UNITED STATES OF AMERICA

NATIONAL TRANSPORTATION SAFETY BOARD

WASHINGTON, D.C.

ISSUED: August 30, 1973

Adopted by the NATIONAL TRANSPORTATION SAFETY BOARD
at its office in Washington, D. C.
on the 16th day of August 1973

FORWARDED TO:

Honorable Alexander P. Butterfield
Administrator
Federal Aviation Administration
Washington, D. C. 20591

SAFETY RECOMMENDATION A-73-65

The National Transportation Safety Board has under investigation an in-flight accident involving a National Air Lines DC-10-10 aircraft on August 10, 1973, en route from New Orleans, Louisiana, to Miami, Florida.

Preliminary information indicates that a flight attendant sustained serious injuries when she became lodged in an elevator shaft between the top of an upward-moving food service cart and the ceiling of the elevator shaft. She reportedly entered the shaft and lay atop the cart in an attempt to release a malfunctioning cart locking system which had prevented removal of the cart from the elevator at the upper deck level of the cabin.

More specifically, following unsuccessful attempts to remove the cart from the shaft at the upper deck level, an attendant overrode the safety switches designed to prevent elevator operation while the door is open, and then lowered the elevator approximately 15 inches. The attendant then crawled into the elevator shaft in the space between the top of the cart and the ceiling of the shaft, in an attempt to reach the release lever of the cart locking system. At this time, another flight attendant in the lower deck galley, unaware of the activities above, actuated the UP switch, thus causing the cart to move upward and compressing the flight attendant between the cart and the elevator shaft ceiling. Initial reports indicate she sustained a fracture of the nose and contusions and lacerations of the face, was hospitalized, and placed under intensive care.

A history of similar malfunctions of this nature in this type of equipment had resulted in the issuance of a special tool to cockpit crews for use in remedying malfunctions of the DC-10 food cart tiedown locking system. This approved method was not used in the present case. The flight attendants involved in this accident reported that they had devised the approach used here as a result of previous similar difficulties and that to their knowledge it was not an authorized procedure.

The reported history of previous malfunctions of this equipment and the specially developed tool for correcting the difficulty suggest that such malfunctions are more than isolated occurrences. Moreover, it seems reasonable that the makeshift remedial procedures used in this case may be resorted to by other flightcrews, thus resulting in a serious injury hazard.

Accordingly, the National Transportation Safety Board recommends that the Federal Aviation Administration:

> Notify on a priority basis all operators of DC-10-type aircraft and other wide-body aircraft equipped with similar elevator/service cart equipment of the need for strict adherence to prescribed procedures, both for the operation of food service galley elevators and for the correction of malfunctions related thereto. Widest possible dissemination of the details of this mishap should be made to illustrate the possible consequences of unauthorized operating procedures.

Reed, Chairman, McAdams, Thayer, Burgess, and Haley, Members, concurred in the above recommendation.

William R. Haley, acting for

By: John H. Reed
Chairman

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