AI2017-6

AIRCRAFT SERIOUS INCIDENT INVESTIGATION REPORT

JAPAN TRANSOCEAN AIR CO., LTD. J A 8 5 2 5

October 26, 2017



JTSB Japan Transport Safety Board

The objective of the investigation conducted by the Japan Transport Safety Board in accordance with the Act for Establishment of the Japan Transport Safety Board (and with Annex 13 to the Convention on International Civil Aviation) is to prevent future accidents and incidents. It is not the purpose of the investigation to apportion blame or liability.

Kazuhiro Nakahashi Chairman Japan Transport Safety Board

Note:

This report is a translation of the Japanese original investigation report. The text in Japanese shall prevail in the interpretation of the report.

AIRCRAFT SERIOUS INCIDENT INVESTIGATION REPORT

ABNORMAL DECOMPRESSION INSIDE AN AIRCRAFT OPERATED BY JAPAN TRANSOCEAN AIR CO., LTD. BOEING 737-400, JA8525 AT ABOUT 55 KM EAST-NORTHEAST OF TANEGASHIMA AIRPORT AT AN ALTITUDE OF APPROXIMATELY 37,000 FT AT ABOUT 8:20 ON JUNE 30, 2015

October 13, 2017

Adopted by the Japan Transport Safety Board Chairman Kazuhiro Nakahashi Member Toru Miyashita Member Toshiyuki Ishikawa Member Yuichi Marui Member Keiji Tanaka Member Miwa Nakanishi

1. PROCESS AND PROGRESS OF INVESTIGATION

1.1 Summary of	On Tuesday, June 30, 2015, a Boeing 737-400, registered as
the Serious	JA8525, operated by Japan Transocean Air Co., Ltd., during a
Incident	flight as the scheduled Flight 002 from Naha Airport to Kansai
	International Airport, at about 55 km east-northeast of
	Tanegashima Airport, made emergency descend to the altitude of
	about 10,000 ft due to decompression inside the aircraft. After that,
	the aircraft continued the flight and landed at Kansai
	International Airport.
1.2 Outline of	This event fell under the category of "Abnormal decompression
the Serious	inside an aircraft" as stipulated Item (xi), Article 166-4 of
Incident	Ordinance for Enforcement of the Civil Aeronautics Act, which was
Information	classified as an aircraft serious incident.
	The Japan Transport Safety Board designated an investigator-
	in-charge and two investigators on June 30, 2015, to investigate

this serious incident.
An accredited representative of United States of America, as
the State of Design and Manufacture of the aircraft involved in the
serious incident, participated in this investigation.
Comments were invited from parties relevant to the cause of
the serious incident and the relevant State.

2. FACTUAL INFORMATION

2.1 History of	The history of the flight is summarized below, based on the
the Flight	statements of the Pilot in Command (PIC) and the first officer (FO),
	the records of the flight data recorder (FDR) and the cockpit voice
	recorder (CVR);
	At 7:26, on June 30, 2015, a Boeing 737-400, registered
	JA8525, operated by Japan Transocean Air Co., Ltd. (hereinafter
	referred to as "the Company") as scheduled Flight 002, took off from
	Naha Airport for Kansai International Airport.
	At 8:18 of after about 30 minutes from a time when the
	aircraft had reached a cruising altitude FL370, a left-side BLEED
	TRIP OFF light was illuminated to indicate malfunction of left-side
	(No.1) BLEED AIR and the supply from the left side bleed air were
	stopped. At that time, WING ANTI ICE was not in use, but
	ENGINE ANTI ICE was in use.
	When starting a checklist for BLEED TRIP OFF, a right-side
	(No.2) BLEED TRIP OFF light was illuminated and the both sides
	of bleed air systems stopped. Checking DUCT PRESSURE which
	indicates a bleed air pressure, both of left- and right-side were
	approximately 0 psi. When flight crew were checking a cabin
	altitude which indicates a cabin pressure, the cabin altitude was
	gradually rising. At 8:20, the cabin altitude was exceeding 10,000 ft,
	then the CABIN ALTITUDE WARNING was operated. The flight
	crew stopped to perform the checklist of BLEED TRIP OFF and
	immediately executed emergency descent, following the checklist
	of CABIN ALTITUDE WARNING or Rapid Depressurization and a
	checklist of Emergency Descent. Following the checklist, the PIC
	and the FO used oxygen masks and operated to drop oxygen masks
	for cabin. The PIC confirmed that the cabin altitude was reaching



	(2) First Officer	Male, Age 30
	Commercial pilot certificate (Airplane) June 19, 2009
	Type rating for Boeing 737	January 10, 2012
	Instrument flight certificate	June 29, 2009
	Class 1 aviation medical certificate	Validity: August 31, 2015
	Total flight time	2,630 hours 58 minutes
	Total flight time on the type of aircraft	2,403 hours 58 minutes
	Flight time in the last 30 days	60 hours 02 minutes
2.5 Aircraft	(1) Aircraft	Boeing 737-400
information	Serial Number: 26605, Date of Manufa	acture: September 1, 1995
	Certificate of airworthiness	No. Dai-11-210
	Validity: Period during which the M	Iaintenance Manual has
	been effective	
	Total flight time	46,550 hours 05 minutes
	Flight time after Periodic Inspection	
	(13C Check, on June 8, 2014)	2,971 hours 59 minutes
	(2) The weight and the position of the cen	ter of gravity (C.G.) of the
	aircraft were within the allowable range	at the time of the serious
	incident.	
2.6 Additional	(1) Bleed Air System	
information	Bleed air system supplies to Enviro	nmental Control System
	Pack (ECS PACK) and others by control	ling the temperature and
	pressure of the high temperature / high p	ressure bleed air supplied
	from the engines.	
	The bleed air bled from High Pressure	e Compressor (hereinafter
	referred to as "HPC") of engine goes thr	ough Pressure Regulator
	and Shutoff Valve (hereinafter referred t	o as "PRSOV") and sends
	to the pre-cooler. The pre-cooler cools th	ne high temperature and
	high pressured bleed air to about 390°F by	y using a cooling air taken
	from an engine fan.	
	Pre-cooler control valve controls the co	ooling air flow sent to pre-
	cooler from engine fan by pre-cooler temp	perature sensor.



On the both of No.1 and No.2 systems of 450 $^{\circ}F$ Thermostats, the malfunctions that the output does not response to the change of temperature were found.

Later on, cracks were found on the sensor section at the time of teardown inspection.

If the output of 450 °F Thermostat did not change corresponding to the temperature change of bleed air, PRSOV could not adjust the valve for the opening/closing corresponding to the temperature change.



Photo 1 Cracks at 450 °F Thermostat

(ii) Pre-cooler Control Valve

On the both of No.1 and No.2 systems of Pre-cooler Control valves, malfunctions were confirmed, which the valve had moved to the position where it generated less cooling air flow than the flow required corresponding to the input from the pre-cooler temperature sensor due to the deterioration.

(4) Service Bulletin by manufacturer of parts

On 2008, there was a report regarding 450 °F Thermostat which had been removed in short time use, and as the results of the investigation by the Parts Manufacturer, because cracks were found within, the Service Bulletin was issued to improve the 450 °F Thermostat to the improved type. The level of urgency was "Recommended".

Furthermore, due to the same reasons, the Service Bulletin for Pre-cooler Temperature Sensor with the same contents to improve was issued.

(5) 450 $^{\mathrm{o}}\mathrm{F}$ thermostat and pre-cooler control valve equipped on the aircraft

The both of No.1 and No.2 systems of 450 $^{\rm o}{\rm F}$ Thermostats were not the improved type.

The use results of 450 $^{\rm o}{\rm F}$ thermostat and pre-cooler control valve equipped on the aircraft were as follows;

Part Name	Loading Position	Total Use Time	Use Time after loading on the aircraft
450 °F	No. 1	34,943	6,730
Thermostat	No. 2	46,425	42,304
Pre-cooler	No. 1	39,259	1,544
Control Valve	No. 2	46,508	5,965

3. ANALYSIS

3.1 Involvement	None
of weather	
3.2 Involvement	None
Of pilot	
3.3 Involvement	Yes
of equipment	
3.4 Analysis of	(1) Occurrences of Malfunction at Bleed Air System
known items	It is probable that the Bleed Air temperature rose because the
	cooling air flow taken out of the engine fan at the left side of Bleed
	Air System while flying at FL370.was insufficient because of the
	malfunction due to the deterioration of the pre-cooler control valve,
	the bleed air could not be sufficiently cooled. It is highly probable
	that the temperature of the bleed air was rising to exceed 450 $^{\circ}$ F,
	but due to the 450 °F thermostat failure, the PRSOV could not
	control the temperature.
	It is highly probable that 490 °F switch closed PRSOV,
	stopped the supply of the bleed air and illuminated the light of the
	left-side BLEED TRIP OFF which indicates the anomaly of the left
	side bleed air because the temperature of the bleed air was rising
	to exceed 490 °F.
	It is probable that the load to the right-side bleed air
	increased because the left-side bleed air supply was stopped. Then
	it is highly probable that as same as the malfunction of the left-side
	bleed air system, the malfunction due to the deterioration of the
	pre-cooler control value and $450\ {}^{\mathrm{o}}\mathrm{F}$ thermostat failure, because the
	temperature of bleed air was rising to exceed 490 $^{\rm o}\mathrm{F},$ the 490 $^{\rm o}\mathrm{F}$
	switch closed PRSOV and stopped the supply of the right-side bleed
	air.

(2) 450°F thermostat failure
When the cooling air cools the Bleed Air sufficiently at Pre-
cooler, 450 °F Thermostat would not be activated, therefore, even if
a failure exists, the failure could not be found.
It is probable that the malfunction of $450~^{\circ}\mathrm{F}$ Thermostat was
existed prior to the occurrence of this incident, based on the
contents of the Service Bulletin by Parts Manufacturer and use
results.
(3) Prevention of similar incident
Failures of 450 °F Thermostat could not be found during a
normal flight or at a maintenance work, therefore it is desirable for
operators to improve based on the Service Bulletins from Parts
Manufacturer as soon as possible.

4. PROBABLE CAUSES

It is highly probable that the serious incident occurred because the supply from the both Bleed Air systems were stopped, abnormal decompression was occurred in the cabin.

As for the stoppage of the both Bleed Air supply, it is highly probable that PRSOV was closed because the Bleed Air temperature was rising and exceeding the specified values in a state of occurrence of failures due to the cracks in the both systems of 450 $^{\circ}$ F Thermostat, and malfunctions were generated due to deteriorations at the both systems of Pre-cooler Control Valve.

5. SAFETY ACTION

The company implemented the repairs according to the Service Bulletin regarding 450 °F Thermostat and soundness confirmation of Pre-cooler control valve on the type of aircraft operated by the company. Furthermore, the company decided to implement the soundness confirmation of Pre-cooler Control Valve at every periodic inspection (C check) repeatedly, replace 450 °F Thermostat at every 16,000 flight hours and inspect it.