Aviation Safety Investigation Report 198800127

Beechcraft A36

15 July 1988

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NOTE: All air safety occurrences reported to the ATSB are categorised and recorded. For a detailed explanation on Category definitions please refer to the ATSB website at www.atsb.gov.au.

Occurrence Number: 198800127 **Occurrence Type:** Accident
Location: 2 km NE of Jandakot WA
Date: 15 July 1988 **Time:** 1310
Highest Injury Level: Nil
Injuries:

	Fatal	Serious	Minor	None
Crew	0	0	2	2
Ground	0	0	0	-
Passenger	0	0	0	0
Total	**0**	**0**	**0**	**2**

Aircraft Details: Beechcraft A36
Registration: VH-MKF
Serial Number: E-30
Operation Type: Aerial Work
Damage Level: Substantial
Departure Point: Jandakot WA
Departure Time: 1230
Destination: Jandakot WA

Approved for Release: 8 February 1989

Circumstances:

The Pilot-under-Instruction selected the left fuel tank during the pre-landing checks as the aircraft joined the circuit on left base leg. Approximately 20 seconds later, and after the aircraft had commenced descent for landing, the engine stopped. The selector lever was returned to the right hand tank position but the fuel boost pump was not turned on. The engine did not restart immediately and the Pilot-in-Command elected to concentrate his efforts on a forced landing. The aircraft touched down in an uncleared bush area and overturned when the nosegear collapsed. The subsequent investigation determined that the fuel selector panel had been fitted with a decal which indicated an incorrect position for the left tank. The decal had been modified some time prior to the accident, with a coloured pen, to show the correct position. The colouring had subsequently worn off, resulting in both correct and incorrect positions being visible. The fuel selector was also fitted with detents to help locate the correct selection positions. A build up of grease and wear on the detent combined to make the left tank detent less positive than normal. When the pilot had moved the selector, he had not noticed the detent, and had inadvertently shut off the fuel to the engine. During his pre-flight inspection, the Pilot-under-Instruction had noted that the selector was different from that discussed during a briefing given by the Pilot-in-Command on the aircraft systems. However, he had not alerted the Pilot-in-Command to the anomaly.

Significant Factors:

The following factors were considered relevant to the development of the accident

1. Inadeqauate maintenance - an incorrect decal was fitted to the fuel selector panel.

2. Inadequate maintenance - the decal was inadequately modified.

3. Inadequate pre-flight inspection - the Pilot-in-Command did not check the fuel system adequately before flight.

4. Inadequate crew co-operation - the Pilot-under-Instruction did not draw the attention of the Pilot-in-Command to the discrepancy with the fuel selector.

5. Both pilots were inexperienced on the aircraft type.

6. Inadvertent mismanagement of the fuel system - the fuel supply to the engine was turned off.

7. The Pilot-in-Command was forced to carry out a forced landing on unsuitable terrain.