

**SUMMARY OF AIRCRASH INVESTIGATION REPORTS PUBLISHED BY THE ACCIDENT INVESTIGATION BUREAU**

No	Report Name	Date of Accident	Date of Report:	Name and Flying Hours of Pilot (s)	Age and condition of aircraft	Number of Injuries/Casualties	Summary of Findings	Recommendations
1.	FINAL REPORT ON THE ACCIDENT TO SOSOLISO AIRLINES DC 9-32 AIRCRAFT REGISTERED 5N - BFD AT PORT HARCOURT INTERNATIONAL AIRPORT	December 10, 2005	July 20, 2006	Pilot in command: Benjamin Adekunle Adebayo: 10,050 total, 1900 type  First officer Gerad Yakubu Andan: 920 hours total 670 on type.	Manufactured 1973. Airworthy	108 persons died and 2 sustained severe injuries.	<p>The aircraft on final approach encountered adverse weather with change in wind speed and direction while the visibility was reducing in thunderstorm and rain.</p> <p>The crew continued the descent and went well below the Decision Altitude without having visual contact with the runway and initiated a 'go-around' below the altitude of 204ft, which is 103ft below the Decision Altitude; the attempt of which was not successful.</p> <p>The aircraft tail section made contact with the grass strip between Runway 21 and taxiway, 70m to the left of the runway edge and 540m from</p>	<p>Pilots flying into Port Harcourt and other coastal areas in the country should be mindful of weather hazards such as wind shear activity.</p> <p>Recognition and recovery from adverse weather/wind shear should be mandatory part of pilot's initial and recurrent simulator trainings.</p> <p>NIMET should provide appropriate equipment to generate data on visibility and cloud conditions near the runway threshold and also ensure that adequately equipped briefing office is provided at the airport (and in all airports) for en route weather information among others.</p>

							<p>the runway threshold.</p> <p>At about 60m from the first impact, the aircraft rear fuselage impacted heavily with an exposed concrete drainage culvert where No.2 engine and the rear staircase of the aircraft were detached and lodged.</p> <p>The exposed concrete drainage structure is badly located and poses a real danger to aircraft landing on Runway 21.</p> <p>The aircraft disintegrated and caught fire along its path spanning over 790m.</p>	<p>The Nigerian Civil Aviation Authority, NCAA should monitor and strictly enforce standards on airfield lightings, fire cover and aviation personnel training.</p> <p>There is the need for the provision of Uninterrupted Power Supply (UPS) to the airfield lightings to ensure that all critical aids are on throughout the operational period of the airport.</p>
2.	REPORT ON THE ACCIDENT TO THE SKY EXECUTIVE AVIATION SERVICES' LET-410-UVP AIRCRAFT REGISTERED 9Q-CGX ON THE APPROACH TO CALABAR AIRPORT	May 21, 2002	August 19, 2002	Captain Celestine (last name and flying hours unclear in document)  S. Jean Pierre (first name and flying hours unclear in	Manufactured 1985.  NOT Airworthy. There was no pre-importation inspection by NCAA before the aircraft was	All 5 on board died.	<p>The aircraft was neither installed with Flight Data Recorder (FDR) nor Cockpit Voice Recorder (CVR) as against the Nigerian Civil Aviation (Air Navigation) Regulations.</p> <p>The probable cause of the accident was the premature</p>	<p>Pilots should endeavour to equip themselves with en-route and destination weather before embarking on their flight.</p> <p>Pilots should adhere strictly to the standard operating procedure by avoiding indiscriminate departure from the</p>

				document)	brought into the country. That means no proper documentations .  There was no maintenance of aircraft or engine.		departure of the aeroplane from the normal Minimum Safe Altitude of 2500ft without ATC clearance until it flew into the terrain.  The contributory factor was the emergence of electrical problem on the aircraft on the commencement of its approach. The problem might have distracted the attention of the Pilots from having undistorted focus on the instruments.  Another contributory factor was the unfavourable weather conditions of low cloud base and thunderstorm, which impaired the visibility at the critical time of the descent.	Minimum Safe Altitude (MSA).  Pilots should also ensure that the laid down procedures are strictly adhered to in case of emergency.  The Honourable Minister of Aviation may consider it necessary to include French language study in the training curriculum of Student Pilots, Air Traffic Controllers (ATC) and Aircraft Maintenance Students, at the Nigerian College of Aviation Technology (NCAT).  It is recommended that those who are to inspect aircraft for airworthiness purposes and conducting audits of approved organisations, are those who know what an aircraft is and what "Aviation Regulations" are.
3	REPORT ON THE ACCIDENT TO THE CHANCHANGI AIRLINES'S BOEING 737-200 AIRCRAFT	February 22, 1998	Not stated in report	Capt. Vjekoslav Mihajlovic (Pilot in Command).  13,000+	Manufactured April 1988  Aircraft was	None	Chief Pilot approached the Air Traffic Controller personally that he would like to fly around the circuit for a training flight.	The fire services at Kaduna Airport must be ungraded and equipped to serve their purposes.

	<p>REGISTERED YU-ANU WHICH OCCURRED AT KADUNA AIRPORT ON SUNDAY THE 22ND OF FEBRUARY, 1998.</p>			<p>Lekic Dragomir (First Officer Left). Flying hours unspecified  Capt. Ostojic Dragan (First Officer Right)</p>	<p>certified airworthy.</p>		<p>Because of the poor visibility, the Pilot then suggested that he would carry out a "Rejected Take-Off' training.  Four rejected take-offs were carried out within an interval of twelve minutes. In the process of carrying out a rejected take-off, as the aircraft accelerates to a speed below VI (The maximum speed at which a rejected take off may be carried out) the thrust reversers and the braking systems are the main systems that will eventually bring the aircraft to a halt after the take off run is rejected.  Consequently, after a rejected take off, the brake units are so hot that the brake cooling schedule of at least 10 minutes between take-offs must be observed.  Thus in carrying out four</p>	<p>Furthermore, the use of fluoro-protein foam compound should be reassessed and may be the pure protein foam agent which was originally used in Nigeria may be reintroduced.  There is definitely a need to adopt a more effective foam compound.  With immediate effect, Captain Mihajlovic Vjekoslav is banned from operating an aircraft within the Nigerian airspace. This is a directive from the Honourable Minister of Aviation in Nigeria.  The Kaduna Airport runway and associated taxiways, should be derubberised, especially the contamination resulting from this accident.  All training programmes must adhere to the recommendations of the aircraft manufacturers.</p>
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4.	REPORT ON THE ACCIDENT TO BOEING 737 AIRCRAFT 5N-AUA THAT CRASHED AT THE NEW KADUNA AIRPORT	November 13, 1995	July 18, 1997	<p>Pilot in Charge- B. Dambazau: 6000 hours total, 4000 on type</p> <p>First Officer C. A. Elom: 5000 hours, 3000 hours on type</p> <p>Chigbo Ndukwe- Supernumerary Officer</p>	<p>Manufactured February 11, 1983</p> <p>Airworthy.</p>	<p>11 people died. 14 sustained serious injuries.</p>	<p>The Flight Cockpit Management was very pitiable in that only the Commander was treating the flight while the First Officer was distracted with other things.</p> <p>There was a rift between the Commander of this aircraft and the jump seat F/O who claimed himself to be a member of the Nigeria Airways management, and hence superior to the Captain . Co-operation between those on the flight deck was rendered impossible.</p> <p>The attitude of the jump seat First Officer adversely affected the professional conduct of the flight.</p> <p>No landing checks were carried out. The right seat scheduled first Officer was too busy assisting in relaying messages between the ground</p>	<p>Extended runway ends are normally designed to accommodate runway over-runs because all materials on the extended centre-line are frangible. The decision of the pilot-in-command to turn into the high speed intersection of the runway actually caused the fire which resulted in the fire outbreak. The captain should have heeded the advice of the other cockpit occupants to hold the aircraft on the Centre line.</p> <p>The Company's flight Operation department must think about compatibility when matching the flight crew members for harmonious and safe operation.</p> <p>Airline operators may wish to constantly advise and encourage their pilots to carry out a missed approach at the earliest hint of</p>

								<p>dispatchers.</p> <p>An NDB approach was flown into Kaduna and reports from eye witnesses and the evidence given from the cockpit indicated that the approach was not stabilised.</p> <p>The alignment of the aircraft was not achieved until the aircraft was far beyond the threshold of the runway.</p> <p>The prominent contributory factor to the number of fatalities was the outbreak of fire.</p> <p>The centre tank ruptured close to the wing root and with sparks from the crumbling metal in the vicinity of aviation fuel a gigantic Inferno soon erupted.</p>	<p>doubt or difference of opinion within the cockpit area.</p> <p>The Fire personnel need more training in the act of modern fire fighting. The fire services need to be better equipped with fire fighting facilities.</p>		
5.	REPORT	ON	THE	September	September	Names	not	Manufactured	None	The accident was caused by the	The landing technique at the time

	ACCIDENT TO THE DASSAULT AVION FALCON 20F REGISTERED 5N-EPN	5, 1995	29, 1995	Mentioned. The Pilot-in-Command: 3200 hours total, 750 hours on type.  The First Officer: 8700 hours total, 800 hours on type.	December, 1972. Airworthy		fatigue failure of the door actuator bellcrank of the left main landing gear due to an improper rigging of the door actuator push rod in the door mechanism.	of this accident is highlighted for observation.  Keeping the belly of the aircraft from making contact with the runway surface at high speeds is fully endorsed by the Accident Investigation Bureau.
6.	REPORT ON THE ACCIDENT TO THE NIGERIA AIRWAYS LTD'S BOEING 707 - 320C ON MONDAY THE DECEMBER 19, 1994 AT KIRI KASAMA, HADEIJA LGA.	December 18, 1994	May 30, 1996	(Names not stated in report) Pilot in Charge: 10,917.35 hours total, 3594 on type.  First Officer: 5201 hours total, 2000+ on type	Manufactured 1972. Airworthy	3 persons died in the crash and 2 sustained serious injuries	The Flight Data Recorder was unserviceable and evidence indicated that the Recorder had been faulty from the point of its installation. However, the Cockpit Voice Recorder contained useful data.  There was a heavy insurgence of smoke into the Cockpit just before a huge explosion rocked the aircraft and rendered the light controls unusable.  The cockpit crew relied heavily on the judgement of the Ground Engineer in determining the severity of the in-flight	Cargo handling Airline Operators are specifically directed to Annex 18 " The safe transport of dangerous goods by air" of the International Standards and Recommended Practices {International Civil Aviation Organization) to ensure compliance with all the provisions of the Annex.  Consignors of cargo must be supplied with a list of items that are classified as dangerous goods. Furthermore, the Airlines must devise a way of educating the owners of cargo on the repercussions of failure to declare

						<p>emergency while the Ground Engineer himself may have been suffering from an acute state of tiredness and duty fatigue.</p> <p>The aircraft may have descended uncontrollably from a height of 34,000 ft. before plunging into marshlands at Kiri Kasama.</p> <p>The probable cause of this accident was a heat generating substance that was hidden in a cargo of fabrics inside pallet No. 11 in the cargo compartment of the aircraft. The heat that emanated from the pallet resulted in smoke that caused a major distraction in the cockpit and later caused an explosion which seriously impaired the flight controls of the aircraft.</p>	<p>dangerous goods.</p> <p>Airlines may design screening methods for the detection of dangerous goods</p> <p>The Commander of an aircraft must ensure that all visitors to the cockpit have access to an oxygen mask. The oxygen mask must be switched to deliver 100% oxygen throughout the visit to the cockpit.</p> <p>Any form of in-flight fire whether controlled or not, should warrant an emergency landing at the nearest aerodrome where a comprehensive inspection can be carried out on the ground. The landing may also minimize any side effects of fumes on the crew.</p> <p>Airline Operators are invited to consider the provision of proper resting facilities, such as bunkers etc. for all their personnel on</p>
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7.	SUMMARY OF ACCIDENT REPORT ADC AIRLINES (LIBERIA) 5N-BBE-DC-9-31 AT JAMES SPRIGGS PAYNE AIRFIELD MONROVIA, LIBERIA	August 18, 1994	No date in report.	Captain Sunday Arome (PIC), 7486 hrs.14min.  Co-Pilot Mathias Dramou, 2264 hrs.	Manufactured in 1968.  Airworthy	All eight-five (85) people on board were successfully evacuated with few minor Injuries sustained by one passenger and two crew members.	VHF two way communications was maintained.  The captains were certified , their bearings and postures did not reflect Persons under the influence of drugs, although no medical tests were carried out .  The aircraft was maintained in accordance with applicable regulations and established maintenance procedures. The Captain was aware of the wet Runway, based on the weather report. Whenever a runway is wet, the coefficient of friction between the a/c tires and the runway surface is reduced from	Navigation and landing aids must be made available at the James Spriggs Payne Airport.  These facilities must be commensurate with the type of airplane using the field.  The requirement for firefighting coverage up to category seven must be urgently established at the airport.  In view of the type of airplane operating into Spriggs Payne Airport, it is considered to be an added safety factor, if the runway length were extended by 1000' .

								<p>that of a dry runway. This reduction can be as much as 30 per cent, thus resulting up to 30 percent increase in the distance required to stop the aircraft.</p> <p>Analysis of the Flight Data Recorder (FDR) indicate the final descent from the NDA to touch-down was at a rate of 1,375ft/min. This is on the high side and clearly demonstrates a pilot forcing himself to land on the field at all costs</p>	<p>Attention must be given to the urgent need to carry out the resurfacing of the runway, more especially the first 2000' of runway-23.</p> <p>It cannot be over-emphasized that crew members must comply with the use of approved check-lists in configuring the aircraft for each phase of a flight</p>
8.	REPORT ON THE ACCIDENT TO THE BRISTOW HELICOPTER BELL - 212 AIRCRAFT 5N-AJY AT EKET	February 24, 1991	June 2, 1992	Captain Micheal A. Parish: 6873 hours total, 219 on type  Co-Pilot Olushola O. Ishola: 1364 hours total, 131 on type	Manufactured June 1974.  Airworthy	9 persons including the co-pilot died from asphyxiation and drowning.  4 persons sustained minor injuries.	<p>At some point during the flight, the Pilot heard a big bang accompanied by a sharp yaw to the right and a sharp pitch down. Captain took over the control and thought initially that the aircraft was uncontrollable.</p> <p>He lowered the lever and entered autorotation.</p> <p>Captain diagnosed tail rotor</p>	<p>Oil Companies operating off-shore rigs and aircraft operators must intensify their efforts of inculcating safety and survival aptitudes of the local helicopter passengers.</p> <p>The presently employed verbal advisory briefings will no longer suffice; Practical Survival trainings like submerging a dummy helicopter capsules in a specially constructed swimming pool is</p>	

						<p>failure and broadcasted “May Day”, by which time the aircraft had reached the sea.</p> <p>The commander misjudged that the helicopter had a tail rotor problem and had over-reacted by not properly isolating the type of the problem before applying corrective measure of a tail rotor drive failure otherwise he would have observed that response to pedal movement, which was skill available to him, would have nullified the wrong diagnosis of a tail rotor failure.</p> <p>Eight of the passengers were unable to find the exit door and swim out when they were completely submerged, while the co-pilot, known to be a good swimmer, must have been knocked unconscious by the crash as he was found still strapped to his seat .</p>	<p>suggested mandatory for frequent helicopter passengers.</p> <p>The emergency door opening mechanism of offshore helicopters must be redesigned to have a quick action opening capability and yet have a fool proof device for unintentional openings.</p> <p>Nigerian registered helicopters certificated for a 2 man crew operation must be' installed with a cockpit voice recorder (CVR).</p>
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9.	REPORT ON THE ACCIDENT TO THE OKADA AIR BAC 1-11 REGISTERED 5N-AOT PORT-HARCOURT INTERNATIONAL AIRPORT ON THE 7TH SEPTEMBER, 1989	September 7, 1989	May 30, 1990	Captain Akinbowale Johnson: 5230 hours total, 3500 on type  First Officer Chinedum Johnson: 783 hours total, 493 on type.	Manufactured 1968  Airworthy	None		<p>The First Officer was flying the aircraft down to 17 seconds before the impact.</p> <p>The aircraft made a hard landing, bounced up and made the second touchdown on its nose-wheel</p> <p>About 82 meters after impact, the aircraft lost the nose gear assembly and fuselage nose section contacted the runway</p> <p>The trench broke off the right hand main landing gear and the aircraft stopped 735 meters after touchdown.</p> <p>The probable cause of this accident is the poor handling of the controls at the critical movement of final approach</p>	<p>The Operator should, with immediate effect produce its Company Operations Manual and distributes copies to all concerned parties.</p> <p>Whenever it is necessary for the flight crew to change over the control at the critical moment of the final approach, pilots should be encouraged to exercise a GO-AROUND.</p> <p>The Nigerian Airports Authority should be made aware of its safety responsibilities to aircraft operators as far as airport operations are concerned</p> <p>The Meteorological Station at Port-Harcourt should be provided with working materials like CLAM Forms, Runway Visual Range</p>

							and landing phases, probably due to the sudden loss of azimuth in the heavy down pour of rain. The contributory factor to the accident is the excavation and improper refilling of the outrageous trenches of wide dimensions along the length of runway 03/21	Equipment etc. Quick dissemination of meteorological information must be made possible at Port-Harcourt and impediments like faulty lifts, radar, recording machines etc must be given their due maintenance.
10.	CIVIL AIRCRAFT ACCIDENT REPORT NO. CIA 129 ON AIRBUS A-310 AT PORT-HARCOURT AIRPORT PORT-HARCOURT	September 8, 1987	February 16, 1988	1. Captain: John Idoko. 7979 hours 2. First Officer: Ayo Garuba- 4021 hours	Constructed November 1984. Airworthy. One yaw damper trips off on take-off and approach. (NOTE: One inoperative yaw damper will not hazardously affect flights and did not contribute to the accident)	2 Crew had serious injuries. 6 of the 93 passengers had minor injuries. There were no fatalities	The crew started to have the problem of unstabilized approach from altitude of 460 feet and 44 seconds away from touchdown. Despite this, the commander decided to go ahead and consequently landed the aircraft at the left edge of Runway 21 after which any correction was too late.  The aircraft, therefore, ran off the runway onto the shoulder. The existence of a trench of such dimensions alongside the runway inflicted damage to the aircraft.	Aerodrome Inspectorate Department must be geared to inspect all airports on monthly basis and to point out potential hazards and advise against those hazards which may exist at any airport.  The trench at runway 21 should be filled immediately and the surface be brought to the load bearing status which the runway design specifies.  The Instrument Landing System (ILS) at Port-Harcourt and all other navigational aids should be

						<p>The ATC tape recorder was unserviceable thereby making it impossible to record the communications with flight WT 104.</p> <p>The Commander was found not to be sent on proficiency trainings yet was allowed by the airline to be in command of the aircraft. The probable cause of the accident was the decision of the Commander to continue an unstabilized approach profile to a touchdown instead of initiating a missed approach at 100ft. or more from the ground.</p> <p>The second contributory factor was the open trench close to the runway shoulder which immediately trapped the left main landing gear in a bid to correct to the runway heading with right rudder.</p>	<p>restored and be made serviceable at all times. The control tower's automatic tape recorder should be rectified immediately to continue recording communications between ATC and aircraft.</p>
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11.	CIVIL AIRCRAFT ACCIDENT REPORT NO. CIA 122 ON BELL 206B JET RANGER III HELICOPTER REGISTERED 5N-AQC AT A LOCATION 7 NAUTICAL MILES N.N.W. OF KADUNA AIRPORT, NEAR THE VILLAGE OF IFIRA	April 26, 1986	July 1, 198(?) Date unclear in report	Check Captain G. N. Igwebike: 4,500 hours total, 149 hours 25minutes on type  Captain on Check, J.Abdullah: 1,550hrs. 59 minutes total, 7 hours 30 minutes on type.	Manufactured 14th of September 1979.  It had a Certificate of Airworthiness No. 497 which was valid in the aerial work category until the 31st of December 1986.  The helicopter was not insured and must have been on the ground between the 3rd of October 1983 and the 1st of January 1986 at a period	Check Captain killed. Captain on Check seriously injured.	The helicopter was being used to carry out a check-ride for one of the Captains employed by Capital Aviation Services Ltd. The Check-Captain was authorized by the Licensing Dept. of the Federal Ministry of Transport and Aviation to conduct the test.  After several hovering exercises were carried out within the aerodrome circuit the aircraft proceeded north of the field for the remaining tests in the programme.  At the end of the tests engine failure was simulated by the check Captain, but the Captain on check hesitated in his reaction to the required procedure.  The report concludes that the	Such Tests are best carried out in a simulator otherwise, adequate briefings should be given by the testing officer.  An additional safe-guard should be placed on the fuel valve switch of this helicopter to prevent unintentional operation of the switch.  The perennial communications problem at Kaduna Airport should be given an adequate attention.  The official assistance of the Ministry of Transport and Aviation should be consulted in going into aviation ventures.  ATC personnel should be made to carry out recurrent checks more especially on those practices which are normally not the

					when it was denied a Certificate of Airworthiness		<p>accident was probably caused by the failure of the Pilot on the controls to react instant to the engine flame-out by immediately putting the helicopter into auto-rotation.</p> <p>The entries in the Aerodrome Watch-Log indicated that there were problems of transmission and reception of radio signals at Kaduna on the day of the accident.</p> <p>The conversion training programme was not carried out in a coercive and professional manner and the Air Traffic Controller failed to monitor the progress of the aircraft while it was in the test zone</p>	<p>routine.</p> <p>The Nigerian Airports Authority must ascertain that at all airports; there is a positive means of contact between the fire stations and the Control Tower on the emergency frequency i.e. 121.7MHz.</p> <p>All ATC recorders in operation shall be fitted with time injectors so as to record the times of each communication.</p>
12.	CIVIL AIRCRAFT ACCIDENT REPORT NO. CIA 119 ALOUETTE III HELICOPTER REGISTERED 5N-ALD AT MEREN 24 OFF-SHORE LANDING PAD (JACKET)	December 6, 1985	February 3, 1986	Captain H. Forques, 4046 hours total, 2500 on type.	Date of Manufacture not mentioned in report. Helicopter was	A minor fore-arm cut on one of the four Personnel working on Meren 24.	<p>There was no formal fire traffic control. Take-offs and landings were only monitored by radio for helicopter location tracking.</p> <p>The probable cause of the</p>	<p>Off-shore meteorological services should be provided to cover helicopter operations.</p> <p>Security of all access hatches on all heliports must be designed</p>

					airworthy.		<p>accident was the displacement of a loose access hatch due to the side force transmitted to it by the compression of the right rear wheel oleo strut as the helicopter was landing.</p>	<p>either with the use of hinges or retaining locks.</p> <p>A training area must be marked out on dry land in order that pilots may practice the proportion of scanning required.</p> <p>Each helipad (platforms and jackets) must be provided with a wind direction indicator in the form of flags.</p> <p>The top surfaces of access hatches must be painted in a colour quite distinct for easy detection from the air by pilots.</p> <p>Annual sampling inspections must be carried out of all off-shore Aviation activities.</p> <p>The survival aspect of the Alouette 111 helicopter with respect to staying afloat in event of having to land on water must be verified.</p>
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