

Double De-Fuelling Incident Blackhawk 104 & Blackhawk 205 Gold Coast Airport 7 Jun 05

SQNLDR Marcus Bromet Headquarters Air Command, Australia



Marcus Who?

- DHC6/B200 32SQN, Tindal
- Unit Flying Safety Officer
- C130E/H 36SQN, Richmond
 - Group Flying Safety Officer
 - Base Flying Safety Officer
- SO2 Ops Air Command, Glenbrook
 - Command Aviation Safety Officer
- B737 AEW&C 2SQN, Williamtown ??





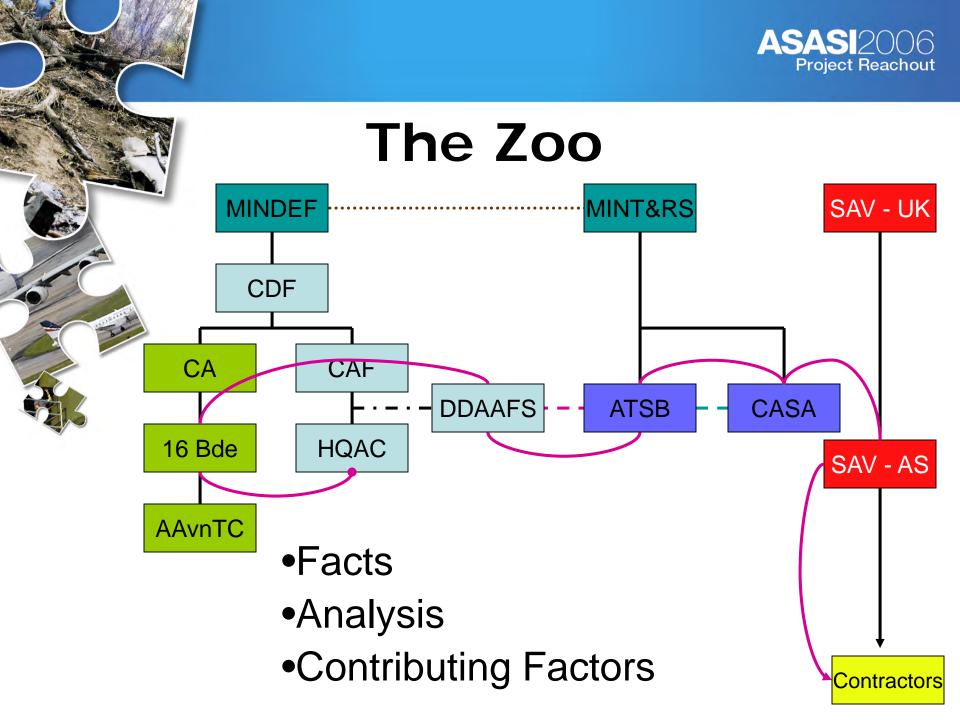
Bringing it all together

- ICAO Annex 13
- Looking at the Whole System
- Don't highlight the obvious, Highlight the obscure!!
- Authority for Investigation (or is that an interpretation...)
- Safety Investigation is not a Turf War
- Subject Matter Experts & Lessons for Free
- Interviewing and collection of evidence
- Using SHELL & The Cheese!
- Team approach, BUT never get stuck with the report!

DISCLAIMER







Facts – Incident

- → 7 Jun 05 (1300) Blackhawk 104 requested a refuel from a civil refueller at Bay 16 at the Gold Coast Airport following a standard training mission.
- Following the refuel the gauges read 20lbs, despite indications that 856L was transferred
- Blackhawk 205 was despatched to provide maintenance support, and 749L were transferred
- → APU Blackhawk 104 flamed out



Facts – Sequence of Events (Crew)

- → Task: Blackhawk 104 to conduct an IFR navigation sortie, whilst performing a series of basic, emergency, and IF procedures.
- Simulator mission flown with the QFI on 06 Jun 05.
- Crew commenced pre-flight planning, departing with full tanks (2300lbs).
- Arrival fuel at the Gold Coast was expected to be just under half (800lbs)
- * Routine refuel, conduct a crew debrief and lunch then RTB
- Aircraft captain self-authorised the sortie, and prior to departure used his mobile phone:
 - + to confirm parking on Bay 16,
 - → to request the SHELL Refueller at 1200hrs





Facts - Sequence of Events (Refuel)

- Daily quality-control (QC) checks were completed
- Commenced refuels on civil aircraft using openline/overwing refuelling
- Waited for Blackhawk 104 at Bay 16





Facts - Sequence of Events

→ Commenced refuels on Blackhawk 104 using closed line /single point refuelling





Facts – Sequence of Events (Post refuel)

- → AC Power prior to main engine start via the APU.
- Aircraft captain noted:
 - →20 pounds of fuel were showing on the fuel indicator;
 - →both fuel low lights flashing;
 - >two associated master caution warning lights.
- Aircraft captain conducted a FUEL IND TEST norm
- → Crew consensus that the aircraft had been refuelled to full internals, and the previously documented electrical history associated with the aircraft, suggested a fuel indication problem was probable.
- → Shut down APU and contact maintenance.



Facts - Sequence of Events (Post refuel)

- Blackhawk 205 arrived & Blackhawk 104 was released.
- → Maintenance personnel removed the Miscellaneous Switch Panel and some sound proofing before requesting the aircrew start the APU
- → Approximately 4-5 minutes under APU power, the APU flamed out.
- → The No.1 fuel tank was visually inspected
- → Refuelling of Blackhawk 205 was terminated and the quantity of Jet A-1 in the truck was visually inspected by the duty refueller.
- → The duty refueller recalled that he had refuelled other aircraft during the course of his shift (ie. Metroliner/Citation).
- → Both aircraft captains discussed the issue of contaminated fuel, but did not raise the issue of contamination with the contractor.
- → Both Blackhawk 104 and Blackhawk 205 were then refuelled by a second contractor using a separate fuel source Blackhawk 104 took a total of 1310L (2331lbs)



Facts - Personnel

- → Blackhawk 104
 - →QFI Captain
 - →Co Pilot
 - **→** Loadmaster
- → Blackhawk 205
 - **→**Crew
 - → Maintenance
- Duty Refueller GCFF
- Refuelling Manager GCFF



Why did a double defuel occur?



















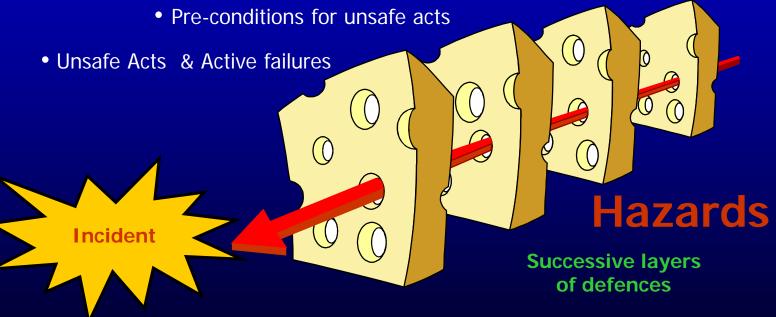
Time (Approx)	Customer	Aircraft	Registration	Meter Start	Meter Finish	Sales		Refueller
						O/W	SPR	
0930	Jetcra ft	Metro III	VH-VZA	7688945	7689745	800		Duty
1300	AAvnTC	BH-104	A25-104	48502008	48502864		856	Duty
1500	Aeromil Pacific	Cessna CJ	N114CJ	7689745	7690545	800		Mgr/Duty
1600	AAvnTC	BH-205	A25-205	48502864	48503613		749	Duty
1700	Sunjet Airways	Cessna CJ	VH-VLZ	7690545	7692480	1935		Mgr

2005-06-07 **23:29** METARAWS YBCG 1330Z 20007G09KT //// 16.6/15.0 Q1024.4 RMK **RF00.0/010.8** CLD:SCT019 BKN074 OVC091 VIS:9999 BV:13.5 IT:25.4



James Reason Accident Causation Model

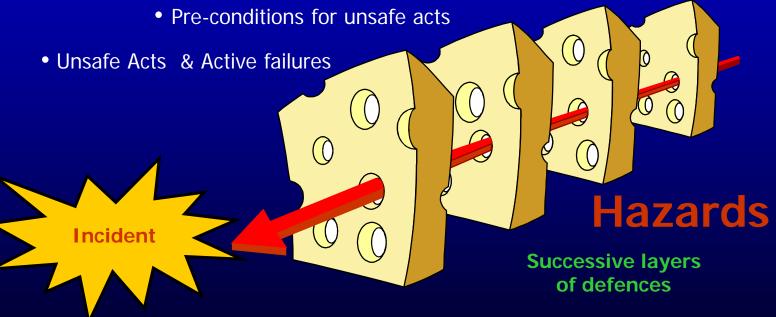
- Organisational Influences
- Unsafe supervision





James Reason Accident Causation Model

- Organisational Influences
- Unsafe supervision





Unsafe Acts



- Unsafe Acts
 - → Duty Refueller switch selection
 - → Captain selection of incorrect refueller
 - → Fuel quarantine procedures violated
- Defences
 - → Aircrew Checklist Discipline
 - → Shell Water Detection Kit



Preconditions for Unsafe Acts



- Preconditions for Unsafe Acts
 - → Aircrew Situational Awareness
 - → Refuel Switch Selector
 - → Refueller Training



Unsafe Supervision



- Unsafe Supervision
 - → Refueller Training



Organisational Influence



- Organisational Influence
 - → GCFF Audit Compliance & Operating Procedures
 - → JFLA audit omissions



Findings

UNSAFE ACTS

- → The captain of Blackhawk 104 selected the incorrect contract refueller
- → The duty refueller at GCFF selected the 'defuel' pump setting on the refuel/defuel master switch
- → GCFF management failed to quarantine contaminated fuel

→ PRECONDITIONS FOR UNSAFE ACTS

- → The loadmaster of Blackhawk 104 received both visual and aural cues
- → The selector switch was mounted against a plain unmarked silver disc, with no lock wire or label protection.
- → The duty refueller received substandard training on the Jet A-1 truck

UNSAFE SUPERVISION

- → Limited number of SPR operations conducted by the duty refueller
- → ORGANISATIONAL INFLUENCES
 - → GCFF had not remedied repeated non-conformance events
 - → JFLA audit omissions



Safety Recommendations

- → Total of 19 recommendations:
 - → GCFF
 - → SAV
 - → JFLA
 - → 16 Bde







- Bringing it all together
 - Construct of an ICAO Annex 13 investigation
 - Looking at the Whole System, not just a part
 - Don't highlight the obvious, Highlight the obscure!!
 - Legal authority for investigation
 - Good relationships between safety professionals
 - Learn lessons and implement recommendations
 - Perishable skills (interviewing/evidence)
 - Common models, common understanding
 - Taxonomy
 - Never get stuck with the report (I did)!!