Chief Inspector of Accidents
Accident Investigation Division
Civil Aviation Department
46th Floor
Queensway Government Offices
66 Queensway
Hong Kong

Serious Incident Bulletin 4/2010

Aircraft type:	Airbus A340-300
Registration:	OH-LQD
Year of manufacture:	2008
Number and type of engines:	4 / CFMI CFM56-5C4/P turbojet
Date and time of incident:	UTC 1724 hours on 26 November 2010 (Local time 0124 hours on 27 November 2010)
Place of incident:	Hong Kong International Airport (VHHH)
Nature of Incident:	A Finnair Airbus A340-300, which was cleared for take-off on Runway 07L, made a wrong turn and attempted to take-off on Taxiway A. Upon detecting the anomaly, ATC immediately instructed the pilot to abort the attempted take-off. The incident is classified as a serious incident as defined under Annex 13 to the Convention on International Civil Aviation.
Type of flight:	Scheduled Public Transport
Persons on board:	Crew 14 : Passenger : 258
Fatalities:	Nil
Serious Injuries:	Crew : Nil Passenger : Nil
Commander's licence:	Air Transport Pilot's Licence
Commander's age:	50
Commander's experience:	11,555 hrs (of which 1,310 hrs were on type)
Other crew	Flight Deck : 2 Cabin : 11
Source of information:	Serious Incident Investigation

Preliminary Report of Investigation on Attempted Take-off on Taxiway A at Hong Kong International Airport on 26 November 2010 (Finnair 070, Airbus A340-300, Registration Mark OH-LQD)

(All times are in UTC. Hong Kong time is UTC+8 hours.)

1. At 1724 hours on 26 November 2010, flight FIN070 of Finnair (aircraft type Airbus A340-300, registration mark OH-LQD) bound for Helsinki, Finland attempted to take-off after making a wrong turn onto Taxiway A. On detecting the anomaly, Air Traffic Control (ATC) instructed the pilot to stop rolling and the attempted take-off was aborted in time. There was no other traffic on the taxiway and there was no injury to persons or damage to the aircraft. The incident is classified as a serious incident and has been reported to ICAO in accordance with Annex 13 requirements. The Accident Investigation Division of the Civil Aviation Department (CAD) has initiated an investigation to determine the causes of the incident by an investigation team comprising qualified inspectors of accidents with professional experience in different aviation disciplines including air traffic controllers, pilots and aerodrome experts. The Air Accident Investigation Board of Finland and the Bureau d'Enquêtes et d'Analyses pour la sécurité de l'aviation civile (BEA) of France, representing respectively the state of registry and state of manufacture of the aircraft involved, have appointed Accredited Representatives to take part in the investigation.

2. The incident occurred at night time during which FIN070 was cleared by ATC to taxi on Taxiway B westbound for departure on Runway 07L. When the aircraft was approaching the western end of Taxiway B, ATC cleared the aircraft for take-off on Runway 07L. The aircraft took the normal right turn at the end of Taxiway B towards Runway 07L but then took a premature right turn onto Taxiway A, a taxiway parallel to and in between the runway-in-use and Taxiway B. With the help of the Advanced Surface Movement Guidance and Control System (A-SMGCS) provided in the Control Tower, ATC observed that the aircraft commenced take-off roll on Taxiway A. On detecting the anomaly, ATC immediately instructed the pilot to stop rolling and the aircraft was stopped abeam Taxiway A5, approximately 1400 metres from the beginning (western end) of Taxiway A.

3. The investigation team has examined the relevant records, including ATC surveillance and communication recordings, weather reports and Aerodrome Ground Lighting (AGL) records. It is determined at this stage that weather was not a

contributing factor, as the weather was good with a visibility of 10 kilometres, cloud base of 2,500 feet with no precipitation. As the South Runway was closed for routine maintenance, the runway and taxiway lights were selected at the normal configuration and setting for single Runway 07L operations. Subsequent to the incident, the Duty Aerodrome Supervisor had ordered a visual inspection by Apron Control staff who confirmed that the runway lights and taxiway lights on Taxiway A and B, including the Stop Bar lights were all serviceable. Review of the ATC radio recording showed that communication between ATC and FIN070 was normal with pertinent information and instructions duly acknowledged by the pilot in accordance with proper radio communication procedures.

4. The French air accident investigation authority, BEA, has been requested to analyse data captured by the Digital Flight Data Recorder (DFDR) and Quick Access Recorder (QAR). Raw data from the DFDR have been received from BEA, which are being evaluated by technical experts of CAD.

5. Whilst the investigation is still in progress, the Investigation Team considers it prudent to institute a temporary ATC procedure to minimize the possibility of recurrence. In this connection, Hong Kong ATC, as an extra precautionary safeguard, issued an Operational Instruction on 29 November 2010, which requires that during Runway 07L operations, the Air Movements Controller shall withhold the take-off clearance until ascertaining that the aircraft has completely crossed Taxiway A.

6. During the course of the investigation, should further safety recommendations be necessary, they will be promulgated immediately.

23 December 2010
