LYNX AH MK 7 XZ210 OCCURRENCE – CONVENING AUTHORITY REMARKS

I am content that the Panel have conducted a thorough and objective Inquiry into this accident and I accept their Findings and Recommendations. The Panel are to be commended for their 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.

The aircraft's crew were faced with an unexpected and sudden catastrophic emergency at relatively low altitude, the handling of which was made much more difficult by the pace of events and the highly aggravating factor of loss of visibility for a critical period in a smoke-filled cockpit. Their skill and success in getting the aircraft onto the ground in the circumstances, enabling them all to escape with only minor injuries, should be acknowledged.

The Panel's findings in relation to the accident sequence and their associated recommendations are valuable, but I am even more grateful for their diligence in examining and identifying some of the broader organizational factors, the exposure and treatment of which have the potential to offer wider and more enduring benefits. Decisions made in Oct 08 by the Lynx IPT Modification Committee to not categorize the LP fuel pipe modifications developed in the wake of the HMS Richmond Lynx XZ256 crash in Jun 02 as flight safety related led to a very protracted delay in implementing modifications that would have been likely to have significantly reduced the severity of the outcome of this accident and the risk to the aircrew. Ineffective tracking of implementation of the relevant recommendations of the XZ256 Board of Inquiry during the period and linking of them to the planned fuel pipe modification, exacerbated the situation. In contrast, following direction from the Army Lynx Delivery Duty Holder just under two weeks after the XZ210 crash, some 70 engines were modified in 11 weeks. By the end of Feb 12, 137 engines across the RN and Army Gem-engined Lynx fleets had been modified. Today, three things should mitigate the risk of having to again bolt the stable door after a second horse has bolted: firstly, the requirement for Duty Holders to be involved in sentencing risks-to-life via their Air System Safety Working Groups; secondly, the growing understanding amongst Duty Holder-facing organizations of their responsibilities to the Duty Holders themselves in identifying and bringing to their attention issues relevant to managing risk-to-life; and, thirdly, the explicit role of the MilAAIB in actively tracking the implementation of Service Inquiry recommendations. Nevertheless, the associated processes and the benefits they will bring will only be realised if they are embraced and exploited fully by all stakeholders – in any given case, there is only one Duty Holder 'captain', but it is unquestionably a team game.

Similarly, the Panel's examination of REME manning at 1 Regt AAC Wksp is illuminating. There will always be a requirement to balance available resources with tasks and to prioritize. However, what is not clear in this case is whether DEME(A)'s actions in attempting to manage competing, and significant, demands for REME manpower, including the Manpower & Gapping Advice provided to the Army Personnel Centre, were fully communicated to, understood and endorsed by the Duty Holder chain. The Panel have found that 1 Regt's OC Wksp had done what might reasonably have been expected at his level to highlight, ameliorate and manage the risks, but there were clearly

inconsistencies across the command chain(s) in understanding the levels of risk arising as a result of under-manning and dilution ofcritical supervision, and who was responsible for addressing them. Moreover, whilst not determined to be factors in this specific accident, a six month backlog in assurance activities, inability to meet administrative demands, and the gaps in training, supervision and quality exposed in examining 1 Regt AAC Wksp's EFD process, all constitute indicators of a system under stress and underperforming. The need to adopt novel manning strategies, particularly when faced with the tensions arising from coincidental high operational pull and the delivery of new equipment capability, is unlikely to go away, but we must ensure that in future such strategies are not developed and implemented in isolation and that Duty Holders are made aware, can inform their implementation and actively manage any associated risks.

As is now the norm, Hd MilAAIB will track implementation of the Recommendations and report to me on progress regularly.