On 2 September 2006, RAF Nimrod XV230 was on a routine mission over Helmand Province, Southern Afghanistan, in support of NATO and Afghan ground forces when it suffered a catastrophic mid-air fire, leading to the total loss of the aircraft and the death of all 14 people on board.

October 2009 saw the publication of the independent Nimrod Review into the accident, which found that the immediate cause of the fire was a fuel leak.

As the report noted, ‘There can be no doubt that the ignition source was [a] duct in the starboard No. 7 Tank Dry Bay [and that] the most likely source of fuel was an overflow during Air-to-Air Refuelling’.

Behind this, however, were fundamental flaws in the Nimrod Safety Case, which was drawn up between 2001 and 2005. It had ‘represented the best opportunity to capture the serious design flaws in the Nimrod which had lain dormant for years’.

But, as the report clarifies, ‘the Nimrod Safety Case was a lamentable job,’ which ‘missed the key dangers’ and was ‘fatally undermined by a general malaise: a widespread assumption by those involved that the Nimrod was “safe anyway” (because it had successfully flown for 30 years)’. The task of drawing up the Safety Case ‘became essentially a paperwork and “tickbox” exercise’.

The report author clearly felt that there were some simple messages to be highlighted and devoted a single page at the front of the document to the box reproduced below:

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**A FAILURE OF LEADERSHIP, CULTURE AND PRIORITIES**

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**Issues arising**

The report makes the point that there are a number of ‘uncanny, and worrying, parallels between the organisational causes of the loss of Nimrod XV230 and the organisational causes of the loss of the NASA Space Shuttle Columbia’. These include:

- The torrent of changes and organisational turmoil.
- Dysfunctional databases.
- The imposition of ‘business’ principles.
- Cuts in resources and manpower.
- The dangers of outsourcing to contractors.
- Dilution of the risk management processes.
- ‘Success-engendered optimism’.

The Nimrod accident also has parallels with other catastrophic accidents, such as Herald of Free Enterprise (1987), the King’s Cross fire (1987), The Marchioness (1989), and BP Texas City (2005).

Each of these cases has shown that ‘there are fundamental organisational causes which lie at the heart of many major accidents, and these have to be addressed in order to learn the real lessons for the future’.

The report also highlighted that the interface between the MOD and the air industry ‘is not working as it should’, that there had been a dangerous ‘selfishness’ regarding the implementation of new ideas as a means of gaining promotion and that there is ‘a lack of corporate memory’.
The Nimrod Report – Operational Feedback

Recommendations

Among its many recommendations, the report advocates the promulgation of and adherence to four key principles, ‘in order to help assure and ensure an effective Safety and Airworthiness regime in the future’:

✓ **Leadership**

There must be strong leadership from the very top, demanding and demonstrating by example active and constant commitment to safety and Airworthiness as overriding priorities.

- “[T]he first priority for a successful safety culture is leadership” (Lord Cullen, Ladbroke Grove Rail Inquiry, 2001)
- “Leaders create culture. It is their responsibility to change it.” (Columbia Accident Investigation Board, 2003).
- “In hindsight, the Panel believes that if [the Chief Executive] had demonstrated a comparable leadership and commitment to process safety, that leadership and commitment would likely to have resulted in a higher level of process safety performance in BP’s U.S. refineries.” (Report of BP U.S. Refineries Independent Safety Review Panel, January 2007).

✓ **Independence**

There must be thorough independence throughout the regulatory regime, in particular in the setting of safety and airworthiness policy, regulation, auditing and enforcement.

✓ **People (not just Process and Paper)**

There must be much greater focus on People in the delivery of high standards of Safety and Airworthiness (and not just on Process and Paper).

- “Safety is delivered by people, not paper” (Commodore Andrew McFarlane, Defence Nuclear Safety Regulator, 2008)
- “It is important to value the individual and ensure that they are familiar with the aircraft and the process” (Garry Copeland, Director of Engineering, British Airways, 2008).

✓ **Simplicity**

Regulatory structures, processes and rules must be as simple and straightforward as possible so that everyone can understand them.

- “There is false comfort in complexity”. (Darren Beck, Secretary to the Nimrod Review, 2008).
- “NASA was so complex it could not describe itself to others.” (Martin Anderson, HSE, 2008).

The full report may be downloaded here: [LINK](#)

Hard copies may be purchased via The Stationery Office online bookshop.