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ACCIDENT INVESTIGATION COMMISSION

MEDIA RELEASE

RELEASE OF FINAL REPORT ON AIR NIUGINI MERCURY SPILL IN B737-800 CARGO COMPARTMENT, JACKSONS INTERNATIONAL AIRPORT, PORT MORESBY, PNG.

The Papua New Guinea Accident Investigation Commission (AIC) today published the Final Report on the investigation conducted into a serious incident involving a B737-800 aircraft that occurred at Jacksons International Airport (Jacksons Airport), Port Moresby, Papua New Guinea (PNG).

On 23 July 2024, at about 09:15 local time (23:15 UTC), the occurrence aircraft, registered P2-PXB, operated by Air Niugini Limited (ANL) was planned to conduct a Regular Public Transport flight from Jacksons Airport, Port Moresby to Nadzab Tomodachi International Airport (Nadzab Airport), Morobe Province, PNG, when during passenger boarding and loading of cargo, there was a spillage of hazardous material, mercury in its aft cargo compartment. There were 67 persons on board the aircraft: 2 pilots, 4 cabin crew and 61 passengers. No injuries were reported.

The AIC was informed at 12:04 local time (02:04 UTC) on 8 August 2024, through a phone call by the Civil Aviation Safety Authority of PNG of the serious incident involving an ANL B737-800 aircraft, registered P2-PXB, that occurred on 23 July 2024. The AIC immediately commenced an investigation. The AIC immediately commenced an investigation in accordance with its mandate under the *PNG Civil Aviation Act 2000* and pursuant to *ICAO Annex 13 to the Convention on International Civil Aviation.*

The investigation found that while the cargo of interest containing seven (7) bottles of mercury was labelled as "excavator parts", which could also be considered 'machinery parts', the Cargo Acceptance Officer did not request further details from the cargo owner or inspect the contents before accepting the cargo. The investigation found that the Acceptance Officer's inaction to inspect the cargo of interest resulted in hazardous substance (mercury) being accepted for shipment.

The Cargo of interest was processed through the x-ray screening machine as required. However, the Screening Officer did not effectively monitor the screen when the cargo passed through. The investigation found that the Screening officer was multi-tasking; loading cargo into x-ray, screening and assisting with unloading onto pallet, and was distracted. This may have resulted in inattention to the cargo being screened.

Aside from human factors, the Final report also identified other contributory factors related to organisational, personnel training and mercury characteristics.

The Final report includes safety recommendations made by the AIC to the operator, with the intention of enhancing operational safety. According to *ICAO Annex 13 Standards*, identified safety deficiencies and concerns must be raised with the persons or organisations best placed to take safety action. Unless safety action is taken to address the identified safety deficiencies, death or injury might result in a future accident.

The Final Report of the investigation is available on AIC's website www.aic.gov.pg

Authorised for release by:

Maryanne J. Wal
Chief Commissioner