PART 1.6 – CONVENING AUTHORITY COMMENTS

1. I am content that the Panel have conducted a thorough and objective Inquiry into this tragic accident and I accept their Findings and Recommendations. In the absence of access to the principal witness and more comprehensive on-board recording devices, the Panel are to be commended for their forensic examination of the available evidence and for their professionalism in interpreting it. My role in reviewing their Report is to draw the key lessons together and attempt to highlight the most important areas to everyone involved in Air Safety, with the aim of preventing recurrence.

2. The loss of Flt Lt Egging in the circumstances of this accident was obviously both unexpected and, moreover, tragic. However, with the benefit of hindsight, the potential for such an accident could have been identified more clearly in advance and more effective mitigations put in place. There are a number of obvious strands that run throughout the Panel's Findings, at a variety of levels and across a number of areas. Namely, standards, workload and capacity, risk management and professional oversight. Taken together, they raise questions about the quality of supervision of the RAFAT, at a number of levels, in place at the time of this accident.

3. Undoubtedly with justification, the RAFAT are regarded by many as providing the benchmark for formation aerobatic display flying. Selection for the team is from amongst the best pilots the Royal Air Force has to offer and considerable care and attention is applied to their subsequent development as members of the Team. In parallel, the detailed arrangement and execution of the Team's displays absorb a significant degree of time and effort in a well-worn, graduated training regime and professionalism is the watchword throughout. Notwithstanding, even elite units, and perhaps particularly so, require a healthy degree of external oversight and assurance to mitigate the chronic risk that over time "we're different and we do it this way" supplants prudent and probing critiquing of procedures, techniques and standards. That said, the difficulty inherent in critiquing an elitist activity is obvious, particularly when doing so requires well established and highly technical procedures to be challenged by 'outsiders'. Implicitly, such circumstances therefore demand a strong commitment to active and intrusive interrogation, if effective assurance is to be achieved.

4. In this case, there is evidence that the questions asked over time by the supervisory chain were inadequate in breadth and depth. This was a significant shortcoming, given that less than 18 months earlier the RAFAT had experienced the loss of an aircraft and serious injury of a pilot as a result of a mid-air collision whilst training in Crete. The subsequent Service Inquiry highlighted, *inter alia*, shortcomings in supervision, standards and risk management. Whilst the chain of command accepted the associated recommendations and indicated a clear intent at the time to implement them, it is apparent from the findings of this Inquiry that they were not in fact acted on as comprehensively as they might have been, and nor was their implementation adequately quality assured subsequently. In the wake of the Crete accident, a significant amount of work had been undertaken to identify and manage risks within the display manoeuvres themselves, but these assessments omitted other aspects of the RAFAT's activities and did not include a sufficiently robust examination of some relevant categories of risk, such as G-LOC. Moreover, the Public Display Approval process, which should have provided the last formal end-to-end assessment of risks-to-life and their mitigation, was in essence bounded by a practical assessment of the flying of the display sequences themselves.

5. This occurrence and the outcome of its associated Service Inquiry must therefore serve as a salutary reminder of the vital role an actively questioning and conscientious mindset in supervisors plays as an essential defence against the thinkable. Such questioning must not be constrained by artificial, or even convenient, boundaries, but should be cast widely, pursued with appropriate

vigour and be exhaustive, if only to ensure that the truly relevant risks are captured fully – this activity may be labour intensive and, at times, a seeming distraction from other priorities, but the potential consequences of deficiency in this area have been painfully exposed in this accident and it must therefore always be accorded appropriate emphasis in future.

6. Since the accident, considerable work has been undertaken proactively by the current chain of command to rectify the shortcomings identified by this Inquiry as it has progressed, including clarifying the supervisory chain and strengthening its oversight, a sharper focus on risk management and a renewed emphasis on standardizing operating procedures. Taken together, these actions should elicit a degree of confidence that the lessons identified by this Inquiry are being learned and acted upon. Continued investment in these critical areas can only serve to underpin the RAFAT's performance, ethos, culture and hard won reputation. As is now the norm, Hd MilAAIB will track implementation of the Recommendations and report to me regularly on progress.