

SEA KING – PART 1.6

1. This accident resulted in the loss of a valuable helicopter and it is fortunate that there were no serious injuries to the aircrew, other than perhaps a dent to their professional pride. The accident should serve as a warning to all of us that fly: that a highly competent and respected QHI, working hard to get the best out of limited resource and conducting a seemingly straightforward exercise on the airfield, should find himself in the cockpit of a wrecked aircraft is a salutary lesson. I commend the Service Inquiry (SI) Panel for their handling of this investigation, their conclusions and recommendations, and for getting the task completed in a respectable timeframe. I agree the cause of this accident as declared by the Panel and note the key findings: lack of preparation; lack of a specific exercise brief; the Handling Pilot's (HP's) lack of understanding of the exercise; an unsatisfactory QHI demonstration, poor skills of the HP, and the extent of effective supervision.

2. There are some key lessons to come from this SI which the Panel have captured and I commend flying supervisors across Defence to take note. Pointing the finger at individuals shrouds the learning opportunities; we must instead consider the efficacy of the training and supervisory system, specifically in this case its ability to identify the potential for the HP to be involved in a human factors occurrence.

[REDACTED]. Given his time on the Squadron, and his planned deployment on the day of the accident, it is clear that the appropriate tools were either not in place, or were not being used, for supervisors to recognise the human factors warning signs, apply mitigation measures, and alert senior squadron management to the associated risks.

3. Notwithstanding the above, the HP was under the supervision of a highly experienced captain and QHI on the day. The critical elements of how this 40 ft Advanced Single Engine Failure (ASEF) exercise was conducted – with no pre-flight ASEF briefing, the helicopter being overweight for the exercise (outside the RTS), a change in the exercise start height to 33 ft following a QHI demonstration from 42 ft, a QHI demonstrated pitch down to 9 degrees (rather than 5 degrees) and a resultant heavy landing (2.95 g at a Vertical Velocity (Vv) of 774 ft/min) against a maximum for the aircraft of 480 ft/min – suggest that the HP's actions can, at least in part, be mitigated. In particular, I note that the QHI continued with the exercise after his demonstration as he did not realise that he had technically made a heavy landing. I have no reason to doubt this experienced pilot's word and if he can make this mistake then others can; accordingly, I consider it appropriate that DHs have been directed to look at the aspect of Vv related to heavy landings across their respective fleets.

4. In summary, a seemingly routine exercise resulted in the loss of this helicopter; this could have been prevented though a combination of better preparation and effective identification and mitigation of pilot training risk. This episode occurred when one of our highly competent QHIs was doing his best to get a number of objectives achieved under a degree of pressure, and a line pilot was attempting to secure his overdue Certificate of Competence. The system could have served them both better. In addition to the supervisory shortcomings already mentioned, I note that many pilots had training deficiencies deferred, some had clearly conducted serials without the necessary qualification, and I would question how long it has been since this particular training evolution was assessed. The 40 ft ASEF is a dynamic manoeuvre, performed close to the ground, with little if any opportunity for the QHI to intervene, and with the simulator deemed unsuitable to practise it. Finally, it is essential that our aircraft be flown within the RTS limitations.

DG MAA