5 RECOMMENDATIONS

This report entails some important lessons for gliding clubs.

This accident emphasises that it is important that everyone participating in glider flight operations realises that small defects on a glider can have an adverse effect on flight safety. It is therefore important that every malfunction should be viewed and assessed, without making any assumptions, with flight safety in a broad sense in mind. If there is any doubt pertaining to issues concerning critical functions, such as related to the takeoff, the glider should be taken out of flight operations for further inspection and should not be flown until it is determined that the glider can be safely operated. However, malfunctions can be hard to recognise as such. Therefore, it is important that occurrences that possibly imply critical malfunctions are recognised and reported. The club's safety management system can guide club members with examples of occurrences that possibly imply critical malfunctions. Furthermore, it is important that clubs stimulate the structural and continuously reporting of occurrences that possibly imply critical malfunctions, that might affect flight safety, and record them. Everyone who participates in flight operations has a responsibility in this. In addition, clubs must ensure that the people who have to make decisions about the airworthiness of a glider (technicians, instructors and pilots) are aware of potential malfunctions and associated risks.

The investigation shows that the way in which the club had organised the allocation of its gliders, made it possible that the pilot, not current on single seater gliders, took off with the LS8. The pilot met the club's requirements to fly locally on the LS8. However, the club's requirements did not account for the lack of currency on single seaters. Although this situation is not relevant for many glider pilots, gliding clubs should be aware that club members may pause flying temporarily or may pause flying on a specific type of glider. Therefore, gliding clubs should incorporate recent experience in the way they allocate gliders to their club members and include this in the safety management system.

The Dutch Safety Board therefore issues the following recommendation:

To the Royal Netherlands Aeronautical Association:

Bring the lessons from this accident to the attention of the Dutch gliding clubs and point out to them that:

1. A club's safety management system must be organised in such a way that occurrences that possibly imply critical malfunctions are recognised, reported, and immediate action is taken on it. A club must stimulate everyone who participates in flight operations to report these type of occurrences.

2. A club's safety management system must be organised in such a way that the members' recent flying experience is taken into account when allocating a glider to a club member.