National Defence Défense nationale

Volume 2, Issue 4 • April 2004

DEBRIEFING

Flight Safety is Everybody's Business

UNSAFE UNLOADING PRACTICES

(13 Jan 04 - Occurrence #114658)

During loading activities on an alert F18, the load crew encountered problems in mating AIM-7 missile on A/C station # 6 with the missile electrical connector did not match the F18 connector. With time running out, the defective missile was downloaded and placed on a trailer already loaded with two AIM-9s on top rack along with two AIM-7s, one on each side, of the bottom rack. As soon as defective missile was set down on R/H side of trailer, load crew proceeded immediately to pick up another missile from L/H side of trailer but, faced with time pressure to complete the load, they did not secure the defective missile to the trailer. Loading of AC was completed and the ordnance installation verification checks carried out as per the technical orders. Immediately thereafter, another technician not involved with the load crew in question, conducted a partial inspection of the trailer, assumed that all weapons were secured, and moved the trailer out of the way without a walking escort to park it inside another quick reaction alert (QRA) bay so that it would be ready for use.

Non occurrence related crew loading AIM-7

Later that day, the trailer had to be moved out of bay in order to tow an A/C inside. Again, a partial inspection of the trailer was done by a qualified weapons convoy technician who also assumed the weapons were secured. The trailer was moved with a qualified escort located on L/H side of trailer. While moving the armament trailer back inside the QRA hangar, it hit a small bump which caused the AIM-7 missile to roll off and fall to the ground, hitting the ground tail first then rolling approximately five feet, destroying the radome in the process. The appropriate emergency EOD response was carried out.

View of occurrence trailer

The investigation concluded that in light of the two omissions where the load was not verified constitutes a Routine Violation. It was also assessed also that the mental state of the crews in their rush to meet their commitments caused the crews to cut corners and omit checklist items. The personnel directly involved in this incident have undergone re-certification training. As this pattern of omission was likely a systemic failure, problem has been addressed with all units of the Wing to ensure that the pattern is broken and replaced by sound habits that reflect the correct procedures.

Specific attention must be paid to sensitizing all personnel active in the handling of air weapons of the insidious nature of this type of omission and its implications. The WFSO rightly pointed out in the occurrence report that if our checklists and written procedures are misapplied they establish incorrect habit patterns and their effectiveness as defense mechanisms is neutralized.

The contents of Debriefing shall be used for no purpose other than accident prevention. This information is released solely in the interests of Flight Safety under the authority of the Director of Flight Safety, National Defence Headquarters, Ottawa.

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