PART 1.7 COMMENTS BY COMMANDER-IN-CHIEF AIR COMMAND (REVIEWING AUTHORITY)

1. I congratulate the President and Members of the Panel for compiling this high quality Report in such a timely manner. It is important that all Service Inquiries are progressed expeditiously to remove uncertainty and to allow recommendations to be acted upon quickly - this Inquiry is an exemplar of how this can be achieved.

2. I agree that this accident was caused by the breaching of defined minimum separation distances during an Opposition Barrel Roll (OBR), a manoeuvre for which safety margins had been eroded over time. I also note that, disappointingly, there was no detail within the training documentation of how to perform the OBR within a safe envelope.

3. It follows that I support AOC 22 Gp's implementation of a formal risk management process to cover all RAFAT manoeuvres prior to work-up for the 2011 display season. This work will formally document each manoeuvre and seek to ensure their configuration control. Likewise, I agree that the RAFAT is included within the HQ 22 Gp Annual Formal Staff Visit Programme, and supplemented by specialist engineering and logistics assistance from HQ AIR as required. Inter alia this should help ensure that the wider issues of assurance and the "can-do safely culture" highlighted within the Report, and especially those regarding engineering practices, do not re-emerge.

4. I have noted the comments relating to the experience of the officers at each level within the RAFAT supervisory chain, and, whilst I agree that a fresh pair of eyes can often be invaluable in addressing the issue of over-familiarity, the highly specialised flying conducted by RAFAT limits the field from which to select candidates. Therefore I direct that at least one of the levels of training supervision should have previous RAFAT experience. However, it is highly desirable that at least 2 of the 4 levels of training supervisors should have previous RAFAT experience and the job specifications for all 4 posts are to be annotated to that effect.

5. The inherent risk in manoeuvres which involve the crossing of flight paths is self-evident and I endorse AOC 22 Gp's decision that all such manoeuvres are prohibited until risks have been mitigated to an acceptable level. In this regard, more work is needed to establish what constitutes an acceptable level of risk. This work is to be led by the flight safety staff and until its conclusion AOC 22 Gp's dictat stands.

6. The recommendation that we should make greater use of simulator training is fully supported. In this accident, the pilots were confronted with a scenario of which they had no previous experience; more thoughtful preparation in a simulated environment could have addressed this and might have equipped them with sufficient situational awareness to avoid a collision.

7. In terms of Post Crash Management, I am disappointed that no RAFAT personnel on the detachment had received recent training; it is essential that at least one member of any overseas flying detachment has completed the Post-Crash Management Incident Officers Course to ensure that we are able to conduct a minimum level of contingency planning and coordination/communication with the emergency services at overseas training locations. I also note the comments relating to PIDAT, and agree that it should be considered as part of any Crash Action Plan, notwithstanding it, or a substitute test, may prove to facilitate overseas.

8. In sum, HAWK T1 XX233 was lost due to a collision with HAWK T1A XX 253 during an OBR at Hellenic Air Force Base Kastelli. When placed in an unfamiliar situation, where the minimum separation distance during the OBR was breached, both pilots were confronted with an unexpected visual picture and they reacted instinctively rather than conditionally. Safety margins relating to this manoeuvre had been eroded over time, caused partly by an absence within the training documentation of specific detail on how to perform it within a safe envelope. Human factors have once again played a significant role in the loss of a valuable RAF asset leading to serious injury to one of our pilots. It is therefore extremely important that the issues identified in this Report are

highlighted to all other flying units, through the Air Command Flight Safety Organisation. If we are to avoid future accidents of this nature, we will need to do better at breaking links in the causal chain.

S Bryant
Air Chief Marshal
Commander-in-Chief
Air Command

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