

FINAL REPORT

510-000323	Incident		
Aircraft:	Boeing 757-200	A/C registration:	TF-FIR
Engines:	2 Rolls-Royce RB211-535	Type of Flight:	Scheduled, IFR
Crew:	8 – no injuries	Passengers:	144 – no injuries
Place:	Denmark N56°30,7 E010°07,7	Date and time:	11.01.2007 at 1642 hrs. UTC

All times in this report is UTC.

The Accident Investigation Board, Denmark (AIBD) was notified about the incident by the Icelandic Aircraft Accident Investigation Board on January 11th 2007, at 1800 hrs.

Synopsis

A few minutes after the descent was initiated from FL370 (37000 ft) the left hand off-wing escape slide separated from the aircraft. The aircraft landed in EKCH and it was confirmed that the left off-wing escape slide was missing. The left stabilizer was damaged by the slide when it separated from the aircraft.

Summary

The off-wing escape slide compartment doors were closed by an unidentified person when the aircraft was in for modification work and C-check inspection. The aircraft left Iceland with the left hand side slide compartment door not properly locked. 16 minutes into the flight the door opened and the advisory light illuminated. The crew observed neither visual nor aural abnormalities, and the PIC decided to continue the flight. 2:06 hrs after the advisory light came on the slide carrier was unlocked and deployed. The slide separated from the aircraft and damaged the left stabilizer.

Safety Recommendations

As a result of its investigation of this incident, the Accident Investigation Board, Denmark makes the following recommendations to the European Aviation Safety Agency (EASA):

- a) Ensure that the aircraft manufacturer modify the cockpit crew checklist procedure (the Boeing 757 Operations Manual/Quick Reference Handbook) concerning the off-wing escape slide compartment door advisory light to include and ensure an immediate flight crew action on the advisory light alone (in case of a visual or aural observation does not confirm the over-wing ramp slide deployed).
- b) Ensure that the aircraft manufacturer evaluates the possibility of a physical or visual verification of the locking of the off-wing escape slide carrier and door lock system.
- c) Ensure that the aircraft manufacturer revises the work task card to ensure proper locking of the off-wing escape slide system.

1. Factual information

1.1 History of the flight

The flight, during which the incident occurred, was a scheduled IFR flight from Keflavik Airport (BIKF) Iceland to Copenhagen Airport, Kastrup (EKCH), Denmark.

The aircraft left the gate at 1425 hrs and departed BIKF at 1436 hrs. Shortly before top of climb approximately 16 minutes into the flight the cockpit crew observed that the “L WING SLIDE” advisory light illuminated on the Engine Indicating and Crew Alerting System (EICAS) screen. At the same time the Auxiliary Annunciation Panel light “EMER DOORS” illuminated. The cockpit crew consulted the Boeing 757 Operations Manual/Quick Reference Handbook (OM/QRH) concerning the advisory messages. The message indicated that the wing slide door was not closed, latched and locked. The crew did not observe any abnormalities and the cockpit crew assumed that they had a false indication. The aircraft was within VHF-radio range of the company maintenance control in Iceland, so the Pilot in command (PIC) called and informed about the advisory indications. Maintenance control gave no directions to the PIC. The PIC asked Maintenance control to prepare the mechanics in EKCH for the problem. The PIC decided to continue the flight to EKCH and filled in the Aeroplane Journey and Technical Log Item 1 with: “EICAS MSG: L wing slide During Climb, completed according to QRH”. At 1642 hrs a few minutes after descent was initiated from FL370 (37000 ft) the left hand off-wing slide deployed and the slide separated from the aircraft. At that time the indicated airspeed was approximately 260 kt. The aircraft yawed approximately 3° to the left and the cockpit crew observed that the control steering wheel was out of trim and the autopilot remained engaged. The crew felt a jerk in the airplane and heard a “bang”. Passengers situated close to the left wing emergency exit hatches described the noise like something was slamming to the airplane followed by an explosive bang. The PIC asked the cabin crew to inspect the area around the left exits. The cabin crew found nothing to report. The PIC did not inform Copenhagen Approach or Kastrup Tower about the situation. The cockpit crew felt that the aircraft performed normally during the descent and the approach to EKCH and at 1706 hrs, the aircraft landed in EKCH.

At the gate, the mechanics found the left slide compartment door open, the slide carrier over-rotated and the off-wing escape slide was missing.

The aircraft was damaged as a result of the slide separation.

The incident occurred in dark night and under visual meteorological conditions (VMC).

1.2 Injuries to persons

<i>Injuries</i>	<i>Crew</i>	<i>Passengers</i>	<i>Others</i>
Fatal	-	-	-
Serious	-	-	-
Minor/None	8	144	-

1.3 Damage to aircraft

The aircraft left wing, flap and fuselage skin aft of the left wing suffered minor damage. The structure around the off-wing escape slide compartment and the left stabilizer was substantially damaged.

1.4 Other damage

No other damage.

1.5 Personnel information

The PIC: Male, 64 years
Certificate: Airline Transport Pilot License (ATPL) issued 26 June, 1980
Medical: Last examination 4 December, 2006

Flying experience:	Last 24 hrs	Last 90 days	Total
All types	2:48	145:18	18.292:24
B757	2:28	145:18	4009:03
Landings	1	25	-

First officer: Male, 34 years
Certificate: Airline Transport Pilot License (ATPL) issued 31 October, 2006
Medical: Last examination 17 October, 2006

Flying experience:	Last 24 hrs	Last 90 days	Total
All types approximately	3:00	186:00	2053:50
B757	-	-	1581:24
Landings approximately	-	-	280:00

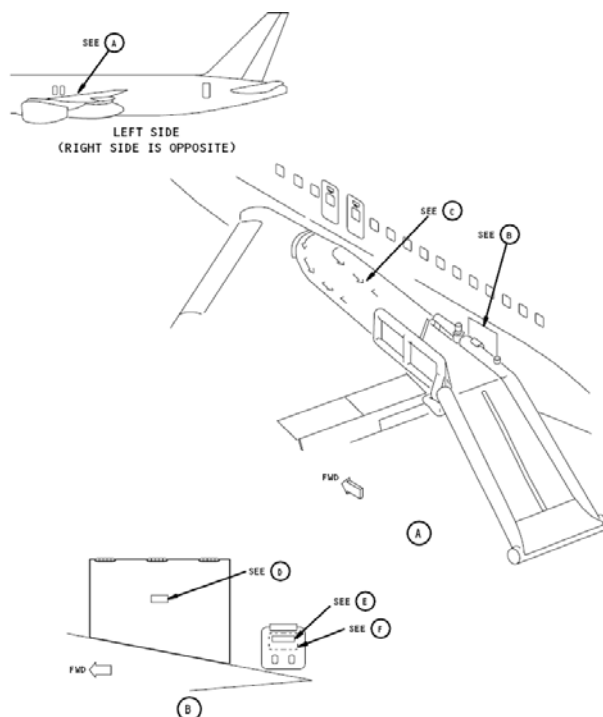
1.6 Aircraft information

1.6.1 General aircraft information

Manufacturer: Boeing
Type: 757-200
Year of manufacture: 1994
Serial number: 26242
Certificate of airworthiness: Valid until 31 October, 2007
Engines: Rolls-Royce RB211-535E4
Maintenance: On January 10th 2007 at 1800 hrs, the aircraft was released to service from C-check and modification work.

1.6.2 Over-wing emergency hatches and off-wing escape slide system information

Two over-wing emergency exit hatches are located on each side of the fuselage above the wing. The off-wing escape slide is located in the outboard corner of the main landing gear wheel well. Slide compartment and maintenance access doors are located above the wing flap area. The maintenance access door is located aft of the slide compartment door.



When the over-wing emergency hatch is opened from inside the cabin the off-wing escape slide is activated. The slide system is operated by air from a pressure bottle. The slide actuator is located behind the maintenance access door. Air pressure from the bottle activates the actuator piston. This will cause the slide compartment door to open, the slide carrier to be unlocked from the compartment and rotate to an over-wing position. The slide will then be inflated by air from the pressure bottle.

1.6.3 Boeing 757 Operations Manual/Quick Reference Handbook.

If the “Emer Doors”, L Wing Slide or “R Wing Slide” advisory light illuminates during flight, the Boeing 757 Operations Manual/Quick Reference Handbook instructed the cockpit crew to take the following actions.

WING SLIDE	
TF-FIH through TF-FIV, TF-FIX	
Message:	EMER DOORS L WING SLIDE R WING SLIDE
Condition:	The EMER DOORS light illuminated indicates that a wing slide door is not closed and latched and locked.
	If visual or aural observation confirms the overwing ramp slide deployed and remains attached to the airplane:
	Minor damage to the trailing edge flap, aft fuselage, and empennage may occur.
	AIRSPEED (As required) REDUCE If necessary operate at a reduced airspeed to minimize slide oscillations and subsequent airplane damage.
	GROUND PROXIMITY FLAP OVERRIDE SWITCH OVRD
	Note: Conditions permitting, use flaps 20 and VREF 20 for landing.
	[May reduce slide oscillations and preclude slide separation on final approach.

1.6.4 Service Bulletin and Airworthiness Directive concerning off-wing escape slide system.

On October 10th 1996, Boeing issued Service Bulletin SB 757-25-0182 to all operators of Boeing 757 aircraft to prevent off-wing slide separations from this type of aircraft. Though Boeing issued the SB, other in-flight off-wing escape slide separations occurred. Therefore, the National Transportation Safety Board (NTSB) USA recommended the Federal Aviation Administration (FAA) to issue an Airworthiness Directive to mandate the incorporation of the SB improvements.

The incident aircraft complied with AD 99-17-20 effective from 24.09.1999 concerning modification of the off-wing escape slide system. This AD was the latest issued on the subject.

1.7 Meteorological information

On January 11th 2007, the general weather condition in Denmark was overcast, rainy and windy. Wind conditions at the position and altitude of the incident were approximately 266° and 60 kt.

1.8 Aids to navigation

Not relevant.

1.9 Communications

The actual Air Traffic Control radio communication was not obtained.

1.10 Aerodrome information

Not relevant since the incident occurred while airborne and the landing were performed without any further occurrences.

1.11 Flight recorders

The aircraft was equipped with a Flight Data Recorder (FDR), a Quick Access Recorder (QAR) and a Cockpit Voice Recorder (CVR). Flight data was downloaded and used in the investigation. The quality of the data was good.

1.12 Off-wing escape slide system in flight deployment investigation information.

1.12.1 Initial investigation

The structure around the off-wing escape slide compartment and the left stabilizer was substantially damaged.



The stabilizer had several impact marks on the leading edge. Also the white collared panel aft of the leading edge had several impact marks.

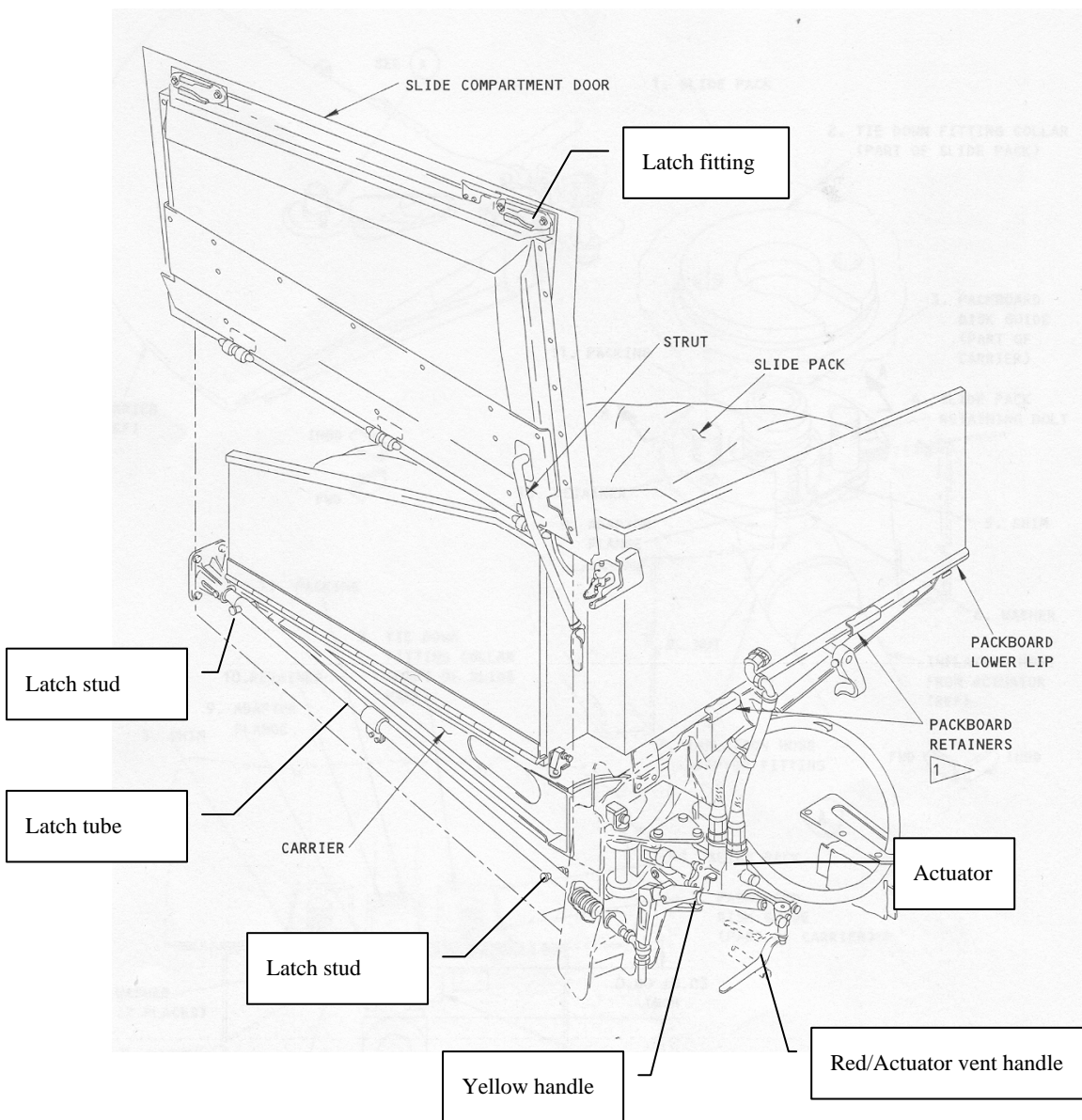
When the slide carrier deployed the slide carrier restraining hook was not able to resist the air stream forces. It broke up and caused the slide carrier to over-rotate. The aft outboard corner of the slide compartment structure was substantially damaged by the over-rotated slide carrier.

Wind direction and speed at the incident altitude indicate, that the slide probably ended up somewhere in the sea of Kattegat east of the incident position. Because it was unlikely to find the slide the AIBD decided not to initiate a search at sea. The slide has not yet been found.

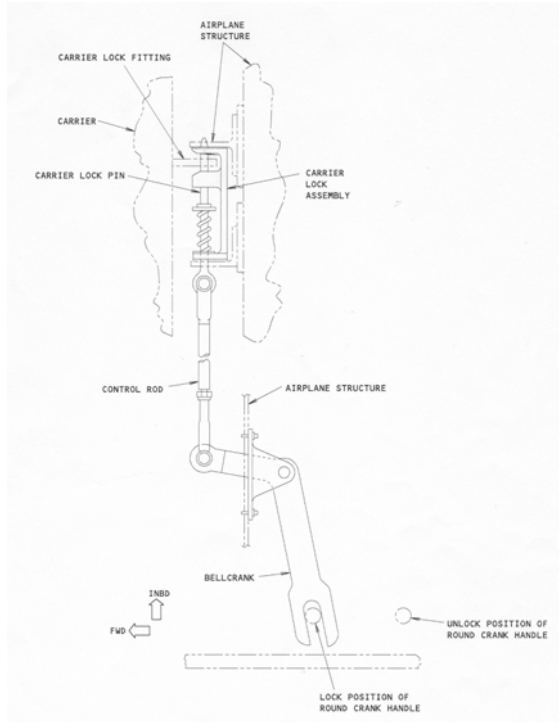
The slide system electrical circuit and the firing squib were intact. The slide system air pressure bottle located in aft cargo bay was found pressurized and the control valve untouched.

1.12.2 Slide carrier and door lock system investigation

The slide carrier lock mechanism was intact and it was possible to lock the carrier into the carrier lock assembly operating the yellow/round crank handle.



The carrier lock fitting had scratch marks on its outer portion. Operating the yellow/round crank handle without pushing hard inwards on the carrier, allowed the carrier lock pin to scratch the outer portion of the carrier lock fitting. The right hand side carrier lock fitting was also examined and the same type of scratch marks was found. It was not possible to lock the carrier without pushing the slide compartment door hard inwards.



Investigators opened and closed the slide system several times according to the procedure described in the Boeing Aircraft Maintenance Manual (AMM) 25-65-09. The system functioned normally and the carrier and compartment door was found satisfactorily locked at all attempts.

The down and locked position of the yellow/round crank handle in relation to the red/actuator vent handle was found inappropriate.



The red/actuator vent handle was turned 90 degrees outboard to the manual position to disarm the inflation system. It was necessary to raise the yellow/round crank handle to give the red/actuator vent handle space enough to be operated inwards.

During this process, the investigators once observed, that the latch studs were not engaged properly in the latch fitting slots. The door was closed and the EICAS light “L Wing Slide” was out, indicating that the door was closed. The door was flush with the fuselage of the aircraft.

With the door in a closed position, it appeared visually to be locked, but the door was not properly locked. The picture below was taken from the main gear wheel well showing the above mentioned lock situation.



When the slide carrier was in place and the compartment door was closed it was physically and visually impossible to verify that the carrier lock pins were fully engaged and the latch studs were fully engaged in the latch fittings. It was only possible by using a borescope from the landing gear wheel well.

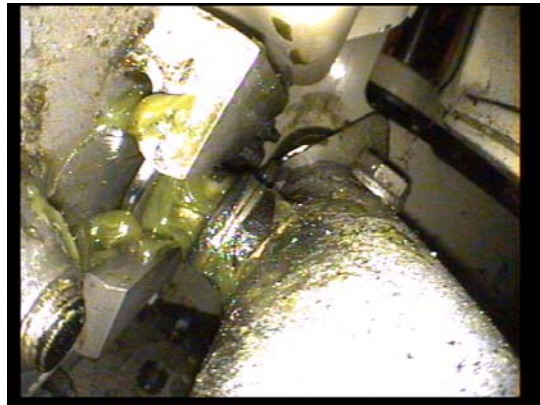
The door sensor proximity switch was found installed according to the Boeing SB 757-25-0182. The EICAS advisory light “L Wing Slide” came on when the door was opened approximately 6 - 10 mm outwards.

1.12.3 Right hand side off-wing escape slide system investigation

Because the right hand side off-wing escape slide system was fully intact, the system locking procedure and function was tested on that side.

The investigators managed to close and lock the system allowing the forward compartment door latch to be unlocked.

The left borescope picture shows the forward latch unlocked and the right picture show the aft latch locked.



The EICAS light “L Wing Slide” remained out, indicating that the door was closed.

The investigators concluded that it was difficult to operate the yellow/round crank handle with one hand and pushing hard inwards on the compartment door with the other hand, particularly when the wing flap was down.

The door was not flush with the fuselage at the lower forward side.



1.12.4 Maintenance

The aircraft had been on ground since the middle of November, 2006. It was undergoing a C-check inspection and a new complete lavatory was installed in the cabin.

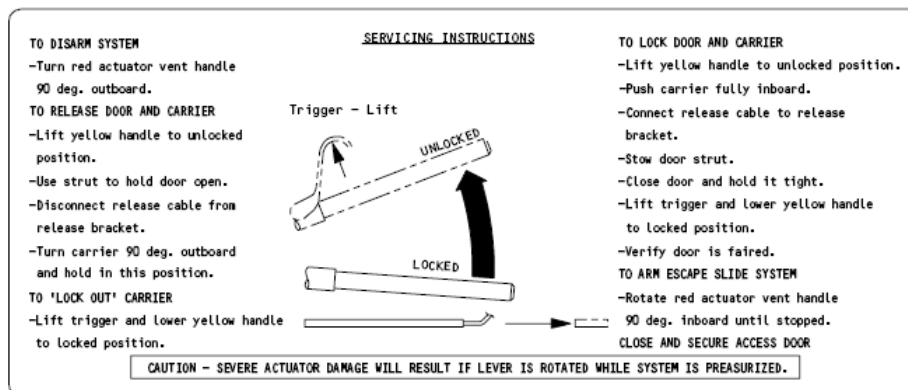
During the C-check inspection the slide compartment doors were opened. The slide carrier lock mechanism, the compartment door latch fittings, and the door latch tubes and studs were lubricated according to the Boeing maintenance task card 12-048-01. The mentioned parts were found newly lubricated.

Maintenance practices regarding disarming and arming the off-wing escape system was described in the Boeing AMM 25-65-00. An armed system can accidentally deploy and cause injury or damage.

Maintenance practices regarding opening and closing the slide compartment doors and slide carrier locks were described in the Boeing AMM 25-65-09.

The investigation revealed that the Boeing task card 12-048-01 regarding lubrication referred to the Boeing AMM 25-65-00. The task card did not refer to the Boeing AMM 25-65-09.

A placard placed on the back side of the slide compartment maintenance access door gave servicing instructions.



Instructions written on the placard were extracts from the Boeing AMM 25-65-00 and 25-65-09. The instructions were not identical to the instructions in the AMM's.

The cautions, notes and warnings mentioned in the AMM's were not printed on the placard.

On the maintenance access door compartment forward frame, there was a witness mark placard in place. The witness mark corresponds to the yellow/round crank handle in locked position. There was no witness mark on the aft frame.

The company maintenance shop work card was identical to the Boeing maintenance task card 12-048-01. The work card had three columns for signing the work performed.

The mechanic who lubricated the slide carrier lock mechanism, the compartment door latch fittings, and the door latch tubes and studs, was told to leave the doors open by the inspector.

The complete work card was signed of by the mechanic on 1 December, 2006.

The inspector told the investigators that he overlooked the system and left the doors open. The inspector left the aircraft to do some other work within the company. Later in December he went back to the aircraft to finish the work. In the mean time, the aircraft had been moved from the west hangar bay to the east hangar bay. The inspector found the slide system doors closed. He did not open the doors again but felt with his finger on the lower frame of the doors and was of the opinion that the doors were locked. He considered the work completed.

The inspector never signed the work card as he was supposed to do and was of the opinion that the circulation of the papers was the reason for this.

The company was not able to give a clear explanation on these matters.

It has not been possible to identify the person that closed the doors. It is the opinion of the maintenance shop, that someone closed the doors because the aircraft was transferred from one hangar bay to another.

On January 10th 2007 at 1800 hrs, the aircraft was released to service the day before the incident flight.

1.13 Medical and pathological information

The crew was properly certified.

1.14 Fire

There was no fire.

1.15 Survival aspects

Not relevant in this incident.

1.16 Tests and research

No test and research done.

1.17 Organizational and management information

No further information.

1.18 Additional information

Since the early eighties, several incidents like this were reported. The scenario for these incidents was almost the same and because the incidents occurred following maintenance, the effort was made to do changes on that subject. AD 99-17-20 became effective on September 24th 1999.

Another off-wing escape slide deployment during flight occurred in Portland Oregon in May 2006. The aircraft had just gone through a maintenance check with some work done to the slide. This is the latest incident that the AIBD was aware of.

1.19 Useful or effective investigation techniques

None used in this incident investigation.

2. Analysis

2.1

The flight crew was properly licensed. The AIBD does not consider the crew to be a contributory factor to the incident.

However, the AIBD cannot exclude, that the separation of the slide could have been avoided if the PIC had diverted to the nearest suitable airport in Iceland, when the EICAS light "L Wing Slide" advisory light illuminated.

The advisory light illuminated 16 minutes into the flight and the cockpit crew consulted the Quick Reference Handbook.

The AIBD is of the opinion that the instruction written in the Boeing 757 Operations Manual/Quick Reference Handbook could mislead the cockpit crew. The OM/QRH instructs the cockpit crew to confirm a slide deployment by visual or aural observation.

At that time the crew did not observe anything abnormal and the cockpit crew assumed they had a false indication. Therefore the PIC decided to continue the flight and informed the maintenance control about

the situation. Apparently, none of the involved was aware of the potential risk that the slide could separate from the aircraft in flight. Maintenance control called the mechanics in Copenhagen to look at the advisory light problem upon landing.

Approximately 2:06 hrs after the advisory lights indicated that the slide compartment door was open, the off-wing escape slide separated from the aircraft.

In the OM/QRH there is no guidance to the crew how to handle an open wing slide door indication if at the same time there are neither visual nor aural observations indicating a slide separation.

The AIBD finds that a warning concerning the potential risk for slide deployment could help the crew to decide what to do in that situation.

The stabilizer was damaged by the off-wing escape slide that separated from the aircraft. This caused the aircraft to yaw to the left and the flight control steering wheel to be out of trim.

Despite of the uncertain situation, the PIC did not inform either Copenhagen Approach or Kastrup Tower about the situation. The flight crew had the aircraft under control during the whole phase of the incident and the landing in Copenhagen was normal.

The weather is not considered to be a factor in the incident.

2.2

The slide system electrical firing squib was intact and the air pressure bottle was found pressurized.

The left hand side off-wing slide compartment door was not properly locked when the aircraft was released to service and left the maintenance hangar.

It was not possible to state exactly how the door was closed and locked. However, the advisory light was out, telling that the door was at least almost flush with the fuselage. The AIBD assumes that the latch studs to some degree were in contact with the latch fittings.

It was necessary to raise the yellow/round crank handle to give the red/actuator vent handle space enough to be operated inwards. This movement of the yellow/round crank handle could partly unlock the door and be the reason for the door to be insufficient locked. It could also be the reason for the slide carrier to be unlocked.

There are two scenarios regarding the slide carrier unlocked situation.

One is the possibility of the carrier to be in place but the carrier lock pin not engaged in the carrier lock fitting. The scratch mark on the outer portion of the carrier lock fitting supports this scenario.

The investigation could not re-create this situation.

The second scenario is created when the slide compartment door opened. The air that flows into the area (indicated airspeed of 260 kt) creates forces that at a certain point were able to unlock the yellow/round crank handle system.

Because the door was closed with the purpose of repositioning the aircraft, the AIBD can not state when and how the slide carrier was unlocked.

Because the aircraft was able to fly 2:06 hrs with the slide compartment door open it is the AIBD point of view that the carrier was locked when the door opened in flight.

The investigators managed to lock the right hand side slide compartment door leaving the forward latch open and the door not flush with the fuselage. The AIBD is aware of this possibility, but found no evidence to support this scenario during investigation on the left hand side compartment door.

2.3

The aircraft was on ground for almost eight weeks due to the lavatory installation. During this time, the C-check inspection was performed.

The off-wing slide compartment was opened because of the C-check lubrication task card. The mechanic did the work and signed of the work card despite he did not close the compartment doors.

The inspector had told the mechanic to leave the doors open, he overlooked the system and he also left the doors open.

Approximately two weeks later, the inspector went back to work on this aircraft and found it moved to another hangar bay.

He found the slide compartment doors closed and was of the opinion that the doors were locked.

The inspector did not open the slide compartment door. He considered the work completed.

There is no physically or visually way to check if the system is properly locked.

The inspector never signed the work card as he was supposed to do.

It is the AIBD point of view that because the mechanic signed the work card it was assumed that the work was finished and nobody focused on the inspector's part of the work.

The maintenance paperwork was not properly completed, but the AIBD found no sign of general quality problems in the maintenance organization.

The person who closed the slide compartment doors is unidentified. The AIBD finds that the person that closed the doors was not focused on the closing procedure described in the Boeing AMM, but on the fact that the aircraft was to be moved from one hangar bay to another. The way he closed the doors is not known, but he did not close the left hand side door properly.

The person who closed the doors temporarily did not inform the maintenance organization about this.

2.4

Because the slide compartment doors were closed in an unauthorized manner, the findings regarding the Boeing AMM procedures and the maintenance access door placard servicing instruction can not be considered as contributory factors to the incident. However, the AIBD can not exclude that the person that closed the doors followed these procedures and instructions.

The AIBD found that the Boeing task card 12-048-01 regarding lubrication referred to Boeing AMM 25-65-00. The task card did not refer to Boeing AMM 25-65-09 that is the procedure to follow when closing the slide systems.

Instructions written on the maintenance access door placard was extracts from the Boeing AMM 25-65-00 and 25-65-09. The instructions were not identical to the instructions in the AMM's.

The cautions, notes and warnings mentioned in the AMM's were not printed on the placard.

It seems that this type of incident still occurs. For that reason, the AIBD is of the opinion that there should be no doubts how the slide system should be closed.

The AIBD finds that if the slide system is closed in according to the Boeing AMM 25-65-09 the system should be properly locked, however, it is not physically or visually possible to confirm this.

3. Conclusions

3.1 Findings

1. The cockpit crew was properly licensed.
2. The aircraft had a valid airworthiness certificate.

3. During C-check inspection lubrication work in accordance to Boeing task card 12-048-01 was performed on the off-wing slide lock system.
4. The mechanic was told by the inspector to leave the slide compartment doors open. In spite of the fact that he left the doors open he signed the work card 12-048-01.
5. The inspector overlooked the slide system lubrication work and left the doors open. He did not sign the work card 12-048-01.
6. An unidentified person temporarily closed the slide compartment doors and did not inform the maintenance organization about this.
7. Approximately two weeks later, the inspector went back to close the slide system. He found the doors closed. The inspector did not open the slide compartment door. He considered the work completed. He never signed the work card 12-048-01.
8. The maintenance paperwork was not properly completed.
9. The day before the incident flight, the aircraft was released to service from C-check inspection.
10. The down and locked position of the yellow/round crank handle in relation to the red/actuator vent handle was found inappropriate. It was necessary to raise the yellow/round crank handle to give the red/actuator vent handle space enough to be operated inwards.
11. It was possible to leave the left hand side slide compartment door with the latch studs not properly engaged in-to the latch fitting slots.
12. The left hand side slide compartment door was not properly locked.
13. After closure of the slide system, it is not physically or visually possible to check the lock condition of the system without a borescope.
14. The "L Wing Slide" and "Emer Doors" advisory lights illuminated approximately 16 minutes into the flight. The cockpit crew consulted the OM/QAH. The crew observed neither visual nor aural abnormalities. The cockpit crew assumed they had a false indication and the PIC decided to continue the flight.
15. In the OM/QRH there is no guidance to the cockpit crew how they should handle an open wing slide door indication if at the same time there is no visual or aural observations indicating a slide separation.
16. The "L Wing Slide" light illuminates when the door was opened approximately 6 - 10 mm outwards.
17. The slide carrier got unlocked at a certain point after the compartment door opened.
18. 2:06 hrs after the "L Wing Slide" light illuminated the off-wing escape slide deployed and the slide separated from the aircraft. The left hand side stabilizer was damaged by the slide.
19. The cockpit crew had the aircraft under control during the whole phase of the incident and the landing was normal.
20. The slide system electrical firing squib was intact and the air pressure bottle was found pressurized
21. The Boeing task card 12-048-01 regarding lubrication did not refer to the Boeing AMM 25-65-09 Close the slide compartment door.
22. The instructions given on the slide compartment maintenance access door placard, was not identical to the Boeing AMM 25-65-09 procedures. The cautions, notes and warnings mentioned in the AMM were not printed on the placard.
23. It was possible to close the right hand side compartment door allowing the forward door latch to be unlocked.

3.2 Factors

1. An unidentified person closed the slide compartment doors temporarily and did not inform the maintenance organization about this.
2. The left hand side slide compartment door was not properly locked.
3. The “L Wing Slide” and “Emer Doors” advisory lights illuminated approximately 16 minutes into the flight. The cockpit crew consulted the OM/QAH. The crew observed neither visual nor aural abnormalities. The cockpit crew assumed they had a false indication and the PIC decided to continue the flight.
4. The slide carrier got unlocked at a certain point after the compartment door opened
5. 2:06 hrs after the “L Wing Slide” light illuminated the off-wing escape slide deployed and the slide separated from the aircraft. The left hand side stabilizer was damaged by the slide.

3.3 Summary

The off-wing escape slide compartment doors were closed by an unidentified person when the aircraft was in for modification work and C-check inspection. The aircraft left Iceland with the left hand side slide compartment door not properly locked. 16 minutes into the flight the door opened and the advisory light illuminated. The crew observed neither visual nor aural abnormalities, and the PIC decided to continue the flight. 2:06 hrs after the advisory light came on the slide carrier was unlocked and deployed. The slide separated from the aircraft and damaged the left stabilizer.

4. Safety Recommendations

As a result of its investigation of this incident, the Accident Investigation Board, Denmark makes the following recommendations to the European Aviation Safety Agency (EASA):

- a) **Ensure that the aircraft manufacturer change the “Emer Doors, L and R Wing Slide” advisory light message level from advisory to warning and revises the cockpit crew checklist procedure (the Boeing 757 Operations Manual/Quick Reference Handbook) to include and ensure an immediate flight crew action.**
REK-01-2007
- b) **Ensure that the aircraft manufacturer evaluates the possibility of a physical or visual verification of the locking of the off-wing escape slide carrier and door lock system.**
REK-02-2007
- c) **Ensure that the aircraft manufacturer revises the work task card to ensure proper locking of the off-wing escape slide system.**
REK-03-2007

5. Appendices

No appendices enclosed.