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El siguiente informe se encuentra en el sitio

http://www.mod.uk/DefenceInternet/AboutDefence/CorporatePublications/BoardsOfInquiry/LossOfHmsSheffieldBoiPhase3Part2.htm

en donde usted puede leerlo directamente en su formato original y acceder al resto del sitio.

Se refiere al hundimiento de la SHEFFIELD, publicado por el Ministerio de Defensa de Gran Bretaña.
A efectos de preservarlo como documento histórico para el caso en que el archivo original o el sitio que lo contiene no figurasen más en internet, a continuación se ha realizado una copia.

COMMANDER-IN-CHIEF FLEET

LOSS OF HMS SHEFFIELD
BOARD OF INQUIRY

Report of Captain Salt
Paragraphs 127 to 204

CONCLUSIONS

INITIAL WARNING AND APPROACH PHASE - OPERATIONAL

127. The time between the initial report of the raid by GLASGOW and missile impact was approximately 3½ minutes. (Annex A)

128. Earlier warning of a possible raid by two aircraft at approximately 40 miles had been detected in the force by GLASGOW but this was not received in SHEFFIELD. (Annex B, Para 1). The absence of AEW was sorely felt.

129. The regular detection of intermittent, fading and spurious radar contacts and the similarity of numerous ESM detections in this particular area of operations appears to have had a significant effect upon this situation with the following results. (86)

a) xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx (Enc:

b) Air Threat warning RED was not passed until some time after SHEFFIELD was hit. (Enclosure 2) S38 S40

c) Zippo 4 was never called. (Annex C, Para 2) S44

130. The threat was incorrectly assessed by SHEFFIELD as Mirage III, this assessment was based on the following facts: (Annex B, Para 4)

a) The aircraft were close, low and manoeuvring and certainly not flying the pre-EXOCET launch profile anticipated or outlined in intelligence briefs.

b) The aircraft flight profile was similar to that flown by Mirage aircraft which had previously attacked Task Force ships. (Annex B, Para 4)

c) Previous identifications of Super Etendards (at least two) had always turned out to be Mirage III. (78)

131. In the future it is possible that the first indication of EXOCET release will be a visual sighting. (15)

132. Due to the speed of events and the fact that the xxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxx in the initial stages the ship did not go to Action Stations. However, had the Action Alarm been sounded on first detection, 2 deck passageways would have been full of men closing up as the missile hit and undoubtedly many more would have died. (83) S38 S40 S44

ARGENTINE TACTICS - OPERATIONAL

133. The Argentines were able to gain sufficient information to mount an air launched EXOCET against the Task Force without the use of real time airborne third party targetting. (Annex H)

134. The attack was well executed, the surprise element of a low level approach (possibly 50ft) was used to good advantage. (Annex H)

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EVENTS AFTER MISSILE IMPACT - MATERIAL

136. There was extremely rapid spread of smoke, probably aggrevated by unspent missile propellant if, as is believed, it was fired at less than maximum range. (7-8 miles assessed). (89)

137. The smoke boundary forward at 2F/G was ineffective. (90)

138. The fact that ventilation had been crash-stopped and the appropriate Electrical Distribution Centres could not be reached to remake the breakers frustrated smoke clearance efforts forwards (91)

139. The unserviceability of N fire pump prior to the attack was critical (94)

140. The primary reason for loss of firemain was a breach at 2 deck level in the region of the explosion, coupled with its operation in a de-isolated state. (96, 101)

141. The inability to start C fire pump, and the failure of the attempt to reach L fire pump and isolate forward of it meant that at no time was ship's firemain available. (95, 96)

142. The ability of a Rover Gas Turbine driven fire pump to take a suction from the forecastle is suspect (103)

143. A Rover Fire Pump will not pass through the flight deck hatch to the Quarterdeck. (47)

144. At least two of the central handwheel, quick release doors on 2 deck which were open prior to impact were distorted and jammed partly shut by the explosion. (105)

145. The present CO2 drenching installation requires access to the CO2 drench cabinet above the fire in order to open the drench valve. (110

146. Some machinery control console indications may have been rendered defective by the explosion. (112)

147. An Upperdeck fire locker would have aided operations particularly on the forecastle. (113)

148. A pre-designated upperdeck area equipped with sound powered telephones and a whole-ship incident board would have aided centralised control of Damage Control operations on the upperdeck. (113)

149. The allowance of survival support devices is inadequate. (116)

150. The forecastle escape hatches are too small. (117)

151. The forward Auxiliary Machinery Space escape route is inadequate. (119)

152. There are anomalies between the watertight control markings of doors and ventilation valves in some sections of the ship. (121)

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153. Damage and spread of smoke would have been lessened if all 2 deck passageway doors had been shut. (122)

154. Had the ship been at Action Stations for this attack more men would have died. (125)

155. One hit by an air-launched EXOCET caused the loss of HMS SHEFFIELD

WEAPONS SYSTEMS - MATERIAL

156. All weapon systems were fully operational before impact. (8a)

157. With the exception of the LAS sights, GWS30 and GSA1 systems appear to have remained fully serviceable after impact. However, they could not be brought into action in Primary control because of the evacuation of the Ops Room and the damage to the LAS sights would have prevented their use in Emergency Control. (Annex K)

158. Had the Quarter Bill detailed a Captain of the Turret in Defence Watches the GSA1 system would probably not have been mistakenly rendered inoperative after impact.

159. SHEFFIELD's Weapon Engineering Hardware demonstrated surprising tolerance to the shock conditions experienced.

CASUALTIES - PERSONNEL

160. Asphyxia caused by smoke inhalation made a significant contribution to the numbers of dead and injured. (Annex J, Paras 1,3,4)

161. AGRs have a limited capability in enabling escape from smoke filled compartments provided the air is not oxygen starved or excessively polluted. (Annex J, Para 7A)

162. Re-entry into smoke filled compartments wearing AGRs instead of BA, contrary to briefing, caused the death of 1 and affected 4 others to the point of becoming unconscious/semi-conscious. (Annex,Para7B

163. Burns to one man were probably aggravated by the wearing of polyester/cotton service overalls next to the skin. (Annex J, Para 7B)

164. The standard issue wool jersey prevented extensive burns to one man. (Annex J, Para 7C)

165. Had anti flash hoods been worn at time of missile explosion some head injuries would have been reduced. (Annex J, Para 7D)

FINAL CONCLUSIONS BY COMMANDING OFFICER

166. Having concluded the individual lessons learnt, I offer the following comments not as an excuse for SHEFFIELD's loss but hopefully as a contribution for the future.

167. I am left with the feeling that perhaps a heavily operator-dependent system such as GWS30 is unable to provide rapid reaction to close range unalerted air attack.

168. The attack on SHEFFIELD on 4th May was in many respects simple; two aircraft against a fairly modern SAM DDG in calm weather conditions, in good visibility with no confusion in the ship caused by potential Blue on Blue. To engage these aircraft we had to rely on the skill, alertness and expertise of 13 operators any one of whose mistakes would have had a direct bearing upon the timeliness and capability of 909 to acquire and then Seadart to launch. xxxxxxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxx S38 S40 S44

169. A 24 mile detection on low fast air contacts is not an unrespectable range of initial detection for 992 particularly if the targets were at 50ft as suspected. Theoretically we had time to acquire and fire at both aircraft before missile release at 7-8 miles. In practices we have done so before (apart from actually firing) but on those occasions of success we have been at least alerted to the imminence of attack if not necessarily the threat bearing.

170. By 4th May, we had been "alerted" for about 70 hours, hence I believe both we and the Force had drifted into a sense of false security based on a successful 1st day and our previous ability to detect incoming raids normally at well in excess of 100 miles.

171. Even so, we made a respectable detection at 24 miles and despite the xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx GWS30 and GSA1 were stood to and the process of Tracking and Indication was started very promptly. We then, I believe, entered into the elements of Systems limitation against a low, fast target xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx as the main reasons for lack of 909 acquisition. xxxxxxxxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx S38 S40 S44

172. We did not fire CHAFF D against the raid. xxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx S38 S40 S44

173. Their misidentification of raid type in the circumstances was I believe excusable. Accepting the previous instances of proven NDOR misidentification, experience to date on Mirage flight profiles and advice on likely EXOCET tactics, it would have been overreacting at that stage to have suspected that a low, fast moving pair of air contacts still manoeuvring inside 15 miles were in fact lining up for an EXOCET attack.

174. It is of course in the circumstances most regrettable that this assessment had to be made before CHAFF D release. It would have been much safer to have been able to fire CHAFF D on Aircraft detection before identification; but with a total of only 7 full CHAFF Patterns onboard this was neither feasible nor in accordance with firing criteria. In passing, I personally found the amount of signalled advice, instruction and comment on CHAFF and EXOCET policy very confusing and it was inconsistent with problems of target identification, the size of the Airborne and Shipborne EXOCET threat and the limited stocks of CHAFF available. Had we fired the recommended pattern size against all suspect contacts on 1st May we would have expended all our CHAFF D stocks on Day One in the T.E.Z. We therefore had to compromise and we got it wrong.

175. For whatever reason, the sad fact remains that HMS SHEFFIELD was lost. At the time she had an effective Weapons System and an average Ship's Company onboard whose determined endeavours were to give of their best, defend the Force and of course protect their own lives.

176. Some members of the Ship's Company deserve commendation for their exceptional efforts during this event. Amongst these the most deserving must be the Computer Room crew who in the face of death remained at their post in a valiant and largely successful attempt to recover the Weapon System after missile impact. In the course of this attempt they lost their lives.

RECOMMENDATIONS

177. Recommendations have been confined to those relevant to actions onboard HMS SHEFFIELD. Task Group recommendations have not been covered.

OPERATIONAL

178. Every effort should be made to make more CHAFF D (particularly N4 rockets) available to the Task Force.

179. In the context of Operation Corporate CHAFF D should be fired against all enemy raids detected inside 50 miles before identification (or misidentification).

180. Until more CHAFF D becomes available to the Task Force the recommended pattern size should be reduced consistent with the need for the Recommendation above.

181. Consideration must be given to fitting more ships with an effective point defence system capable of dealing with low targets and sea skimming missiles.

182. In the absence of Point Defence Systems GWS30 reaction time must be reduced.

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185. Intelligence information sent to ships should be filtered such that only authoritive, up to date information is disseminated.

186. Ships must always be fully prepared for the surprise attack even when the threat appears to be low.

187. A trained Captain of the Turret should be closed up in Defence Watches.

MATERIAL

188. At State 2, the ship should operate with the minimum of ventilation fans running. At State 1 all ventilation should be stopped.

189. N firepump should have a bolted plate in 3 deck immediately above it to allow motor removal.

190. The firemain should be isolated in NBCD States 1 and 2.

191. A trial should be carried out in a Type 42 to establish the feasibility of obtaining a sea suction from the forecastle with a Rover Gas Turbine driven firepump.

192. The CO2 drench system should be modified to allow full operation from the upperdeck, as should as Upperdeck First Aid locker.

193. An upperdeck stowage for firefighting equipment should be provided.

194. Ships should designate an upperdeck damage control headquarters position which should be equipped with sound powered telephones to Fwd and Aft and a whole ship incident board.

195. The allowance of Survival Support Devices should be increased to allow sufficient to be placed in each space on 3-deck and below to cater for the maximum number of men likely to be closed up there.

196. Type 42 Destroyers should be retrospectively fitted with a full sized forecastle hatch. In future designs this should be a Naval Staff Requirement, as should a sufficiently large flight deck hatch for a Rover Gas Turbine to pass through.

197. The forward Auxiliary Machinery Room escape route requires redesign.

198. A check on the ventilation systems forward and their isolating valves to ascertain their effect upon the spread of smoke should be carried out.

199. The 2 deck passageway doors, currently marked "Z" should be re-designated "Y".

200. Spare hands at Action Stations should not be stationed in the centre of the ship or below 2 deck.

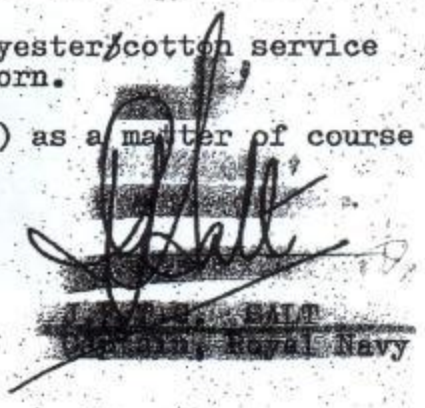
PERSONNEL

201. In the context of smoke filled compartments AGRs should only be used for a minimum period in order to escape. They should never be used for re-entry.

202. Polyester/Cotton overalls should be withdrawn from service at sea and replaced by cotton.

203. If it is necessary to wear the polyester/cotton service overalls, cotton undergarments should be worn.

204. Anti-flash should be worn (relaxed) as a matter of course at State 2 to enable quicker donning.



[redacted], RAN
Captain, Royal Navy

MV BRITISH ESK
25th May 1982