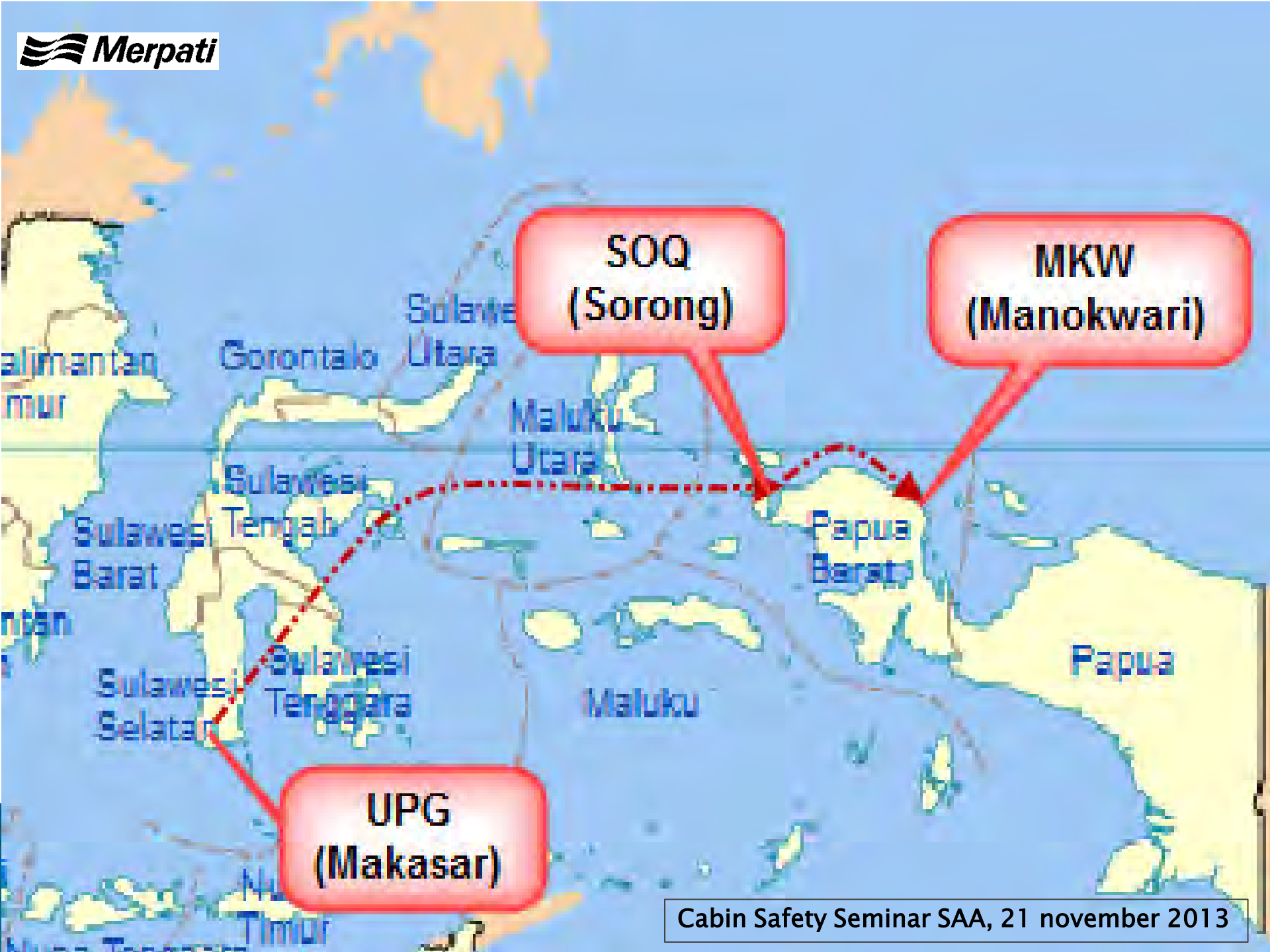
By:
Fridman Ervianto
Cabin Safety Inspector

13 April 2010



Accident Data

- ▶ A/C Type : B 737-300.
- ▶ Registration : PK-MDE.
- ▶ Date : Wednesday, 13 April 2010.
- ▶ Route : UPG-SOQ-MKW.
- ▶ Passenger on board : 97/03/03.
- ▶ Injury : 1FC, 1 FA and 8 passengers minor injuries.



**SOQ
(Sorong)**

**MKW
(Manokwari)**

**UPG
(Makassar)**

Factual Information

On 13 April 2010, a B 737-300 was on a flight from Makassar (UPG) to Manokwari (MKW), Papua and stop over in Sorong (SOQ). The departure from Sorong delayed about two hours due to heavy rain over Manokwari.

Arrival at Manokwari the weather was slight rain. Witness stated that the aircraft made a normal touched down and the engine reverser was not heard during the landing roll. No deceleration was felt.

The aircraft overran the end of the runway and came to a complete stop about 205 meters beyond end of the runway in a narrow river.



Aircraft track after over run the runway



Aircraft stopped on a narrow river





Speed indicator shown 70 knots when a/c stop



Cockpit From Outside



Forward Cabin Picture



Aft Cabin Picture



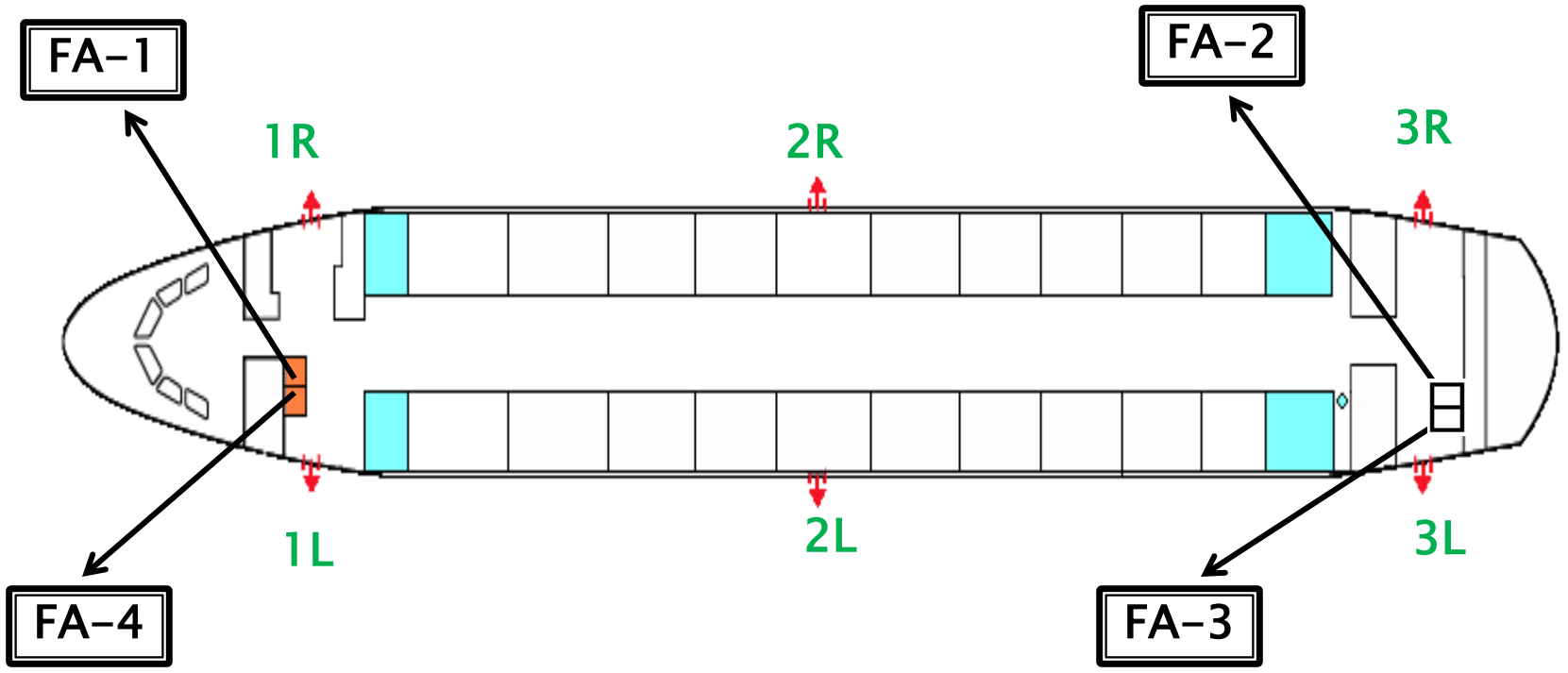




Evacuation process

- ▶ FA 3 hit the door control handle.
- ▶ The second impact was hard.
- ▶ Aircraft was severe damage
- ▶ Two infants released from mothers grasp.
- ▶ FA initiated Evacuation.
- ▶ Cockpit Door blocked.
- ▶ SIC tried to open aft entrance door from outside while slide was at armed position.

FA Station



FA1

- ▶ After aircraft stopped, the FA 1 shocked and felt blank in a few seconds.
- ▶ After look at the damage of the aircraft, he initiated the evacuation.
- ▶ FA1 gave command to the passengers to evacuate through the aft cabin exits.
- ▶ FA1 opened 1L door.
- ▶ Cockpit door could not be opened.
- ▶ FA1 instructed the flight crew to evacuate through sliding window.
- ▶ FA1 was the last person who abandon the aircraft after evacuation completed. (through 3L)

FA4

- ▶ 1R Door blocked because the forward galley was collapse down.
- ▶ She went to the centre cabin to assist evacuation passengers by grasp the wiring on the ceiling.
- ▶ She found the baby on the floor against the partition and gave the baby to the mechanic
- ▶ After evacuation completed, she left the aircraft through 3L door.

FA2

- ▶ He stood up but the vision to the cabin was blocked by 'dust' that might come up from material on the cabin wall.
- ▶ He noticed that the FA3 had injured and fell down on the floor and blocked 3L door. Then he put FA3 on the jump seat.
- ▶ He checked outside condition through 3L door viewing window, he saw river outside and decided to block that door.
- ▶ He opened 3R door and evacuated the passengers, during evacuation the SIC tried to open 3L and he holded the control handle.
- ▶ After evacuation completed he assist FA3 to evacuate through 3R door.

FA3

Injured on the lower back and bleeding on forehead.

She sat down on the jump seat during the evacuation process.

After passenger evacuation completed, she was assisted by FA2 to leave the aircraft through 3R door.

Findings

- ▶ No command from the pilots after aircraft stopped due to lost of electrical.
- ▶ SIC tried to open the door 3L from outside while the slide was still at armed position.
- ▶ 2 infants lost from their mother's grasp.
- ▶ FA3 has opened one harness in intention to collect the infant life vests before aircraft completely stop.

Recommendation

- ❖ Should performed joint emergency procedure training between flight crew and flight attendant.
- ❖ Every aircraft should be equipped with infant seat belt.
- ❖ Collecting infant life vest should be performed after all passengers disembarked.
- ❖ Briefing to all flight attendants for reviewing emergency procedures to anticipate unexpected situation and shall use common sense.

Joint SEP between FC and FA



Cabin Safety Seminar SAA, 21 november 2013

Improving Cabin Safety

- ❖ Indoctrination to all flight attendants related to positive Safety, Security and Quality (SSQ) culture.
- ❖ Recruitment flight attendant as SSQ inspectors.
- ❖ Developing Voluntary Reporting System.

SAFETY PROMOTION

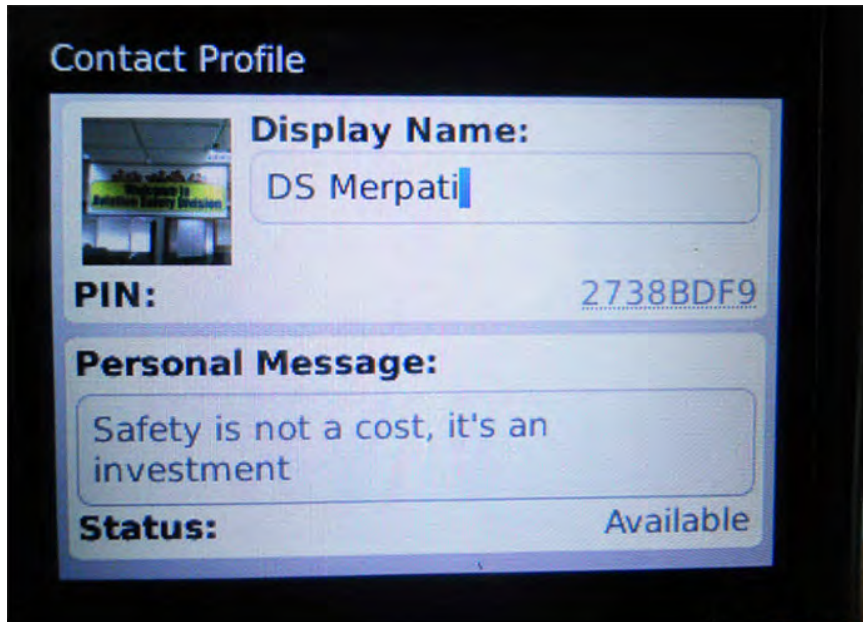
▶ Contingency Procedure Card



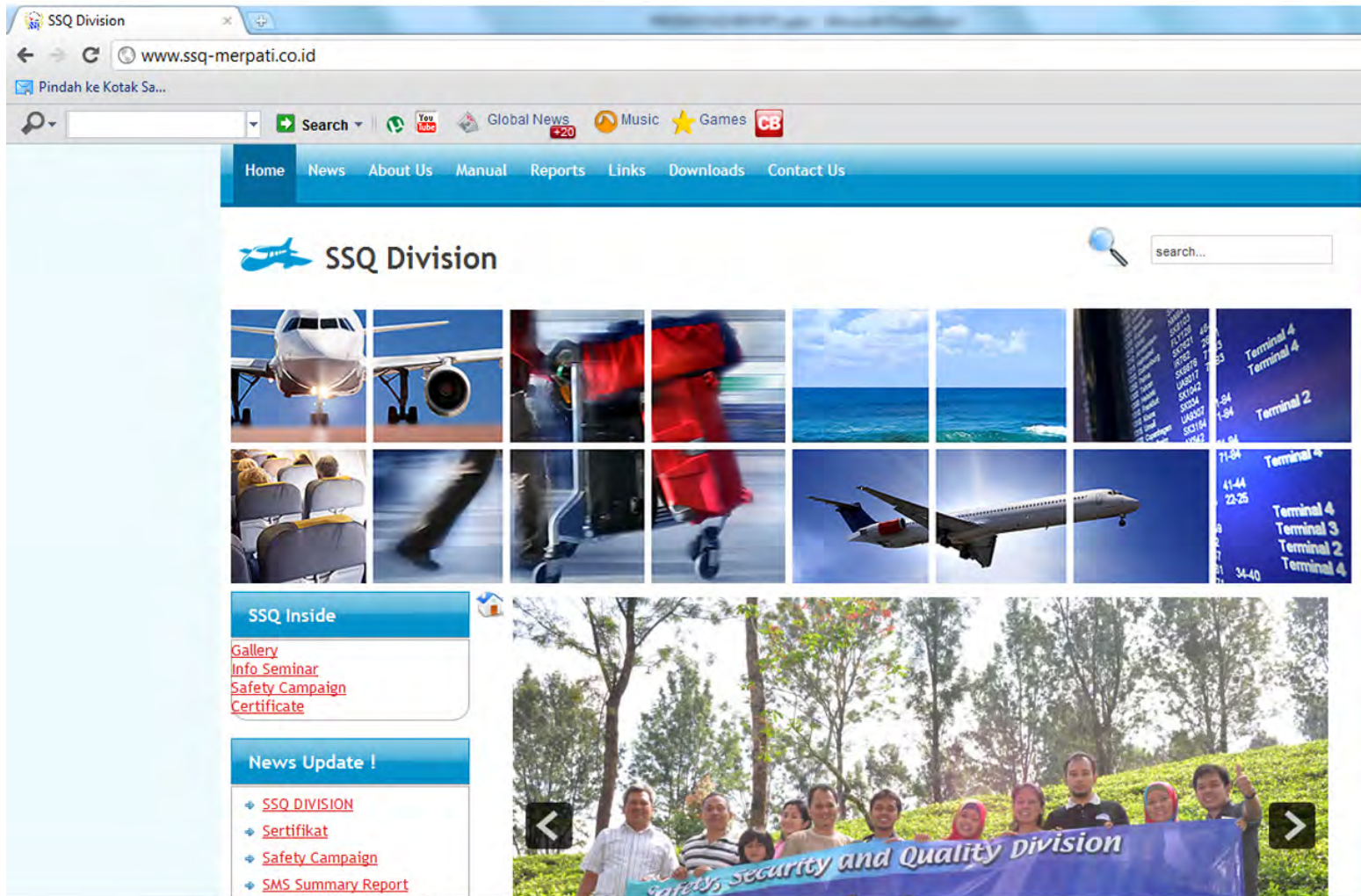
Safety Campaign Posters



▶ Safety Communication Channel



► Safety Website

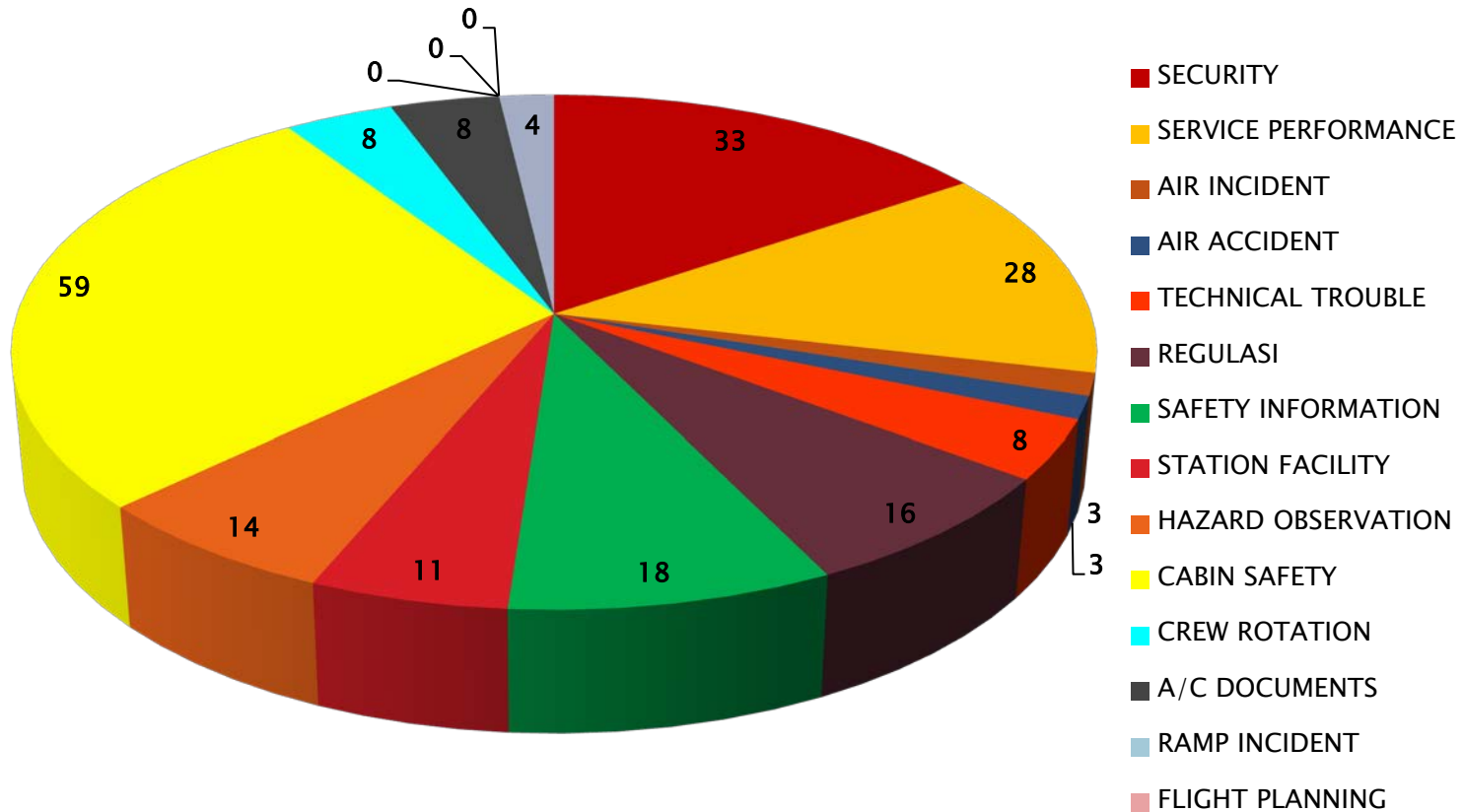


The screenshot shows a web browser window with the address www.ssq-merpati.co.id. The website features a blue navigation bar with links: Home, News, About Us, Manual, Reports, Links, Downloads, and Contact Us. Below the navigation bar is the SSQ Division logo and a search bar. The main content area displays a grid of images related to aviation, including an airplane on the tarmac, a person pushing a luggage cart, a view of the ocean, and an airplane in flight. To the left of the grid is a sidebar with the following sections:

- SSQ Inside**
 - [Gallery](#)
 - [Info Seminar](#)
 - [Safety Campaign](#)
 - [Certificate](#)
- News Update !**
 - [SSQ DIVISION](#)
 - [Sertifikat](#)
 - [Safety Campaign](#)
 - [SMS Summary Report](#)

At the bottom of the page, there is a large photograph of a group of people holding a blue banner that reads "Safety, Security and Quality Division".

Reporting System results (2011)



The Best Safety Device is an Employee
Who Makes SSQ as the Basis of Decision
Making.

Every Accident will never be the same so
prepare for the worst hope for the best.

Thank You