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25 Sep 12

JHCHQ (DComd)*

INVESTIGATION INTO [redacted] SERVICE COMPLAINT

References:

A. Legal Advice to [redacted], dated 29 Sep 09.
B. Letter to [redacted] from [redacted] regarding the Service Inquiry, dated 20 Oct 09.
C. Response to Ref B, dated 27 Oct 09.
D. Letter to [redacted] from [redacted] regarding the Service Inquiry, dated 15 Oct 09.
E. Response to Ref E, dated 19 Oct 09.
F. Human Factors Report, dated Sep 08.

Summary of conclusions

- It would have been appropriate for [redacted] to have had a chance to respond to the Service Inquiry (SI) before it was signed as complete.

- If the President had made some amendments to the SI report, as he had done in response to [redacted], then [redacted] may not have pursued this issue any further. Crucially, the President suggests that [redacted] comments would likely form an addendum to the SI.

- Some of the additional alleged inaccuracies in the SI report detailed in the Service Complaint (SC) have merit; however, as they were not raised originally it is considered to be too late to expect an amendment to be incorporated at this stage.

- Many of the points raised concerning supervision were systemic and had been a feature of Ex WOODLARK for a number of years. However, there were areas in which [redacted] could have used his position to influence change.

- The Human Factors (HF) report was compiled by suitably qualified psychologists with an HF background. The HF report provides an independent view on the accident from an HF perspective.

- [redacted] should have been given the opportunity to read the HF report as part of his rights under Rule 11/Reg 18. This was a significant oversight.

- The HF report had a significant bearing on the SI report. This could be argued as wholly appropriate given the nature of the accident. However, legal advice does warn against this.

- The Rule 11 paperwork could have been administered better. When changing from a BOI to a SI the raising of Reg 18 paperwork would have been the optimum solution. However, [redacted] rights were clearly outlined on the paperwork and he should have been left in no doubt that evidence had been uncovered that may call his professional conduct into question.

Introduction

1. [redacted] submitted a SC in response to the SI for ZJ247, the Squirrel wire strike and subsequent crash on 29 May 08, near Kingscott in Devon. The SC has 3 strands: specific issues with the SI; [redacted]. This report concerns only the first strand, namely the specific issues with the SI, with the other 2 strands being addressed by the Prescribing Officer[redacted].

2. There are 3 key issues at the centre of the SC regarding the SI:

   a. An assertion that the report had inaccuracies and procedural inconsistencies that could not be challenged.

   b. An assertion that the Human Factors (HF) report was flawed and that its influence on subsequent findings could not be challenged.

   c. An apparent failure to adhere to Rule 11 (and later Reg 18) and [redacted] inability to challenge any findings that questioned his professionalism.

3. [redacted] desired outcomes have been stated as[1]:

   a. Appropriate consideration of his side of the story and acknowledgement that there were potential inadequacies in the Board's procedures. He may request that some form of addendum is added to the SI Summary.

   b. Amendment to JHC Accident Investigation Procedures.

4. In order to formulate my conclusions and in addition to the documents listed in the References, I have had access to the following information:

a. [redacted] SC (dated 30 Jan 12), with the covering letter from Lt Col Smith (the Prescribing Officer), dated 15 Jun 12.

   b. Full SI Folder, dated 30 Jul 09. This includes all the evidence, the HF report and the witness statements.

[1] Letter from [redacted] to DComd JHC, dated 15 Jun 12.

c. Comments on the conduct of the Inquiry by DPA(A), 30 Oct 09 (Draft)

d. Meeting at Middle Wallop with [redacted], 31 Aug 12.

Aim

5. The aim of this report is to provide an independent view on [redacted] SC regarding the SI to enable DComd JHC to write a consolidated reply 1 Oct 12.

Assertion that the SI report had inaccuracies and procedural inconsistencies that could not be challenged

6. **Selection of President.** As SO1 AFSSI at the time, the selection of [redacted] as the SI President was in-line with AAC policy. [redacted] states in his SC that this was 'wholly inappropriate' as he was a former CFI 3 years previously and therefore 'many of the practices and procedures at the time of the accident were initiated or had been in place during his tenure and had remained largely unchanged'. I agree that this policy may have led to a potential conflict of interest, although under single Service arrangements it would have been difficult to select a President that could be regarded as truly independent. It is likely that under MAA selection procedures, the SI President would have been from another Service. That said, I can find no evidence to suggest that the President's deliberations were influenced by his previous assignment as CFI.

7. **Opportunity to respond.** [redacted] states in his SC that by the time he was offered the opportunity to read the SI report it had already been passed to the chain-of-command and therefore it was too late for him to make any form of redress or to influence the content:

a. The SI was signed by [redacted] on 30 Jul 09. The legal advice at Ref A, dated 29 Sep 09, recommended that [redacted] be provided with copies of the Findings of the SI within 2 weeks. Having been presented with the Findings, [redacted] replied to [redacted] on 20 Oct 09 (Ref B).

b. [redacted] letter focussed on only 5 areas that he believed to contain inaccuracies:

(1) A2 monthly check.

(2) Induction training.

(3) Supervised training.

(4) TORs.

(5) Radalt setting procedure.

c. The response at Ref C acknowledges many of [redacted] comments and, I believe crucially, states that they would likely form an addendum to the full Report. It is my opinion that had these 5 areas of the report been amended to reflect the inaccuracies, or perhaps more detail added to provide the necessary context, then [redacted] may not

have pursued this issue any further. It is worth noting that Ref C is not contained within the SI paperwork; I received my copy directly from [redacted].

8. **Additional inaccuracies detailed in the SC.** [redacted] details several additional alleged inaccuracies in the SI report in his SC dated 30 Jan 12. These are too numerous to tackle individually, suffice to say that there is sufficient merit in some of them to warrant further investigation. However, these additional alleged inaccuracies were only identified in the SC some 2 ½ years after the SI report was finalised and therefore it could be argued that it is now too late for the SI report to be amended.

a. **Signing of transcipts.** [redacted] states in his SC that there were unacceptable delays between making a statement and subsequently signing the transcripts. These delays range between 3 and 5 months, which does seem a long period. That said, [redacted] could have asked to listen to the tape recordings before signing the transcripts to aid his recollection if he had wished.

b. **Supervision.** I do not believe that the SI report focuses unduly on a lack of supervision; indeed, the SI report articulates well the systemic pressures and high Sqn workload at the time of the accident. As part of the investigation the supervisory processes were analysed and conclusions drawn that subsequently led to some recommendations. Many of the supervisory weaknesses could be put down to systemic or cultural weaknesses and that over-familiarity with the Ex by key pers had led to a 'blindness' with regard to some practices:

(1) **High Workload**.

(a) It is clear from reading the SI report and witness statements that the pressure on the Sqn to train a large volume of students at a sustained high tempo was significant. In addition to this was an increase in the training burden due to extra courses, such as pre-QHI and pre-AH/return to flying refresher courses, being assigned to the Sqn. This had resulted in back-to-back courses with no time for instructor training between them.

(b) The ongoing re-write of the OTP course had placed a significant staffing burden onto the Sqn instructors and Execs for which they were not established.

(c) At the time of the accident [redacted] was deputising for the CFI and DCFI who were both absent from work due to injury and leave respectively.

(d) [redacted] explains that he did not visit Ex WOODLARK due to his high workload but that he mitigated this by: his Flt Comd having been in charge of the Ex before, bolstering supervision by sending his SSM (an A2 instructor) and by speaking daily with his Flt Comd. However, I do not think that it would have been unreasonable to expect [redacted] to visit the Ex for at least one day to provide some supervisory oversight.

(2) **Staff folder.**

(a) It appears that the Staff folder, which contained a list of hazards and avoids, had been a feature of Ex WOODLARK for a number of years. Unfortunately the nature of such a publication is that it lacks ownership, is not subject to amendment and is not regulated. Also, by not publishing it more widely, vital air safety information was inaccessible by the wider defence aviation community.

(b) The SI report[2] contains the following statement about a list of potentially dangerous wires in the staff folder: 'The Kingscott Valley wires, struck in the accident, were the second set of wires on this list'. Although this is factually correct, what is also of interest is that these wires were marked as potentially dangerous for a 5-6km stretch, not specifically in that particular valley[3]. This is an example of where more detail would provide the context needed by someone reading the SI report.

(3) **A2 Monthly check.** The SI report[4] states the fact that an A2 monthly check had not been completed in May. Although it does not unduly stress this point, more detail, such as the planned A2 monthly check was for the previous day but was cancelled due to weather, would provide the reader with the wider context and would have satisfied Ref B.

(4) **Self authorisation.** Self authorisation by instructors, be it QHI or QFI, has been a feature of flying training for some considerable time. Although now minimised under JHC policy, this practice would not have been regarded as suboptimal at the time of the accident. However a lack of an outbrief to a Duty Instructor, as was the procedure when at Middle Wallop, meant that there was no supervisory overwatch.

(5) **TORs.** The SI report[5] states that there were no TORs for the Flt Sgt Maj (FSM), Flt Comds or Ex WOODLARK Det Comd. This is challenged by [redacted] at Ref B and he even provides the computer file location. In my opinion this warranted further investigation and, had the TORs been located, an amendment made to the SI report.

9. **Conclusions.**

a. Most of the comments made by [redacted] at Ref B seem correct and in most cases have already been acknowledged as such by the President.

(1) It would have been appropriate for [redacted] to have had a chance to respond to the SI before it was signed as complete.

(2) Despite this oversight, had the President made some amendments to the SI report, as he had done in response to [redacted] (References D and E), then [redacted] may not have pursued this issue any further. Crucially, the President suggests that [redacted] comments would likely form an addendum to the SI.

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[2] Page 4-5, para 32

[3] Ref D and E refer.

[4] Page 4-3, para 15.

[5] Page 4-4 para 26 and 4-7 para 37.

b. Some of the additional alleged inaccuracies in the SI report detailed in the SC have merit, although they were not raised at Ref B; therefore, it is considered to be too late to expect an amendment to be incorporated at this stage.

c. Many of the points raised concerning supervision were systemic and had been a feature of Ex WOODLARK for a number of years. However, there were areas in which [redacted] could have used his position to influence change, such as use of the Staff Folder. It may have been that he had been too close to the Ex for so long that he was 'blind' to some of the issues.

Assertion that the Human Factors report was flawed

10. **Qualification of HF report authors.** [redacted] comments regarding the Human Factors (HF) report at Ref F echo many of the comments made in the legal advice at Ref A. Indeed, I needed to confirm through [redacted] that [redacted] had not seen Ref A to be sure that he had not been influenced by its findings. However, contrary to [redacted] claim, it is common practice for the HF trained psychologists who write the HF reports to be only observers rather than Board members. By the nature of their role they are generally non-aviators, although are qualified psychologists with an HF background.

11. **Not offered as evidence.** The HF report should have been made available to [redacted] as part of his rights under Rule 11/Reg 18. This is a significant oversight by the President.

12. **Bearing that HF report had on SI report.** I do agree with [redacted] that the SI report relied heavily on the HF report. Arguably this is appropriate given the nature of this specific accident although legal advice at Ref A, para 9, warns that "a BOI which has clearly been influenced by this Human Factors Report is vulnerable to challenge".

a. Examples of astute comments made in the HF report are as follows:

(1) **Wires awareness.** Ref D[6] makes a very insightful comment about wires awareness. Despite the purpose of TACEX 2, which is to demonstrate the danger posed by domestic wires that are suspended across a valley, there seemed to be a misguided belief that domestics do not pose a significant hazard.

(2) **Low level instruction.** The HF report[7] identifies instruction in a low level environment as a key area in which QHI training was not sufficient. On the QHI course a trainee QHI is shown how to teach low flying handling skills but not how to instruct non-handling skills in a tactical environment whilst acting as the handling pilot. This was also an omission within the formal training of QHIs on 670 Sqn.

[6] Page 12, para e.

[7] Page 17, para d.

(3) **Map recce.** The HF report[8] identifies that QHIs on Ex WOODLARK were not conducting sufficient map recce prior to flight and that the chain of command were surprised by this.

b. To balance this, there are some examples where a lack of specific army aviation knowledge was evident in the HF report:

(1) **Wire marking.** The marking or highlighting of wires by day is not a process that is taught at Shawbury or on the OTP. The HF report repeatedly makes reference to the lack of wire marking and this is a point that [redacted] should not have included in his SI report except possibly to generate a recommendation that this should become future practice.

(2) **Use of SAAFRs.** The HF report[9] argues that an unreasonably small amount of time was devoted to planning the ingress and egress routes. However, the purpose of standard routings was not highlighted, ie to enable more time to be available for planning the target objectives.

13**. Conclusions.**

a. The HF report was compiled by suitably qualified psychologists with an HF background. The HF report provides an independent view on the accident from an HF perspective.

b. [redacted] should have been given the opportunity to read the HF report as part of his rights under Rule 11/Reg 18. This was a significant oversight.

c. The HF report had a significant bearing on the SI report. This could be argued as wholly appropriate given the nature of the accident. However, legal advice at Ref A does warn against this.

Apparent failure to adhere to Rule 11 (and later Reg 18)

14. [redacted] claims that Rule 11 (and later Reg 18) was not administered correctly. Having reviewed the evidence I agree that Rule 11 could have been better administered:

a. Where the Rule 11 paperwork required a selection to be made, [redacted] had not indicated a choice of sentences of those available. This could have rendered the paperwork being considered as incomplete.

b. The evidence that had led to the Rule 11 action being taken was not stated on the relevant part of the paperwork.

c. There is no evidence that Reg 18 action, when the BOI became an SI, was administered; however, having already placed him under Rule 11 this could be seen as a reasonable oversight.

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[8] Page 13, para 62.

[9] Page 16, para e and f.

15. However, despite all this I believe that [redacted] would have been in no doubt that the SI had uncovered evidence that may subsequently have called his professional conduct into question. Significantly, the paperwork clearly outlined his rights under Rule 11.

16. **Conclusions.** The Rule 11 paperwork could have been administered better. When changing from a BOI to a SI the raising of Reg 18 paperwork would have been the optimum solution. However, [redacted] rights were clearly outlined on the paperwork and he should have been left in no doubt that evidence had been uncovered that may call his professional conduct into question.

Comments on [redacted] desired outcomes

17. **Desired outcome one (para 3a).** I have assumed that, as the SI report Summary has been published and is available via the internet, it is considered too late for an addendum to be added. Despite this, I believe that it would be useful if an acknowledgement that the Board's procedures were inadequate in the following areas could be made:

a. [redacted] should have been given the opportunity to read the SI report before it was finalised.

b. [redacted] suggested that Ref B and C would likely form an addendum to the full report; this does not appear to have occurred. [redacted] should be informed that it is too late for the additional points raised in the SC to be investigated and included in an addendum.

c. [redacted] should have been given the opportunity to read the HF report.

d. The Rule 11 paperwork could have been administered better. However, it should be made clear that the intent of the paperwork and, crucially his rights under Rule 11, are not in question.

18. It should be noted that para 17b is the most controversial in that [redacted] was led to believe that his points would likely form an addendum to the full report. If, as assumed, this is no longer a viable option, a letter detailing these failures in process from an appropriate individual may be the most advisable route to closure.

19. **Desired outcome 2 (para 3b).** The comments regarding JHC Accident Investigation Procedures are easily closed. Comd JHC is no longer the convening authority for JHC aircraft accidents. The convening authority is DG MAA, who makes the decision on whether an aircraft accident warrants an SI. Additionally, Presidents of SIs are now

generally chosen from a different Service to ensure that potential conflicts of interest cannot be alleged.

<original signed>

[redacted] SH STANEVAL