Ministry
of Defence

Air Command Secretariat
Spitfire Block
Headquarters Air Command
Royal Air Force
High Wycombe
Buckinghamshire
HP14 4UE

FOI 2016/10741

11 Nov 2016

Dear

Thank you for your letter of 13 October addressed to the Officer Commanding RAF Flight Safety Centre in which you requested the following information in relation to the Jet Provost XR658 incident on 26th October 1971:

'...a more in depth incident/accident report of this event'

I am treating your correspondence as a request for information under the Freedom of Information Act 2000.

We have now completed a search for the information you requested and I can confirm that the aircraft accident report relating to this incident, which falls within the scope of your request, is held and is attached. You will notice that a small element of this information has been withheld, this is because it is exempt from release under section 40 (personal data) of the Freedom of Information Act. Section 40 is an absolute exemption and there is therefore no requirement to consider the public interest in making a decision to withhold the information.

If you are not satisfied with this response or wish to complain about any aspect of the handling of your request, then you should contact me in the first instance. If informal resolution is not possible and you are still dissatisfied then you may apply for an independent internal review by contacting the Information Rights Compliance Team, 2nd Floor, MOD Main Building, Whitehall, SW1A 2HB (e-mail CIO-FOI-IR@mod.uk). Please note that any request for an internal review must be made within 40 working days of the date on which the attempt to reach informal resolution has come to an end.

If you remain dissatisfied following an internal review, you may take your complaint to the

Information Commissioner under the provisions of Section 50 of the Freedom of Information Act. Please note that the Information Commissioner will not investigate your case until the MOD internal review process has been completed. Further details of the role and powers of the Information Commissioner can be found on the Commissioner's website, http://www.ico.org.uk.

Yours sincerely,

Air Command Secretariat

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Royal Air Force

AIRCRAFT ACCIDENT REPORT

Jet Provost T Mk4 XR658
6 FTS
26 October 1971

Directorate of Flight Safety (RAF)
London

OK/

ROYAL AIR FORCE

AIRCRAFT ACCIDENT REPORT

Date:	26 October 1971
Aircraft:	Jet Provost T Mk 4 XR 658
Crew:	Two
Sortie:	Navigational Training
Casualties:	Nil
Aircraft Damage:	Category 5
Unit:	6 FTS, RAF Finningley

Circumstances

1. After a low level navigational training exercise, whilst returning to base at 2,000 feet, the pilot demonstrated to the student navigator the effect of aircraft speed on turning radius by carrying out a starboard turn through 90 degrees at 350 knots, pulling +3½ 'g', followed by a reverse turn through 90 degrees. As the aircraft rolled out of the manoeuvre the canopy left the aircraft. This was followed by a violent pitch-up which stressed the aircraft in excess of +10 'g'. The aircraft climbed almost vertically out of control and into cloud. The pilot pushed the stick forward without effect. At this stage he considered that he and his student would have to eject, but discovered that he had lost intercom. Having shouted a re-assurance to the navigator, the pilot found that the aircraft was beginning to respond to the controls. He regained control and descended out of the cloud. He then discovered that his loss of Intercom was caused by his helmet lead becoming disconnected. Unable to find the pilot's aircraft R/T lead, the student connected the pilot into his own R/T lead. Although this left the student without Intercom, it restored R/T facilities to the pilot.

2. The pilot then carried out a low speed handling check and found that he could control the aircraft satisfactorily. He transmitted a PAN call which was acknowledged, and returned the aircraft to base where the pilot of a shepherd aircraft carried out a visual check for any significant damage and monitored the approach and landing. Fearing that the slipstream might actuate the face blinds and deploy the drogue shute the pilot and student inserted the seat pan handle pins in their ejection seats but did not attempt to insert the top pins because of the risk of injury to their arms in the slip stream.

Determination of Causes

3. The Board of Inquiry established that the starboard canopy rail had become detached from the aircraft, and the canopy had shattered as a result. It found no evidence of mechanical failure, and concluded that the rail had been fitted

incorrectly. The Station practice was to fit the canopy without using the special tool supplied for the purpose; further investigation has revealed that inadequate servicing of the canopy jettison mechanism was fairly common in the Jet Provost fleet. The Board also found deficiencies in the description of fitment of the canopy in AP 101B-2304-1, and recommended amendment action.

Survival Aspects

4. The insertion of the ejection seat pan pins was probably unneccessary. The advice of the MOD(Air) Specialist Branch is that it is highly unlikely that the slipstream would apply enough force to a face blind to initiate the seat. The period of greatest risk was during canopy disintegration when the blind might have been extracted by debris. Experience has shown that even with the blind partially pulled, and folded back over the top of the seat, it is unlikely to fire from slipstream effects. There have been no occurrences of actuation in these circumstances.

Remarks of the Air Officer Commanding-in-Chief

5. The AOC-in-C stated that the accident arose from a servicing error on the part of the tradesman who actually carried out the task; coupled with the failure of the engineering staff to supervise and check properly the actions of the airman. He directed that disciplinary action be taken against the SNCO who oversigned the fitment of the canopy.

6. He stated that the pilot of the aircraft acted with commendable skill in bringing the aircraft under control, and executing a safe landing.

Subsequent Action

7. A fleet check was carried out under Preliminary Warning/Jet Provost/46 on all Jet Provost aircraft to examine the canopy rail locking mechanism. Eight aircraft were found to have maladjusted mechanisms and a further six had bent tie rods.

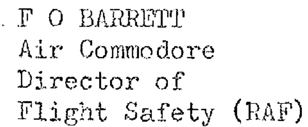
8. A check of the integrity of the canopy locking mechanism by the manufacturers was recommended by the Air Officer Commanding. Subsequent pull-off tests showed that the canopy rails were absolutely secure if correctly locked in position.

9. An amendment to the Air Publication for the Jet Provost detailing more explicit instructions for canopy fitment is in progress.

DFS(RAF) Cause Coding

10. Main Cause Group: Inspection and Servicing Error.

11. Codes: 330.1 (Servicing Error - Airframe) - MAIN.
320.1 (Supervision Error - Airframe).
350.1 (Organisation - Flight Level).
101.16 (Hood Rail Locking Mechanism).
106.2 (Hood).
105.2 (Tailplane).
105.17 (Control Restrictions).



F O BARRETT
Air Commodore
Director of
Flight Safety (RAF)

Ministry of Defence
15th September 1972
See Distribution List

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