

TABLE OF CONTENTS

NIAS ISLAND SEA KING ACCIDENT BOARD OF INQUIRY REPORT

EXECUTIVE SUMMARY

Introduction

Conduct of Inquiry

Direct Accident Consequences

Operation SUMATRA ASSIST

The Accident

Crashworthiness Consequences

The Primary Cause of the Accident

Organisational Deficiencies

817 Squadron Sea King Detachment

817 Squadron

Naval Aviation Command and Management

Australian Defence Force Systems Support

- a. The Navy Safety System
- b. The ADF Airworthiness System
- c. Aviation training and Education System
- d. Aviation Logistics Support

Crashworthiness Management

Cause of Post Accident Fire

Causal Themes

- a. Non Compliant Practices
- b. Poor Communications
- c. Understanding Why?
- d. Compliance
- e. Understanding Responsibilities
- f. A Safety Champion
- g. Trust

Accident Responsibility

Accident Accountability

Prevention of a Recurrence

Attachment

1. Nias Island Sea King Board of inquiry Findings and Recommendations

SECTION 1: INTRODUCTION

CHAPTER 1: CONDUCT OF THE BOARD OF INQUIRY

Introduction

Appointment of the Board

Terms of Reference

Scoping the Inquiry

Conduct of the Inquiry

Location of Hearings

Schedule

Public Inquiry

Hearing Phase

Chapters

Evidence and Witnesses

Emergent Issues

Procedure at the Inquiry and the Approach of the Board

The Board of Inquiry Report

Structure of the Report

Findings and Recommendations

Conventions used in BOI Report

Honours and Awards

Annexes

Appendices

CHAPTER 2: BIOGRAPHIES OF THE DECEASED MEMBERS AND THE SURVIVORS

The Deceased Members

Lieutenant Paul John Kimlin, RAN

Lieutenant Jonathan Curlewis King, RAN

Lieutenant Mathew Philip Goodall, RAN

Leading Seaman Scott Andrew Charles Bennet

Squadron Leader Paul Stuart McCarthy

Lieutenant Mathew Peter Davey, RANR

Flight Lieutenant Lynne Elizabeth Rowbottom (nee Eadie)

Petty Officer Stephen Craig Slattery

Sergeant Wendy Elizabeth Jones

The Survivors

Leading Seaman Shane Robert Warburton

Leading Aircraftman (now Corporal) Scott Andrew Nichols

CHAPTER 3: BACKGROUND TO THE ACCIDENT

Introduction

Conventions

- Aircraft Nomenclature/Callsigns
- Conventions used in this Report
- Headquarters and Commanders Abbreviations

Nias Island

Operation SUMATRA ASSIST I (OSA)

Operation SUMATRA ASSIST II (OSA2)

Chronology of Key Events

Command and Control

- Introduction
- ADF Command and Control
- Operational Command
- Tactical Command
- Operational Control
- Tactical Control
- Theatre Command
- Administrative Control

Command in Combined and Coalition Operations

Naval Aviation Command and Control

- Introduction
- Deputy Chief of Navy
- Maritime Commander Australia
- Commander Australian Navy Aviation Group
- Squadron Commanding Officers
- Air Capable Ship Commanding Officers
- Naval Aviation Detachments and Flights

Operation SUMATRA ASSIST Command and Control

ADF Airworthiness System

- General
- Definition
- Structure
- Technical Airworthiness
- Operational Airworthiness
- Vulnerability
- Structure within Naval Aviation

Pre-Deployment Activities

Selection of HMAS KANIMBLA for Operation SUMATRA ASSIST I

Selection of Sea King for Operation SUMATRA ASSIST I

- Background
- 817 Squadron
- Notification
- Squadron Status
- Operational Response Squadron
- Selection of Detachment Personnel
- Flight Senior Maintenance Sailor and Watch Organisation
- Selection of Detachment Aircraft
- Pack-Up Kit
- Pre-Embarkation Inspection
- Aviation Workup
- Pre-Embarkation Briefings

Involvement of COMAUSNAVAIRGRP with the Sea King Detachment Preparations

Shipboard and External Services for the Sea King Detachment

- General
- Shipboard Services
- External Services

Aircraft Maintenance Documentation

Conclusion

CHAPTER 4: RESPONSIBILITY AND ACCOUNTABILITY

Introduction

Responsibility and Accountability

- Directives and Frameworks Relevant to this Inquiry

Analogies Presented

- Analogy of Junior Officer Preparing a Passage Plan
- Playing Out the Passage Plan Analogy
- Personal Accountability
- Junior Rank Accountability
- Navy Out of Touch?

Conclusion

SECTION 2: THE ACCIDENT AND PRIMARY CAUSE

CHAPTER 5: THE FINAL FLIGHT OF *SHARK 02* AND THE RESCUE OF SURVIVORS

Introduction

The Accident

- Chronology of Key Events on the Day of the Accident
- Sea King Sorties on 02 Apr 05 - Pre-Accident
- Purpose of the Accident Sortie
- Occupants of N 16-100 at the Time of the Accident
- The Accident Sortie
- The Accident Sequence
- The Fire Sequence
- The Initial Fire
- Fuel for the Initial Fire
- Subsequent Development of the Fire

Rescue of Survivors

- Rescue from the Crashed Aircraft
- Recovery by *Shark 21*
- Singaporean Chinook Helicopter at Tuindrao
- Confirmatory Flight 02 Apr 05

Final Confirmation of the Fatalities

Security of the Crash Site

Body Recovery Operation

- Interference with the Bodies
- Interference with the Wreckage

Mission Planning on 02 Apr 05

- General
- Mission Analysis for Operation SUMATRA ASSIST
- Sea King Aero-Medical Evacuation Capability
- Mission Planning for Operation SUMATRA ASSIST II
- Mission Planning for Accident Sortie
- Mission Risk Profile
- Briefing Material

Weather and Environmental Conditions

Flight Authorisations

- Force Assignment and Command and Control
- Flight Authorisation
- Pre Flight Authorisation Considerations
- Authorisations of Flights on 02 Apr 05
- Review of Form AO 100 compiled on 02 Apr 05

Qualifications, Aircrew Currency, Experience and Medical Category of each Occupant of *Shark 02*

- Aircrew
- Passengers
- Other Persons Directly Involved

Compliance with Orders, Regulations and Briefings

- Commanding Officer Handover Routines
- Flight Commander Handover Routines
- Passenger Manifests
- Passenger Briefings
- Protective Clothing and Equipment
- Cabin Security within *Shark 02*

Nature and Adequacy of Shipboard Services on 02 Apr 05

- General
- Fuel Quality
- Flight Following

Nature and Adequacy of External Services on 02 Apr 05

- General
- Meteorological Support
- Search and Rescue

Serviceability and Recent Maintenance History of N16-100 (*Shark 02*)

- General
- Routine Scheduled Servicing
- Unscheduled Maintenance
- Period between the R2/R3 Servicing and the Accident
- Carried Forward Unserviceabilities for N16-100 (*Shark 02*)
- Serviceability of N16-100 (*Shark 02*) on 02 Apr 05

Conclusions

- Annexes

CHAPTER 6: THE PRIMARY CAUSE OF THE ACCIDENT AND ASSOCIATED ISSUES

Introduction

- AAIT Investigation and Report
- DSTO Report
- Expert Witnesses

The Principal Body of Evidence

- Eye Witness and Survivor Reports
- Primary Wreckage Evidence
- Analysis of Ground Marks and Wreckage Location
- Crash Data Recorder Analysis
- Cockpit Area Microphone Analysis
- Summary of Principal Body of Evidence
- Secondary Body of Evidence

Possible Causes of the Pitch Change – Environmental or Mutual Interference Factors

- Environmental Conditions
- Obstructions and Obstacles
- Other Distracting Activities in Vicinity of Accident

Possible Causes - Manual Control Input or Interference

- Pilot Deliberate Control Input - Emergency Actions
- Pilot Deliberate Control Input - Suicide
- Unintentional Pilot Control Input or Passenger Actions
- Summary

Possible Causes - Aircraft Configuration Change

Possible Causes - Main Power Train Failure

- Main Engines
- Main Rotor Gearbox

Possible Causes - Flight Control System Failure

- General
- Flight Control Redundancy
- Failures of the Sea King Flight Control System
- Hydraulic System Failures - General
- Hydraulic Fluid Leaks
- Hydraulic System Pump Failure
- Servo Jack Failure
- Pilot Valve Failure
- Uncommanded Hydraulic System Inputs
- Mechanical Failure of Flight Control System

AAIT and DSTO Experimentation on the Effect of Bellcrank Separation

- How the Fore/aft Bellcrank became Disconnected
- Scientific Examination and Expert Opinion
- Fore/aft Bellcrank Pivot Bearing
- Mixing Unit Lugs
- Pivot Bolt Failure
- Fore/aft Bellcrank Connecting Bolt Orientation
- Castellated Nut Failure
- Split Pin Failure
- Evidence of Split Pin Failures
- Wreckage Evidence

Evidence of Defective Split Pins and their Impact on Connection Security
Potential for Sabotage or Tampering with the Fore/aft Bellcrank
Most Probable Explanation for Failure of the Pivot Bolt Connection

Conclusion

The Cause of the Accident: Summary Findings
Annexes

**SECTION 3: PRIMARY CONTRIBUTORY CAUSES OF THE
ACCIDENT**

CHAPTER 7: IMMEDIATE CONTRIBUTORY CAUSES OF THE ACCIDENT

Analysis of Key Maintenance Events Immediately Prior to the Accident

Maintenance error during the R2/R3 Servicing of N16-100
Description of the R2/R3 Scheduled Services

Early Watch Activities 04 Feb 05

Initial Determination of Bellcrank Unserviceability
Removal of the Bellcrank
Aircraft Maintenance Documentation Entries
Aircraft Maintenance Documentation Record of Bellcrank Maintenance
Fore/aft Bellcrank Refitment
Maintenance Flight Activities after 05 Feb 05
Re-Certification of the Fore/aft Bellcrank CFU 30 Mar 05

Conclusion

Prevention of a Recurrence

Response to Terms of Reference

Annexes

CHAPTER 8: ANALYSIS OF THE MAINTENANCE ACTIVITIES

Introduction

Human Performance and Error

Error and Violation Producing Substandard Conditions

The Environment and its effect on the Mental and Physiological States
of the Maintenance Detachment
Equipment
Publications
Workspace

Error and Violation Producing Conditions - Substandard Practices

Crew Coordination, Communication and Situational Awareness
Training and Knowledge
Authorisations/Qualifications

Performance of Supervision

Inadequate Supervision
The Planning of Maintenance Operations
Supervisory Violations

The Prevalence of Error and Non-Compliance in ADF Aviation Maintenance

Conclusions and Causation

The Combination of Error and Violation

Prevention of a Recurrence

Response to Terms of Reference

SECTION 4: 817 SQUADRON ENVIRONMENT

INTRODUCTION TO SECTION 4

Introduction

Section 4 Structure

Supporting Background Information

Annexes

**CHAPTER 9: NON-COMPLIANT MAINTENANCE PRACTICES WITHIN THE
817 SQUADRON MAINTENANCE ENVIRONMENT**

Introduction

Commonly Used Acronyms and Abbreviations

Non-Compliant Maintenance Practices

Definitions Relevant to this Chapter
Preconditions for Non-compliant Maintenance Practices

Chronology of Maintenance Related Events

817 Squadron Maintenance Standards

CO 817 Squadron PCR Minute of 12 Nov 04
Evidence of Non-Compliant Maintenance Practices at 817 Squadron
Aircraft Maintenance Documentation and Servicing Manuals
Failure to Consult Maintenance Publications
Improper Completion of AMD
Not Conducting First Level Certification within 30 Minutes
Certifying Maintenance Conducted by other Tradesmen
Certification of Tasks that are not Actually Conducted

Certification of Maintenance Inspections that had not been Performed
Not Documenting Maintenance Performed
Other Non-Compliant Maintenance Practices
Evidence within N16-100 Wreckage
Review of Significant ASORs

Other Key Indicators and Recognition of Non-Compliant Maintenance Practices

Non-Compliant Maintenance Practices, Errors and Omissions Observed on N16-100

Terms of Reference

Prevention of a Recurrence

Conclusion

CHAPTER 10: MANAGEMENT OF NONCOMPLIANT PRACTICES BY CO 817 SQUADRON

Introduction

817 Squadron

817 Squadron Role and Capabilities
817 Squadron Resources and Structure
817 Squadron Rate of Effort – Operational Tempo and Personnel Experience

Management of the 817 Squadron Environment

Commanding officer 817 Squadron Authority and Responsibilities
Commanding officer 817 Squadron Accountability

Management of Operational Tempo

CMDR Macaulay-Black Tempo Management

817 Squadron Readiness for Operation SUMATRA ASSIST

Operational Response Squadron
Pre-Embarkation Inspection

Management of 817 Squadron Maintenance Standards

Management of 817 Squadron Maintenance Standards by CMDR Macaulay-Black
Management of Maintenance Standards by CMDR Tobin
The Pitch Change Rod Incident
Winch incident
Response to the Pitch Change Rod Incident
Advice to CMDR Tobin from LCDR Watson 817 Squadron Aircraft Engineering Officer
Assessment of Effectiveness of Maintenance Reform Measures
Effectiveness of CMDR Tobin's Initiatives
CMDR Tobin's Disciplinary Response

Resistance to Change
CMDR Tobin's Advice to MCAUST, the Navy Aviation FEG, Fleet Aviation
Engineering Unit

**Commanding Officer 817 Advice to Commanding Officer HMAS KANIMBLA
and Sea King Detachment Commander**

Conclusion

Prevention of a Recurrence

**Chapter 10 Terms of Reference
Annex**

CHAPTER 11: NAVAL AVIATION FEG HQ SUPPORT OF 817 SQUADRON

Introduction

Chronology of Key Events

Navy Aviation FEG Organisation and Structure

Background of Key Persons

CDRE Ledger's Aviation Experience and Background

CANAG's Authority and Responsibilities

CMDR Varcoe's Aviation Engineering Background and Experience

FAEO Authority and Responsibilities

Accountability Framework

Aviation Group Management Framework

CDRE Ledger's Performance as MAB of 817 Squadron

CDRE Ledger's Knowledge of 817 Squadron Maintenance Standards Issues

Management of Tradesmen and Supervisor Experience and Skill Levels

Aviation FEG HQ Management of Tempo

CDRE Ledger's Knowledge of 817 Squadron Tempo

Effects of High Tempo

Responses to Undesirable Effects of Tempo

Aviation FEG HQ Oversight of 817 Squadron's Maintenance

Discussions at the 2003 Airworthiness Board about the 2003 DGTA AMO Audit

AIRCDRE Schmidt's Minute of 02 Apr 03 and Telephone Call to CDRE Ledger

Action Taken after 02 Apr 03

Consequences of the FEG not passing on the Final Report

FEG oversight of 817 Squadron in 2004

Communication with MCAUST

COS AVN Support to 817 Squadron

FAEO Support to 817 Squadron

Conclusion

Review of Accountability Framework – CDRE Ledger
Annexes

CHAPTER 12: MARITIME HEADQUARTERS SUPPORT OF 817 SQUADRON

Introduction

Naval Aviation Command and Management

Command of the Navy
Maritime Command – Command and Management
Command and Control of RAN Aviation Squadrons

Command Airworthiness Responsibilities

Accountability Framework for MCAUST
Airworthiness Training and Education

Management of 817 Squadron Maintenance Standards by MCAUST

Chronology of Events
RADM Gates – MCAUST Jul 02 to Jun 04
What did RADM Gates know of 817 Squadron Maintenance Practice Standards?
What did RADM Moffitt know of 817 Squadron Maintenance Practice Standards?
RADM Moffitt's Understanding of Technical Airworthiness Responsibilities
RADM Moffitt's Communication and Support System within MHQ
What did RADM Moffitt know of 817 Squadron's Predicament?
CMDR Tobin's email of 13 Aug 04
CMDR Whittaker's 17 Aug 04 Brief to MCAUST about the PCR Issue
CMDR Tobin's email of 06 Sep 04
COMAUSNAVAIRGRP's Minute of 28 Oct 04
CMDR Tobin's email of 15 Dec 04
What RADM Moffitt says he would have done, had he been given the full facts
Style of Communications with MCAUST
Did RADM Moffitt Sufficiently Inform Himself?

Conclusion

Review of Accountability Framework
Avoidance of a Recurrence of a Similar Accident
Annex

SECTION 5: SYSTEM CONTRIBUTORY CAUSES OF THE ACCIDENT

CHAPTER 13: THE DEFENCE AND NAVY SAFETY SYSTEM

Introduction

Navy Commitmen to Safety

Safety System Structure

Strategic Safety System Management

- Defence Occupational Health and Safety Branch
- Defence Aviation Safety-ADF Activities
- Safety Information Flow across the ADF
- Defence Aviation Hazard Reporting and Tracking System
- Safety Climate Surveys
- Risk Management, Safety Management and the Airworthiness System

Aviation FEG Safety Management

- Airsafe Board
- Airsafe Board Consideration of Sea King Crashworthiness

Fleet Aviation Safety Officer and ASOR Management

- Air Safety Systems Working Group
- Human Factors Working Group

817 Squadron Safety Management

- Safety Continuation Training

Sea King Workplace Safety

- Defence OHS Obligations
- Safety Record
- BOI Recommended Sea King Aircraft System Changes
- Aircraft Design and Safety Configuration
- Sea King Compliance with Civil Standards
- Comparisons with Overseas Defence Force Sea Kings
- Sea King Fire Crashworthiness and Safety Considerations
- Additional Considerations Related to Sea King Utility Role Safety
- Sea King Work System Safety

Summary of Aviation Safety System Contributory Causes to the Accident

Conclusion

CHAPTER 14: ADF AIRWORTHINESS SYSTEM ANALYSIS

Introduction

ADF Airworthiness Management System Structure

- Airworthiness Framework

Airworthiness Judgements

Airworthiness Management System Functions

Operational Airworthiness Management

Technical Airworthiness Management

- Director General Technical Airworthiness-ADF
- Commander Australian Navy Aviation Group
- DGTA Interaction with Command
- Authorised Maintenance and Engineering Organisations Status
- Technical Airworthiness Audit Processes
- Maintenance Authorisation and Certification
- Maintenance Regulations
- Squadron Quality Systems
- 817 Squadron Technical Instructions and Orders

Sea King Aircraft Airworthiness Certification

- 2003 Sea King FAR Safety Compliance Review

Airworthiness Boards

Airworthiness History of 817 Squadron in the Years Before the 02 Apr 05 Accident

- Achievement of Authorised Maintenance Organisation Status
- The 817 Squadron 2003 DGTA AMO Surveillance Audit
- 2003 Sea King Airworthiness Board
- 2003 DGTA 817 Squadron AMO Audit CAR Close-out Processes
- Aircraft Maintenance Capability Review Team
- FAEU Support to 817 Squadron in 2003
- The 817 Squadron 2005 DGTA AMO Surveillance Audit
- 2005 Sea King Airworthiness Board
- Management and Command Response to Airworthiness Findings
- May 2005 DGT A Health Check

Analysis of Airworthiness Management System Structure

- ACP Airworthiness Review

Summary of Airworthiness Issues Relevant to the Accident

Prevention of a Recurrence

- Improving Airworthiness System Performance

Conclusion

- Annexes

CHAPTER 15: NAVY AVIATION TRAINING SYSTEM AND EDUCATION

Introduction

The Navy Aviation Maintenance Training Continuum

- Generic ADF Aviation Technical Sailor Training
- Navy Aviation FEG Technical Training
- Squadron Technical Training

Aviation Education

Qualifications, Currency and Training of Aircrew

Conclusion

CHAPTER 16: LOGISTICS SUPPORT SYSTEM ANALYSIS

Introduction

The Navy Aviation Logistics System

NASPO Navy Aviation Systems Program Office Support to 817 Squadron

NASPO Spares Support

817 Squadron Detachment Pack-Up Kit

Split Pin Spares on HMAS KANIMBLA

Next of Kin Aircraft Parts Submission

NASPO Bellcrank Resupply

NASPO Support from Original Equipment Manufacturers and Other Military Users

NASPO Engineering Support

NASPO Bellcrank Advice

NASPO N16-100 Tail Cone Damage Advice 9 Feb 05

NASPO Split Pin Advice

NASPO Publications Support

Sea King Maintenance Publications

HMAS KANIMBLA Logistics Support

Working Conditions in HMAS KANIMBLA

DGTA Logistics Support

Maintenance Regulations

Planned Servicing Schedule System

Sea King Maintenance System

RAN Sea King Maintenance Philosophy

Maintenance Responsibilities

Analysis of Bellcrank Removal and Replacement Activity

Aircraft System Design and Planned Life of Type

Summary of Logistics Contributory Causes to the Accident

Prevention of a Recurrence - Logistics System

Improving Logistics System Performance

Terms of Reference

SECTION 6: OTHER BOARD OF INQUIRY AND INVESTIGATION RECOMMENDATIONS

CHAPTER 17: PREVIOUS AUSTRALIAN DEFENCE FORCE BOARDS OF INQUIRY AND INVESTIGATION RECOMMENDATIONS

Introduction

- Accident and Incident Investigation Processes
- Tracking of Implementation of Board Recommendations

Bamaga Sea King Accident - 30 Jul 1995

- Bamaga Aircraft Accident Investigation Unit Recommendations
- Bamaga Sea King Accident Board Recommendations
- Intent of Bamaga Board Recommendation 20.14 Regarding Harnesses
- Responsibility for Implementation of Recommendation 20.14

Chronology of Events Relating to Sea King Passenger Harnesses

Sea King Crashworthy Seat Considerations 1975-1996

Sea King Life of Type Extension

Sea King Crashworthy Considerations 1997-1999

Sea King Crashworthy Considerations 2000-2003

Conclusion

Prevention of a Recurrence

SECTION 7: MANNER AND CAUSE OF DEATH

CHAPTER 18: THE MANNER AND CAUSE OF DEATH

Introduction

Background

- NSW Coroner's Involvement
- The Place and Time of Death
- Body Recovery and Repatriation to Australia
- Identification of the Deceased

Manner of Death

- Medical Causes of Death

Forensic Pathology in Context

- Causes of Injury in Helicopter Accidents
- Disposition of Crew, Passengers and Stores
- Summary of Accident Sequence

Post Accident Fire
The Medical Cause of each Death
LEUT Paul Kimlin – Aircraft Captain
LEUT Jonathan King – Co-Pilot
LEUT Mathew Goodall – Observer
LSA Scott Bennet – Utility Aircrewman
SQNLDR Paul McCarthy – Medical Officer
LEUT Mathew Davey – Medical Officer
FLTLT Lynne Rowbottom – Nursing Officer
POMED Stephen Slattery – Medical Assistant
SGT Wendy Jones – Medical Assistant
Summary of Findings
Issues Relating to Causation
The Act, Omission, Neglect, Carelessness or Misconduct of Any Person
Non-Compliance With Orders, Instructions or Safety Procedures
Any Equipment Limitations, Malfunctions or Failure
Observations about Victim Identification
Military Identification Tags

SECTION 8: AFTERMATH AND NON CAUSAL ISSUES

CHAPTER 19: NON CAUSAL ISSUES

Introduction

Post Accident Management of Notifications to Next of Kin

Emergency Contact Details
Demands by the ADF for Information from Families
Support by the Defence Community Organisation
Other Issues

Deployment and Support of the AAIT

CMS Response and Post Accident Management of Personnel

CMS Response to Crash of *Shark 02*

Search And Rescue Alerting System Failure

The COSPAS-SARSAT System
Sea King Crash Data Recorder
N 16-100 Crash Data Recorder and an Emergency Locator Transmitter System
N 16-100 Beacon Detections as Reported by AMSA

Primary Care Reception Facility Equipment

Board Access to Evidence Gathered by AAIT

Security and Preservation of the Wreckage of *Shark 02*

Body Recovery Operation

Repatriation of the Nine Deceased ADF Personnel

- ADF Policy at the Time of the Accident
- Policy for Operation SUMATRA ASSIST
- Storage of Human Remains
- Quarantine Requirements
- TNI and ADF Vigil at Sibolga during Night of 03 Apr 05
- Ceremony at Sibolga and Transfer to RAAF C130 Hercules
- Transported to Hiam Base – Small Ceremony
- Arrival at Sydney on 05 Apr 05 – Met by Next of Kin

Defence Community Organisation and Follow-on Support

The Regulation 34 Notice to WOATA Cinello

CHAPTER 20: COMPENSATION AND REMEDIATION

Introduction

OPERATION SUMATRA ASSIST

- The Nature of Service
- Force Assignment

Force Assignment and Conditions of Service for Operation SUMATRA ASSIST Phase I and Phase II

- Occupants of Aircraft - Duty Status
- Occupants of Aircraft - Nature of Service in ADF
- Injuries Suffered by ADF Members
- Known Injuries
- Exposure to Hazardous Substances

Remediation of Accident Site at NIAS Contract for Remediation

Remediation Standards and Site Survey

Remediation Activities

Independent Review of Remediation Activities

- Persons Involved in Post Accident Procedures
- Loss or Damage to Civilian Property
 - Indonesian Property
 - Personal Property of Occupants of *Shark 02*
- Eligibility to Claim for Compensation – General
- Eligibility to Claim for Compensation – Next of Kin of Deceased Members and Injured Members
- Eligibility to Claim for Compensation - Parents
- Out of Pocket Expenses
- Outstanding Action to Finalise Compensation
- Appointment of Advocate
- Review of Board's Recommendations
- Annex

SECTION 9: CONCLUSION

CHAPTER 21: CONCLUSION

Introduction

Dominant Themes

- Poor Understanding of Airworthiness Responsibilities
- Compliance versus Safety – the need for a Safety Champion
- Reliance on Audits and ASORs as Measures of Safety
- The Diminution of Standards
- Reliance on Trust
- Communication of Issues to Command
- The Requirement for Culture Change
- Acknowledgement of the Good Work of Those Who Operate and Support the Sea King
Capability
- Disciplinary and Administrative Action Consideration
- Annexes

Nias Island Sea King Board of Inquiry Report

Intentionally Left Blank