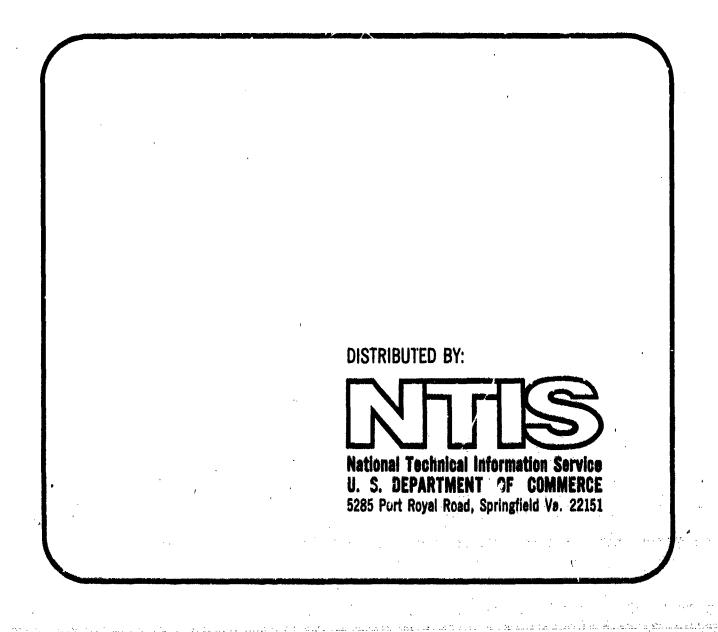
AD-764 868

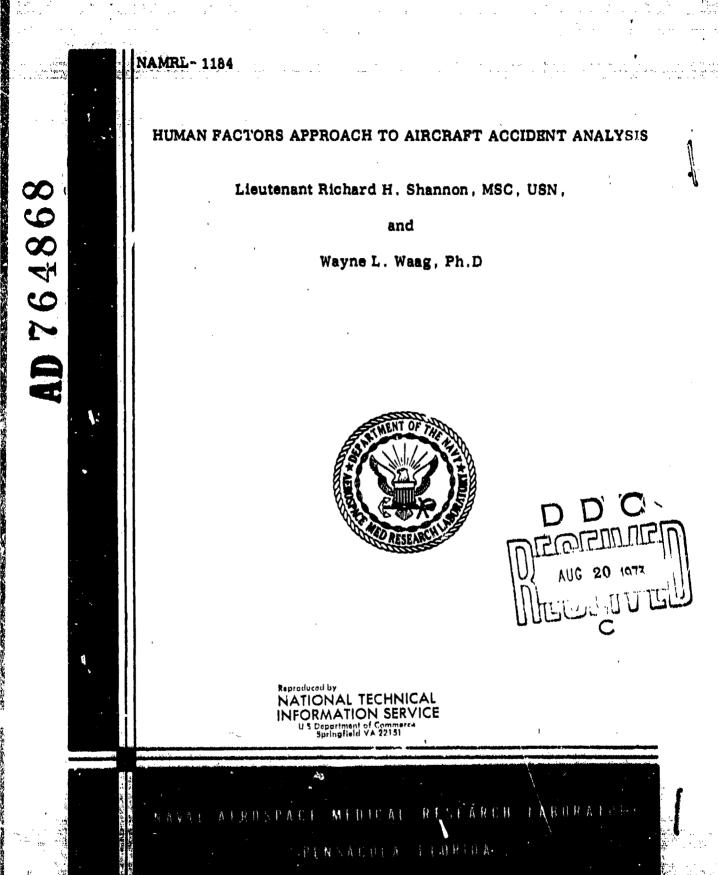
HUMAN FACTORS APPROACH TO AIRCRAFT ACCIDENT ANALYSIS

Richard H. Shannon, et al

Naval Aerospace Medical Research Laboratory Pensacola, Florida

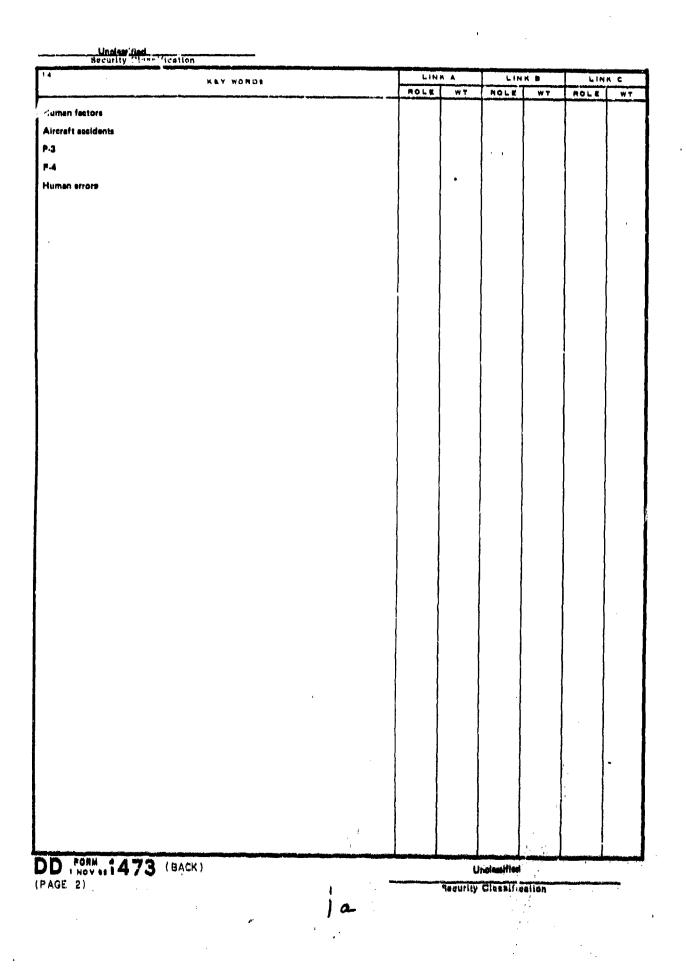
18 Juna 1973





Approved for public release; distribution unlimited.

Security Classification DOCUMENT CONTROL DATA - R & D (Security Classification of this, body of abstract and indexing annulation basis be untered when the averall report is classified) Contains time Activity (Corporate author) Nevel Accepted Research Conterner Nevel Accepted and Resional Medical Center Nevel Accepted and Regional Medical Center Penseoole, Florida 32512	Unclassified		*	
prevents (insufficiant of the body of abster and hide ing amount in and the water d well at a classified of a classified classified of a classified of a classified of a classified of a	Security Classification			
Concerning the concerning of the second sec				n nonalt tannet in star-stimut
New Acception Medical Institute Present Acception Medical 2011 Institute Present Acception Medical 2011 Institute Acception Medical 2011 Institute Acception Medical 2011 Institute Acception Me	1. ORIGINATING ACTIVITY (Curporate author)		IR REPORT	SECURITY CLASSIFICATION
Presence, Riorid 32812 INSTRUCT TITLE Hurson Factors Approach to Alexant Academic Analysis 4. UNION FILTER (Fyrer all report and inclusive allers) 4. UNION FILTER ALERATION ADD. UNI May be those for a state of the filter allers and inclusive allers) 5. Minor 1973 5. CONTRACT CONTRACT CONTRACT CONTRACT ACADEMIC 1. A DISTRUCT FILTER ALERATION ADD. UNI May be those for a state of the filter allers and analysis operations of the server are and filerate accord by the filter allers for all and the server has a filter all and the server has a server has a filter all and the server has a server has a filter all and the server has a	Neval Asrospace Medical Research Luboratory Neval Asrospace Medical Institute			noiasified
Humon Restors Approach to Alinesi Academi Analysis 4. DELECTION (First humon, statistic instance, insth	Navel Aerospace and Regional Medical Center Pensecole, Florida 32512		20. 64004	
ULECHIVELEY "2183 (Pype of report and inclusive later) A CONTRACT ONLY TOTAL (Pype of report and inclusive later) A CONTRACT ON TAKES (Pype of report and inclusive later) A CONTRACT ON TAKES (Pype of report and inclusive later) A CONTRACT ON TAKES (Pype of report and inclusive later) A CONTRACT ON TAKES (Pype of report and inclusive later) A CONTRACT ON TAKES (Pype of report and inclusive later) A CONTRACT ON TAKES (Pype of report and inclusive later) A CONTRACT ON TAKES (Pype of report and inclusive later) A CONTRACT ON TAKES (Pype of report and inclusive later) A CONTRACT ON TAKES (Pype of report and inclusive later) A CONTRACT ON TAKES (Pype of report and inclusive later) A CONTRACT ON TAKES (Pype of report and inclusive later) A CONTRACT ON TAKES (Pype of report and inclusive later) A CONTRACT ON TAKES (Pype of report and inclusive later) A CONTRACT ON TAKES (Pype of report and inclusive later) A CONTRACT ON TAKES (Pype of report and inclusive later) A CONTRACT ON TAKES (Pype of report and pype of report and pype of report and pype of report and pype of report and the contract of the report and the report of the report and the report of the	I REPORT TILE	ن میں اور بین کر کر کر کر کر کر کر کر ایک ایک ایک کر		<u>ى دەر مەرە بىلەر بەرە بىلەر بەرە بەرە بەرە بەرە بەرە بەرە بەرە ب</u>
AUTIONITY Proceedings of the second sec	Humon Factors Approach to Aircraft Accident Analysis			
AUTIONITY Proceedings of the second sec				
LT Filebard H, Bhanzon, MEC. UBN Wayne L, Mag, Ph.D A REPORT DATE B AND UP REFORMENT NO. A REPORT DATE B AND UP REFORMENT NO. A REPORT NO. A REPORT NO. MPB1,824,004-2008DX6L C A REPORT NO. MPB1,824,004 A REPORT NO. MPB1,82	4. ULSCHIPTIVE "OTES (Type of report and inclusive date	**)		
Wayne L. Wasg, Ph.D A INCREMENT ON THE 1973 A INCREMENT ON THE 1973 A INCREMENT AND UP REFERENCE IN UNDERNEED IN AMARL 1984 A CONTRACTOR AND THE ADDREED IN UNDERNEED IN AMARL 1984 A CONTRACTOR AND THE ADDREED IN UNDERNEED IN AMARL 1984 A CONTRACTOR AND THE ADDREED IN UNDERNEED IN AMARL 1984 A CONTRACTOR AND THE ADDREED IN UNDERNEED IN AMARL 1984 A CONTRACTOR AND THE ADDREED IN UNDERNEED IN AMARL 1984 A CONTRACTOR AND THE ADDREED IN UNDERNEED IN UNDERNEED IN THE ADDREED IN THE ADDRE		وه موجد المالة المقالية بن من الإكرى و معالية بين الحاويرين.		بينيها ووربية بالألاق بماحاته بيريد أحيانا كالأساد
18 June 1973 12 June 2012 AD. CONTRACT OF GRANTNO. IN ONIGINATION FOR THE PORT NUMBER (1) IN ROUTE F NO. MP81,534,004.2008D XSL NAMRL - 1184 II. III. STATESTANDING III. STATESTANDING III. III. STATESTANDING IIII. STATESTANDING III. IIII. STATESTANDING IIII. STATESTANDING III. IIII. STATESTANDING IIIII. STATESTANDING III. IIII. IIIII. IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII				
18 June 1973 12 June 2012 AD. CONTRACT OF GRANTNO. IN ONIGINATION FOR THE PORT NUMBER (1) IN ROUTE F NO. MP81,534,004.2008D XSL NAMRL - 1184 II. III. STATESTANDING III. STATESTANDING III. III. STATESTANDING IIII. STATESTANDING III. IIII. STATESTANDING IIII. STATESTANDING III. IIII. STATESTANDING IIIII. STATESTANDING III. IIII. IIIII. IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII				
EXECUTIVALE FOR DRAWT NO. Ise. ORIGINATOR'S REPORT NUMBER(I) b. RROJECT NO. MP81,824,004-2008DXSL c. Interpretation of the state of the stat		TAL TOTAL NO. 0	2-46	
the CTIER AR PORT NOTE (Any other numbers that may be are the CTIER AR PORT NOTE (Any other numbers that may be are the CTIER AR PORT NOTE (Any other numbers that may be are the CTIER AR PORT NOTE (Any other numbers that may be are the CTIER AR PORT NOTE) to DISTINUTION STATEMENT Approved for public release: distribution unlimited. The SUBPLEMENTANY NOTES to APONEDRING MILITARY ACTIVITY the other are common and any preside operations and flow ray preside, respectively. The original density for any area operations in both algorith. An indepth hudy was performed in a well as preside to both algorith. The P3 and P4 algorith was algorithm of their operations and handling characteristics. To the F4 accident reports and handling characteristics. To the F4 accident reports, 437 human errors were subted while the P3 reports contained 388 orea. The accident reports reporting 25,0% and F4 St of the stold error, reported had no any of as preformed in a common and any appreciate of the area area which both algorith and any other theory of the f4 accident reports, respectively. The results of this investigation suggest that allower the F4 representing 25,0% and F4 St of the stold error, reporting in the P3 and F4 allower to the area which both algorith and in a common treat the angle of the error which both algorithm in algorithm of the f4 representing 25,0% and F4 St of the stold error, reports were that allower to the area which both algorithm and and presentes of total errors. The solded errors are the loolet area area by the the f4 representing 25,0% and F4 St of the stold error, reporting in the part of total errors. The solded errors area be looleted areas and charger error in the f4 representing 25,0% and F4 St of the stold error, reporting and the error which both algorithm and area error which allower that any area of total errors. The solded errors area by the the f6,0000 of the sold errors, reparting and the error which both error which both errors which bo	BH. CONTHACT OF GRANT NO.	MA. ONIGINATOR	B REPORT NO	
the CTIER AR PORT NOTE (Any other numbers that may be are the CTIER AR PORT NOTE (Any other numbers that may be are the CTIER AR PORT NOTE (Any other numbers that may be are the CTIER AR PORT NOTE (Any other numbers that may be are the CTIER AR PORT NOTE) to DISTINUTION STATEMENT Approved for public release: distribution unlimited. The SUBPLEMENTANY NOTES to APONEDRING MILITARY ACTIVITY the other are common and any preside operations and flow ray preside, respectively. The original density for any area operations in both algorith. An indepth hudy was performed in a well as preside to both algorith. The P3 and P4 algorith was algorithm of their operations and handling characteristics. To the F4 accident reports and handling characteristics. To the F4 accident reports, 437 human errors were subted while the P3 reports contained 388 orea. The accident reports reporting 25,0% and F4 St of the stold error, reported had no any of as preformed in a common and any appreciate of the area area which both algorith and any other theory of the f4 accident reports, respectively. The results of this investigation suggest that allower the F4 representing 25,0% and F4 St of the stold error, reporting in the P3 and F4 allower to the area which both algorith and in a common treat the angle of the error which both algorithm in algorithm of the f4 representing 25,0% and F4 St of the stold error, reports were that allower to the area which both algorithm and and presentes of total errors. The solded errors are the loolet area area by the the f4 representing 25,0% and F4 St of the stold error, reporting in the part of total errors. The solded errors area be looleted areas and charger error in the f4 representing 25,0% and F4 St of the stold error, reporting and the error which both algorithm and area error which allower that any area of total errors. The solded errors area by the the f6,0000 of the sold errors, reparting and the error which both error which both errors which bo	A BROLECTING. MEET 894 MA SAME VEL		L. 1184	u "
A 10 TO DISTRIBUTION NATEMENT Approved for public release: distribution unlimited. The support of public release: distribution unlimited. The release problem where one more and public of public release the support of the arror watch were support of different feet missions and an appendic taports were support on the provide addition of the arror where the out of the arror where the dist component here or the provident reports are lutter analysed of the arror where the dist arror. The analyse of the arror with here the out arror to anothere the dist arror. The results of this investigation suggest that although common errors can be isolated across highly diamilar alrorart with highly differ the arror with here the arror on arror of arror on arror		•]	-	
10 DISTRIBUTION STATEMENT Approved for public release: distribution unlimited. 11. SUPPLAMENTARY NOTES 12. SUPPLAMENTARY NOTES 13. APONEDRING MILITARY ACTIVITY 14. SPONEDRING MILITARY ACTIVITY 15. ALM INACT 14. APONEDRING MILITARY ACTIVITY 15. ALM INACT 16. ADIA AND AND ADIA ADIA ADIA ADIA ADIA A	С, ,	wh. OTHER NEPC this report)	AT NOISI (AN	other numbers that may be are
Approved for public release: distribution unlimited. 11. SUPPLEMENTARY NOTES 12. SUPPLEMENTARY NOTES 13. APONEONING MILITARY ACTIVITY Inscription of the postal reports involving the P-3 and P-4 alreart were examined over seven and five-year periods, respectively. The critical identity those problems which and analyse operational flight new errors in both alrearts. An indepth study was performed in identity those problems which and analyse operational flight new errors in both alrearts. The P-3 and P-4 alrearts were selected because of their could different fleet missions and heading the series. The acident reports dontation and periods for the Soft of the errors while both alrearts. Port the P-4 societant reports (47) human errors were kulated while the P-3 reports contained 345 errors. Twenty-slipht major error protes emerged from the analysis of these errors. The acident reports and the error type of Procedures, shared the most common and the error reports of the errors while the dincomp. The acident reports is antidoted analyse of the start actively of errors concerned character reports and the two shereft. The results of this investigation augest that although common errors can be isolated acress height diaminite altreater with highly different indices and character site with highly different in question. Implications in the remedial areas of error occordination, training, discipline and chargen are discussed. DD roth and 14.273 (PAGE 1)	d. '		10	
different fleet inisions and handling characteristics. From the P-4 socident reports, 437 human errors were isulated while the P-3 reports contained 348 errors. Twenty-eight major error gories emerged from the enalysis of these errors. The accident reports were further analysed for the errors which both altoret had in commo free energied from the enalysis of these errors. The accident reports were further analysed for the errors which both altoret had in commo free energied from the enalysis of these errors. The accident reports were further analysed for the errors which both altoret is reported. The flight segment of Takcoff/Landing, and the error type of Procedures, shared the most commonality across the two altorets. The results of this investigation suggest that although common errors can be loolated across highly disamilar altorets with highly diff flight mileions, they comprise a relatively small percentage of total errors. By far, the majority of errors concerned characteristics unique to porticular alterest in question. Implications in the remedial areas of error coordination, training, discipline and classien are discussed. DD FORM 1473 (PAGE 1) Undiazonal Nov es 1473 (PAGE 1)		13 SPONSONING	MILITARY AC	TIVITY
DD NOV 41473 (PAGE 1)	TI. SUPPLEMENTARY NOTES	raft were sxemined over seven at	d five-veer pe	inds, remeatively. The critical i
DD 1 NOV 1473 (PAGE 1)	11. SUPPLEMENTARY NOTES 13. ANALINACT Navel Accident reports involving the P-3 and F-4 aird technique we used to estalogue, describe, and analyze oper identify those problems which were common as well as spec different fleet missions and handling characteristics. From the F-4 accident reports, 437 human errors we gories emerged from the analysis of these errors. The accident Twenty common error groups were found to occur in the P- flight segment of Takeoff/Landing, and the error type of Pr The results of this investigation suggest that although	araft were examined over seven at rational flight craw errors in both sific to both alreraft. The P-3 and intre isolated while the P-3 reports and the P-4, representing 22.9 Deedures, shared the most comm a common errors can be isolated.	d five-year per elteraft. An in d F-4 elteraft w sontained 345 for the errors for the errors for and 12 8% o onality across merces histiky d	iods, respectively. The critical in i-depth study was performed in i ere selected because of their cor i errors. Twenty-sight major erro which both elecreft had in eomn i the total errors, respectively. T the two alroraft.
DD 1 NOV 1473 (PAGE 1)	11. SUPPLEMENTARY NOTES 13. ANALINACT Navel Accident reports involving the P-3 and F-4 aird technique we used to estalogue, describe, and analyze oper identify those problems which were common as well as spec different fleet missions and handling characteristics. From the F-4 accident reports, 437 human errors we gories emerged from the analysis of these errors. The accident Twenty common error groups were found to occur in the P- flight segment of Takeoff/Landing, and the error type of Pr The results of this investigation suggest that although	araft were examined over seven at rational flight craw errors in both sific to both alreraft. The P-3 and intre isolated while the P-3 reports and the P-4, representing 22.9 Deedures, shared the most comm a common errors can be isolated.	d five-year per elteraft. An in d F-4 elteraft w sontained 345 for the errors for the errors for and 12 8% o onality across merces histiky d	iods, respectively. The critical in i-depth study was performed in i ere selected because of their cor i errors. Twenty-sight major erro which both elecreft had in eomn i the total errors, respectively. T the two alroraft.
S/N 0101-807-6801 Beduity Classification	11. SUPPLEMENTARY NOTES 13. ANALINACT Navel Accident reports involving the P-3 and F-4 aird technique we used to estalogue, describe, and analyze oper identify those problems which were common as well as spec different fleet missions and handling characteristics. From the F-4 accident reports, 437 human errors we gories emerged from the analysis of these errors. The accident Twenty common error groups were found to occur in the P- flight segment of Takeoff/Landing, and the error type of Pr The results of this investigation suggest that although	araft were examined over seven at rational flight craw errors in both sific to both alreraft. The P-3 and intre isolated while the P-3 reports and the P-4, representing 22.9 Deedures, shared the most comm a common errors can be isolated.	d five-year per elteraft. An in d F-4 elteraft w sontained 345 for the errors for the errors for and 12 8% o onality across merces histiky d	iods, respectively. The critical in i-depth study was performed in i ere selected because of their cor i errors. Twenty-sight major erro which both elecreft had in eomn i the total errors, respectively. T the two alroraft.
	11. SUPPLEMENTARY NOTES Navel Accident reports involving the P-3 and F-4 aird technique we used to estalogue, describe, and analyse oper identify those problems which were common as well as spec- different fleet missions and handling characteristics. From the F-4 accident reports, 437 human errors we pories emerged from the analysis of these errors. The accident twenty common error groups were found to occur in the P- flight segment of Takcoff/Landing, and the error type of Pr The results of this investigation suggest that although flight missions, they comprise a relatively small percentage of porticular alreaft in question. Implications in the remedial DD 100 yes 1473 (PAGE 1)	araft were examined over seven at rational flight craw errors in both sific to both alreraft. The P-3 and intre isolated while the P-3 reports and the P-4, representing 22.9 Deedures, shared the most comm a common errors can be isolated.	d five-year per aircraft. An il d F-4 aircraft w sontained 348 if or the errors w and 12 8% o onality across marces highly d try of errors co ing, disvipline	lods, repeatively. The critical in- depth study was performed in ere selected becaus of their cor- ere selected becaus of their cor- which both ercres, respectively. The total ercres, respectively. The total ercrest, respectively. The two elected second constants with highly diff nearned observed with highly diff nearned with



· /

Approved for public release; distribution unlimitea.

HUMAN FACTORS APPROACH TO AIRCRAFT ACCIDENT ANALYSIS

Lieutenant Richard H. Shannon, MSC, USN

and

Wayne L. Waag, Ph.D

Bursau of Medicine and Surgery MF51.524.002.5012 DX5X.

Approved by

Ashton Graybiel, M.D. Assistant for Scientific Programs Released by

Gaptain N. W. Allebach, MC, USN Officer in Charge

Naval Aerospace Medical Research Laboratory Naval Aerospace Medical Institute Naval Aerospace and Regional Medical Center Pensacola, Florida 32512

SUMMARY PAGE

THE PROBLEM

Naval accident reports involving the P-3 and F-4 aircraft were examined over seven and five year periods, respectively. The critical incident technique was used to catalogue, describe, and analyze operational flight crew errors in both aircraft. An in-depth study was performed in order to identify those problems which were common as well as specific to both aircraft. The P-3 and F-4 aircraft were selected because of their completely different fleet missions and handling characteristics.

FINDINGS

From the F-4 accident reports, 437 human errors were isolated while the P-3 reports contained 345 errors. Twenty-eight major error categories emerged from the analysis of these errors. The accident reports were further analyzed for the errors which both aircraft had in common. Twenty common error groups were found to occur in the P-3 and the F-4, representing 22.9% and 18.8% of the total errors, respectively. The flight segment of Takeoff/Lending, and the error type of Procedures, shared the most commonality across the two aircraft.

The risults of this investigation suggest that although common errors can be isolated acreas highly dissimilar aircraft with highly different flight missions, they comprise a relatively small percentage of total errors. By far, the majority of errors concerned characteristics unique to the particular aircraft in question. Implications in the remedial areas of crew coordination, training, discipline and design are discussed.

ii -

INTRODUCTION

The F-4 aircraft is a supersonic, long-range, all-weather fighter which is powered by two turbojet engines. The aircraft is designed for fleet air defonse through intermediate and long-range interceptions using a variety of air-to-air missiles. It is secondarily designed for use as a bomber through target interdiction and strike missions using conventional air-to-ground missiles, rockets and bombs as well as nuclear armaments. The F-4 has a crew of two, consisting of a pilot and radar intercept officer (RIO). The pilot ensures that the aircraft is operated within the prescribed flight limitations at all times while the R'O is primarily concerned with the operation of the air-intercept radar and other electronic search/detection equipment. Proper coordination between these two crew members is of great importance.

The P-3 is a four-engine, turboprop aircraft with a normal complement of 12 personnel--patrol plane commander, co-pilot, third pilot, tactical coordinator, flight engineer, second flight engineer, ordnanceman, radio operator/ communicator and four sensor operators/observers. Primarily, the P-3's mission is to detect, identify, and track foreign submarines and shipping. In addition to anti-submarine warfare (ASW) and surveillance/intelligence missions, the aircraft is used in search and rescue operations. The P-3 can fly extended distances and remain over the search area for prolonged periods. It makes use/of a multitude of rensor systems--airborne, surface, and underwater--in ord/or to satisfy its mission objectives. Like the F-4, one of the most important elements is the proper coordination between the personnel aboard the aircraft.

Since their introduction into fleet operations, the F-4 and P-5 have been involved in accidents/incidents resulting in fatalities, injuries, dest, oyed or damaged aircraft, extra maintenance hours, and incomplete flight massions. While many accidents result strictly from material failure, a large mamber involve human error. The purpose of the present investigation was to provide a detailed analysis of F-4 and P-3 accident/incidents, collectively referred to as mishaps, involving human error among naval personnel

An accident 'incident mishap is a unique event. First. it is an unlikely event--mishap rates are extremely low. Second, the conditions tonder which a mishap occurs are rarely identical. Differences in operational aircraft readiness, orew readiness, and environmental operating conditions most always exist. For these reasons, the ad-hoc predictability of a mishap involving human error is quite low. Despite the limitations inherent in the study of the mishap phenomenon, useful information can be extracted from the post-hoc analysis of such occurrences. The value of such analyses lies in the effectiveness of changes in aircrew operating procedures, training programs, and aircraft systems design. In other words, its usefulness depends upon the extent to which mishaps are reduced as a result of the implementation of its recommondations.

The task analysis approach appears to have merit in meeting these objectives. In order to extract the maximum amount of commonality from mishap data, human error should be categorized according to: (1) type of error; (2) time or phase of operation during which error occurs; (3) personnel involved; and (4) content. The resulting error categories must ultimately be related to the mishap itself. It is assumed that the importance of an error is tied to its concequences in terms of frequency, sericusness and cost. Those errors which are costly, leading either to major mishaps or to high-frequency minor mishaps, are of greatest significance. High frequency errors resulting in minor mishaps are significant in terms of minor aircraft damage, extra maintenance hours, and incomplete flight missions; while errors resulting in major mishaps are costly in terms of major damage to aircraft, and personnel injuries and fatalities. In all cases, the ultimate criterion, squadron effectiveness, is greatly reduced. From a knowledge of these most costly errors, remedial recommendations can be made.

ł

The present study is an attempt to apply this approach to human error in the P-3 and F-4 aircraft. A further aim was to define those error categories common to both aircraft. Remedial recommendations resulting from these common errors should provide useful information in terms of emphasis within both the undergraduate and graduate phases of pilot training. In other words, potential errors common to diverse aircraft should be emphasized early in training.

METHOD

The critical incident technique (1) appeared to be quite applicable to the aims of the present investigation, which was to catalogue, describe, and analyze the most common and significant types of aircrew errors. The incidents with which this technique deals are descriptions of directly observable complex human activity which are autificiently complete in themselves to permit inferences to be made about the person performing the act. For the incident to be critical, it must describe segments of human behavior that are pertinent to a desired objective. In other words, if the purpose of the study is to reduce human errors in the aviation environment, the observer must describe situations in which human errors do occur in the aviation environment.

Mishap data involving the F-4 and P-3 aircraft were obtained for the periods between July 1966 to June 1971 and January 1963 to December 1969, respectively, from records kept on file at the Naval Safety Center in Norfolk, Virginia. This agency maintains standardized and readily ccessible information pertaining to accidents/incidents/mishapa involving naval aircraft and personnel. Situations in which aircraft are demaged, personnel are injured, or certain aircraft malfunctions have occurred (e.g., the actual feathering of an engine) must be reported to the Safety Center via either an accident or incident report. These reports follow a standardized format of commentary and are completed by knowledgeable and competent observers in the aviation community.

For this investigation, human error was defined to be any deviation by squadron aircrew personnel from a previously established, required, or expected standard of human performance which resulted in or occurred during a mishap. Errors were categorized according to time of occurrence rather than the time they became manifest. Furthermore, it was possible that two or more errors occurred during a single mishap. These were reported as separate errors. A further distinction attempted to define an error's relationship to the actual mishap. Accordingly, an error could be: (1) <u>causal</u>, if its occurrence was directly responsible for the mishap; (2) <u>contributory</u>, if its occurrence, although not directly responsible, enhanced the conditions ultimately leading to the mishap; and (3) <u>contiguous</u> if it occurred at the same time as the mishap yet had no relation to it.

In order to classify human errors in terms of its behavioral components or types, three categories were adopted: Vigilance (VIG) errors, Procedural (PROC) errors, and Perceptual-Motor (PM) errors. Human errors were further grouped according to time of occurrence. Accordingly, four flight segments were defined: (1) Segment I--Servicing/Preflight/Postflight; (2) Segment II--Start/Taxi/Shutdown; (3) Segment III--Takeoff/Landing; and (4) Segment IV -Inflight. Four remedial areas were defined where possible action might be undortaken to reduce aircrew human errors. These included: (1) Crew Coordination (CC); (2) Training (TRA); (3) Discipline (DIS): and (4) Design (DES). Definitions of these types of errors, flight segments, and remedial areas are presented in Table 1.

RESULTS

This section will be divided into two parts: (a) aircrew human errors specific to each sircraft, and (b) aircrew human errors common to both aircraft. Specific human error will be described according to number of occurrences, number of major accidents and fatalities, type of aircraft, major error categories, remedial areas, and types of error.

3

Category	Symbol	Description
ype of Liror	•	
Vigilance	VIG	inadequate monitoring, discrimination, detection and identification of possible problems; failure to use sensory cues to detect changes in a display of the environment.
Procedural	PROC	Confusion of relationships and/or implications; the omission or misordering of required steps; substitution of untested and unapproved steps; failure to use all available information in deriving needed solutions; use of inappropriate problem solving techniques in decision-making.
Perceptual-Motor	PM	Lack of eys/hand/foot coordination.
light Segment		
Servicing/Pre-flight/Post-flight	1	Time prior to engine start and following engine shutdown,
Start/Taxi/Shutdown	II .	Time between angine start and prior to takeoff roll. Time between landing rollout completion and engine shutdown.
Takeoff/Landing	111	Time within takeoff roll and landing rollout. Time while aircraft is airborne and within control zone of aircort or carrier.
Inflight .	1V	Time in which aircrait is airborne and is outside control zone of airpoit or carrier.
emedial Area		
Crew Coordination	CC	Development of the team concept-ability of two or more crew members to work together in order to afficiently carry out their assigned mission.
Training	THA	Re-education of flight skills and procedures through ground/flight instruction. Development of an aware ness within flight crews concerning the most commo
		problem areas within aircraft and how to prevent their occurrence.
Discipline	DIS	Closer monitoring of flight crew behavior in order to prevent purposeful violation of NATOPS regulations
Design	DES : peur Die en A	Need for human factors appraisal of cockpit design where there appears to be a poor interface between man and equipment, and of engineering deficiencies within certain aircraft systems.

Type of Error, Flight Segment, and Remedial Area Descriptions

Table I

AIRCHEW ERRORS SPECIFIC TO P-3 AND F-4 AIRCRAFT

Α.

Table II presents a summary of the mishap statistics for the F-3 and F-4 aircraft. It should be pointed out that these mishap reports were based on seven and five-year periods for the P-3 and F-4, respectively. As evidenced from these figures, the number of major accidents and fatalities were substantially higher in the F-4 aircraft. Whenever a major accident occurred, however, the fatality rate in the P-3 was higher as a result of its larger crew size. When scanning this table, it must be emphasized that the number of errors are not the additive results of major and minor mishaps. In some mishaps, two, three, or four errors may have occurred, thereby making the number of error totals higher than the mishap totals. Further, the definitions for a minor accident, an incident, and major and minor injury are outlined in OPNAV Instruction 3750.6 series. However, the criteria outlined in this instruction are not stable and could be redefined at any time.

Table II

	P-3 Jan 63 -	F-4 Dec 69 July 66 - June 7
Number of Errors	345	437
Major Mishaps (Aircraft destroyed or substantially damaged)	8	114
Minor Mishaps (Minor accidents and incidents)	294	111
Fatalities	. 40	78
Personnel Injuries (Major and minor)	11	76

Summary of Mishaps Involving Human Error

A content analysis was performed on the individual human errors in an attempt to establish major error classifications or categories. From the total errors of the P-3 and F-4, 28 major error categories emerged which in turn established a foundation for error analysis and classification for this study. These results are presented in Table III. Improper servicing/refueling/fuel

			% P-3 Error	P-3 Aircraf Major Accidents	Fatali-	% F-4 Error	F-4 Aircra Major Accidents	Fatali
		IAN ERROR IN THE P·3 AND F-4 AIRCRAF ROR CATEGORIES.	۳T					
Α,	Vi	gilunce Errors	,*					
		Poor instrument scen. Inadvertent/incorrect actuation of cockpit controls.	.9 4.1	1	8	8.5 5.9	16 3	18
		Poor monitoring, poor supervision. Poor pre-light inspection-discrepancies not noted.	2.0 4.1	••	•••	3.4 2.7	··· 1	••
	5.	Poor external visual lookout.	••		••	1.8	· ۲	6
	6.	Misinterpretation of hand signals. Inservent angine ingestion.	··-	•••	•• • • ··	.8 .7	· · ·	
		Vigilance Error Totais.	11.0	1	. 8	23.6	27	24
В.	Pri	pcodural Errors			·*·			
	1.	Improper servicing/refueling/fuel transfer procedures.	21.7	•••	••		1	••
		Improper ordnance handling/release procedures.	2.8	1	13	2.5	1	1 1
		Improper muintenance/troubleshooting procedures.	2.3	••	••	1.1	1	1
		Poor angine operating/restarting pro- ceduras. Checklists not complete.	2.6 1.2	 1	••	.7 3.9	1 5	·· . 3
	6.	Improper procedures used in a takeoff or a landing,	3.5	•	• ·	4.1	7	1
	7.	Poor communication procedures, pertinent information not communi- cated.	.6	••		3.2	1 、	1
	_	Improp instrument/navigation pro- cedures.	1.2	1	12	4.1	4	0
		Improper emergency procedures. Improper procedures within a thunder- storm area.	1.2 .9	••	••	4.8 • •	1	•••
		Poor judgment, flight should not have been flown.	•••	•	••	1.1	1	2
	12. 13.	Performance of unauthorized actions. Parts not properly secured by aircrew- man, not checked for security.	23.5	•••	•••	1.8 1.8	5	г • •
	14.	Improper survival/ejection procedures.	<u></u>	<u></u>	<u></u>	12.4	- <u></u>	13
		Procedural Error Totala:	61.2	3	25	42 6	28	30
c.	Pe	rceptual-Motor Errors.						
		Misjudged safe distance or speed.	3.8	••	• ••	7.6	15	6
		Poor control of brakes. Poor rudder control.	16.8 1.7	 1	· · 1	4.8 2,3	5 3	**
	4.	Poor atleron control.	.6		'	.2		••
	5.	Porr power/nose control-coordination of t oth controls.	.3	1	6	3.0	3	••
	6.	Poor throttle control.	4.3	2		4.3	11	. 2
		Pour sievator control.	.3			11.9	11 22	17
		Perceptual-Motor Error Totals:	27.8	4	7	33.9		24

Table III

Analysis of Major Human Error Categories in P-3 and F-4 Aircraft

6

o

at al. Weig

transfer procedures, parts not properly secured or checked for security, and poor control of brakes were the prominent error categories in the P-3 aircraft representing 62.0% of the total error. Poor instrument scan, improper survival/ ejection procedures, poor elevator control, and misjudged safe distance or speed were the significant categories in the F-4 aircraft accounting for 40.4% of the total error.

Table IV presents the most significant errors in the P-3 aircraft. Loose propeller oil caps, underserved propeller oil reservoirs, and brake applied inadvertently accounted for most of the human error in the P-3 aircraft. Remediation for these three errors involves primarily that of design. Since the time of the initial preparation of this report, both the propeller and braking systems have undergone design changes. An examination by Lane (2) of the anthropometric characteristics of P-3 per sonnel involved in inadvertent braking mishaps revealed that the soat and rudder pedal adjustments were inadequate for pilots with large buttock-knee lengths, and that the location of the rudder pedal close to the deck combined with inadequate instrument panel clearance encouraged inadvertent braking. However, the effectiveness of these design changes cannot be determined until sufficient data have accumulated to warrant a new critical incident investigation.

The remedial areas of training and crew coordination were the most important, as shown in Table V, in reducing the effects of the most significant errors in the F-4 aircraft. Collisions with other aircraft, ground or water due to poor altimeter instrument scan; poor external visual lookout; and misjudging a safe distance or speed during formation, inflight refueling and air combat maneuvering are in many cases a result of ineffective crew coordination. These errors could be reduced if each member of the crew properly monitors the other's behavior. The crew concept in the F-4 is of utmost importance and should be stressed at all times.

Elevator control is a recurring problem area in the operation of the F-4 aircraft. Excessive sink rate on glide slope and induced aircraft stall/overstress during tactical maneuvering indicate difficulty in the proper use of the elevator control. Such errors may be reduced through a training program of ground and flight instruction which strongly emphasizes the most common problem areas of the aircraft and how to prevent their occurrence.

The 12 groups of errors in Table V accounted for 36.4% of the total error in the F-4, while the eight groups of errors in Table IV accounted for 71.3% of the errors in the P-3. The diversity and frequency of human error in the F-4 as compared with the P-3 is indicative of the difficulty and complexity of its operation.

		Error Description	No. of Errors	%Error of Total	Major Accds	Fatali- ties	Remedial Areas
A .	Vigilar	nce Etrors					
		or preflight inspection-discrepancies not ted.					
	•	external parts loose or open	11	3.2		••	CC
) ,	Proces	iural Errora					
		ts not properly secured by aircrewman, t checked for security.					
	٠	loose prop oil filler caps	79	22.9	••	••	DES
`		proper servic 'ng/refueling/firui transfer ocadures.					
		low oil in prop reservoir	72	20.9	•	••	DES
		proper procedures used in a takeoff or a ding.					
	•	landing gear raised too quickly after take- off, inrdequate tire cooling period	10	2.9	••		TRA
2.	Percep	tusl-Motor Errors					
	1. Po	or control of brakes.	· ,				
	(a)	inadvertent brake application along with rudder during engine(s)-out or regular four-engine takeoff or landing.	47	13.6			DES
	(b)	poor braking technique during four-engine takeoff abort or landing	11	3.2	••	•••	TRA
	2. Mi	sjudged safe clistance or speed.					
	•	aircraft collisions on taxiway or t ight line	10	2.9	••	· ••	cc
	3. Po	or throttle control.					
		pitchlock induced during eported-takeoff/					
		landing by rapid manipulation of power into reverse	6	1.7	2	•••	DES
			246	71.3	2	••	LES 59.1%
							CC 6.19
							TRA 8,19

Most Significant Aircrew Errors in the P-3 Aircraft

Table

		Error Description	No. of Erron	% Error of Total	Major: Aceds	Fatali- ties	Reinedia Areas
۹.	Vigil	lance Errora					
	1.	Poor Instrument sean.					
		 of altitude indicator resulting in ground/ water collision 	23	5.3	10	16	CC
	2.	Poor sxternal visual lookout.			•		
		- collision with other electraft	8	1.8	7	6	CC
١,	Proc	edural Errors		,			
	1.	Improper survival/ejection procedures.		~			
		(a) flight/survival equipment not worn	16	3.7		••	DIS
		(b) late ejection from an engine failure, uncon- trolled flight or stalled aircreft	13	3.0		11	TRA
	2.	Checklists not complete. (takeoff, landing, etc.)	17	3.9	6	3	CC
	3.	Performance of unauthorized actions.					
		 flathatting, low altitude rol¹, unscheduled ACM, acrobatics at low altitude 	7	1.6	4	8	DIS
3.	Perc	eptual-Motor Errors	:				
	1,	Poor elevator control.					
		(a) high on glide slop.), lowered nose, high sink rate	21	4.8	2	••	TRA
		 (b) induced aircraft stall/overstress during tanti cal maneuvering (ACM, bombing, etc.) 	15	3.4	11	7	TRA
	2.	Misjudged safe distance or speed.					
		(a) collision during formation or inflight refueling	12	2.7	7	1	CC
		(b) collision during ACM	5	1.1	5	4	CC
	3.	Poor control of brakes.					
		 poor braking technique during two-engine takeoff abort or landing 	13	3,0	3	• •	TRA
	4.	Poor throttle control.					
		 high sink rate, not enough power on glide slope 	9	2.1	7	2	TRA
			159	36.4%	61	58	TRA 16.3
							GC 14.8
							DIS 5.3

29

- \$T K

an Ada y

÷.,

Table V

Most Significant Aircrew Errors in the P-4 Aircraft

A more detailed listing of the errors in tables IV and V are presented in Appendices A, B and C. Appendix A contains all Vigilance errors for the P-3 and F-4 aircraft during the seven and five-year periods, respectively, which are described in this paper. Appendix B includes all Procedural errors for the same time frame, while Appendix C presents all Perceptual-Motor errors. Each human error is described according to number of occurrences, number of major accidents and fatalities, type of aircraft, flight segment and personnel involved.

Table VI presents a breakdown of errors according to personnel involved. As indicated, 49.6% of all P-3 errors were attributed to the flight engineer (FE), while 45.8% were attributed to the pilot. In the F-4, the pilot committed 77.5% of the total errors.

Human Errors by Personn	el Involved	•
Aircréwman	% of Total P-3 Errors	% of Total F-4 Errors
Pilot (P)	45.8	77.8
Radar Intercept Officer (R)	* N A	17.0
Flight Engineer (FE)	49.6	*N A
Ordnanceman (ORD)	2.3	* N A
Flight Leader (#L)	. • N A	2.7
Crew - Pilot or RIO, not specified (CR)	* N A	2.5
Tactical Coordinator (T)	.6	* N A
Enlisted Crewman and/or Sensor Operator (CMN)	1.7	* N A

	TÁL		
 		5	

* Not applicable.

Table VII presents a breakdown of aircrew human errors according to type of error and flight segment. The highest percentage of errors cocurred during Segment I (Servicing/Preflight/Postflight) in the P-3, and Segment III (Takeoff/Landing) in the F-4. According to type, most errors were Procedural in nature for both aircraft.

Table VIII presents a breakdown of major accidents and fatalities according to type of error and flight segment. For both aircraft, most major accidents occurred during Segment III (Takeoff/Landing), while most fatalities occurred during Segment IV (Inflight). According to type, the findings were the same for both aircraft. Most major accidents involved perceptual-motor errors, while most fatalities resulted from procedural errors.

ģ

Flight Segment	<u>µ.3</u> No.		No.	%	<u>p.</u> No,		OC F.	-	P. No.		<u>F.</u> No.	4	<u>р.</u> No.	-		-4 -%
l Servicing/Pre-Flight/ Post-Flight -	• 14	4.1	13	3.0	187	45.5	31	7.1		• •		• •	171	49.6	44	10.1
li Start/Taxi/Shutdown		••	18	1.8	3	0.9	18	4.1	12	3.5	11	2,5	15	4,4	37	8.4
III Takeoff/Landing	7	2.0	27	6.2	18	5.2	66	15.1	84	24.3	96	22.0	109	31.5	189	43.3
IV Inflight	17	4.9	55	12.0	33	9,6	1 21	16.2		<u></u>	41	9.4	50	14.8	167	38.2
Totai:	38	11.0	 103	23.0	211	61.2	136	42.5	96	27.8	148	33,9	348	100.0	437	100.0

Teble VII

Total Human Errors by Type of Error, Flight Segment and Aircraft

Table VIII

, r¹

Total Major Mishaps and Fatalities by Type of Error, Flight Segment and Alroraft

		VIG				PROC				P-M				Total			
		p.	3	F	.4	p.	.3	F.	4	p.	3 -	г— г	.4	P	.3	F-	4
	Flight Segment	Maj Acc	Fatal- ities	•	Patal- ities	Maj Acc	Fatai- ities		Patal- ities	Mej Aca	Fotal- Ities		Fatal- ities	Maj Acc	Fatal- itios	Mej Aco	Fatal- ities
(Servicing/Pre- Plight/Post- Flight			1 	•••			1 1 	2			 	• -		••	2	2
	Start/Taxi/ Shutdown		<i>.</i> .	ι Ι	••			1	••		••	1 			••	2	••
	Takeoff/Land- ing		••	10 	10	1	••	17	9	4	7	31 	9	5	7	58	28
IV	Inflight	1	8	16	<u>14</u>	2	25	9	<u>19</u>	:	<u></u>	27	<u>15</u>	3	<u>33</u>	52	48
	Totel:	1	8	27	24	з	25	28	30	4	7	1 89	24	8	40	 114	78

Ŋ

В

AIRCREW HUMAN ERRORS COMMON TO BOTH P-3 AND F-4 AIRCRAFT

Table IX presents a listing of human errors which were found to be common to both aircraft. Twenty groups of errors were found to occur in both the F-4 and P-3, representing 18.8% and 22.9% of the total errors (F-4: 437, and P-3: 345) respectively. While common errors can be isolated across these two dissimilar aircraft, they comprise a relatively small percentage of the total errors. The majority of errors are concerned with characteristics which are unique to the particular aircraft. Nevertheless, the finding that some common errors do occur indicates they should receive greater emphasis early in training.

If these twenty errors were to be restated as training objectives for student pilot education, they would read:

1. Develop proficiency in the following areas:

a. taxiing the aircraft on the ground.

b. maintaining glide slope with the power control and the coordination between power and nose attitude.

c. maintaining line-up on the runway with the use of rudder control during both normal and engine-out operations.

d. stopping the aircraft properly with brakes during the rollout.

e. maintaining altitude with a proper instrument and visual horizon scan.

2. Develop an awareness of the importance of the following areas:

a. performing a proper preflight inspection.

b. insuring landing checklist completion.

c. computing aircraft weight prior to landing.

d. preventing inadvertent brake application along with the rudder while maintaining line-up on the runway.

e. cross-checking airborne position with the use of available navigational aids.

Table IX

, Aircrew Human Errors Commercito Both P-3 and F-4 Aircraft

			P-3 /	Aircraf	t	Γ	F-4/Å	rera	 •	
					-					P
	Flight Sogment	No. of Encrsby Personnel	% P.3 Common Errors (N = 79)	Major Accidents	Fatalities	No. of Errors by Pursonnal	% F.4 Common Errors (N = 82)	Major Accidents	Fatalities	Remedial Artes - both
 A. Vigilance Errors. 1. Poor preflight inspection-discrupancies not noted. external parts loose or op:n, doors or panels. 2. Poor instrument scan. 	1	99	11.4			8CR	7,3	• •	a u	cc
 altitude indicator, collision with water/ ground while an route to destination or fiy- ing in on a night surface contact. 3. Poor monitoring, poor supervision. 	IV	1P	1.3	1	J	2P 2R	4.9	2	4	೧೭೨
 checklist completion not monitored, gear not down for landing. 4. Indivertent/Incorrect adjuation of dockpit con- trols. 		1P	1.3	••	• •	2 A	2.4	• ·	•••	cc
 (a) ordnance switches, rocket launcher jettisoned due to switch in drop position or wrong station selected. (b) shgine/fuel switches, main fuel tank valve 	IV	2P	2.6	••		6P	8 1		••	DES
switch closed or selected "OFF" asssing angine to shutdown.	<u></u>	<u>2FE</u>				1P	1.2	:1	-	DTS
Vigilance Error Totals:		13P 2FE	19.0	1	8	8P 4R 6CR	21.9	2	4	
 B. Procedural Errors. Improper ordnance handling/release procedures. bomb/napaim tielivery below recommended altitude, aircraft damaged from collision with trees or bomb/napaim blast. Improper engine operating/restarting procedures. engine restart-lack of knowledge or poor pro- cedures concerning engine restart. Improper instrument/nevigation procedures. poor inflight navigation procedures, did not use available navigational aids to cross-check position. Checklists not complete. gear up landing, landing checklist. Improper proceduros used in a takeoff or a landing. unsuthorized overweight approach and land- ing attempted. Procedural Error Totals: 		1P 2P 4FE 2P 1P 1P 7P 4FE	1.3 7.6 2.5 1.3 	 1 1	 12 12	3P 1R 1P 1R 2P <u>1P</u> 8P 2R	4.9 1.'2 2.4 2.4 <u>1.2</u> 12.1	 1 <u>1</u> 2	··· ··· ···	DIS THA TRA CC DIS
 Misjudged safe distance or speed. (a) aircraft collisions on taxiway and flight line with other aircraft, revotment, indicator light or sawhorse. (b) aircraft taxied off taxiway. (c) overran runway on landing rollout. Poor Throttle Control. (a) high sink rate; not enough power on glide slope. 	11 11 111	6P 1P 1P 4P	7.6 1.3 1.3	•••	••	69 20 1P 91'	6.1 2.4 1.2 11.0	1 7		CC CC CC
(b) not enough power on glide slops, low on final, collision with drydosk, seawall or landed short.	111	2P	2.5		••	31	3.7	\$	•	TRA

13

Table IX (Continued)

Airgrew Human Errors Common to Both P-3 and F-4 Airgraft

and here which is the little with the state of the second state of the second state of the second state of the

1. . .

			P-3 Air	araft			P-4	Airorafi	1	
	Flight Segment	No. of Errors by Personnel	X P.3 Common Errors (N = 79)	Major Accidents	Factories	Na. of Errors by Personnel	% F-4 Car vece Enors (M = 82)	Major Accidents	Faculities	Remedial Ares - both A/C
 Poor Fuwer/Nose Control. high sink rate on glide slope, low power and high nose attitude. Poor control of brakes. (a) poor braking technique during takeoff rbort or landing dur to too much brak. 	111	1P	1.3	1	8	BP	9.8	3		TRA
ing, braking too early, and braking at high speed. (b) insdvertent brake application with rud- der during regular (sil-engines function- ing) takeoff, landing, or aborted take-		11P	13. 9	•••	••	13P	13.9	3	••	TRA
off. 5. Poor rudder control. (a) swerve developed during regular takeoff	111	21P	26.8	••		38	3.7	1		DES
or landing, (b) swerve developed during engine(s)-out takeoff/landing,		1P <u>6</u> P	1.3 6.3	1	1	9P 1P	11.0 <u>1.2</u>	3	· · ·	TRA TRA
Percuptual-Motor Error Totaia:		63P	97.3	2	7	64P	66.0	20	2	
Total Errors (All Error Types)		73Þ 6pe	100.0	6	27	70P 6R 8CR	100.0	24	6	

f. insuring proper selection of cockpit switches to prevent inadvertent ordnance drops or engine shutdown.

g. releasing ordnance at the recommended altitude.

h. knowing airborne engine restarting procedures.

Flight Segment III (Takeoff/Landing), Perceptual-Motor type of error, and pilot error had the most commonality across the two aircraft. From the table, it is evident that the remedial area of training is the most important to those errors in common. This would re-emphasize the importance of over-training the common errors early in training.

DISCUSSION

The results of this study indicate that while common errors can be isolated for the P-3 and F-4, their frequencies are relatively small. The majority of human errors were specific to the aircraft. Such error specificity is most evident in the F-4 as indicated by Table V. While these most significant errors were numerous, they accounted for a much smaller percentage of total error when compared with the P-3. These differences in diversity are related to the characteristics of the two aircraft as well as to their flight missions. The percentage of commonality should increase, however, as the similarity of the two aircraft increases. In a comparison between two different fighter aircraft such as the F-4 and F-8, human error a mmon to both should be quite high due to their similar flight missions.

As indicated earlier, the mission objectives and flight characteristics of the F-4 and P-3 are vastly different. The demands placed upon the orew are consequently not the same. As Table VII indicates, the human error occurring during Segment IV, Inflight, in much higher in the F-4. It is likely that inflight operating procedures and characteristics are responsible for this difference. To fulfill its mission objectives, the P-3 must fly "straight and level" at subsonic speeds for extended periods of time, while the F-4 is often engaged in acrobatic maneuvers near or above supersonic speeds in which the aircraft is operated at or beyond its normal flight envelope.

Crew coordination, which is of great importance in both aircraft, is further confounded by these differences in operating characteristics. The P-3 is a more forgiving aircraft due in part to the speeds at which it normally operutes. Generally, there is more time to correct a mistake whenever an error is made. Furthermore, there are traditional influences which tend to reduce effective crew coordination in the F-4. The F-4 is the first modern naval fighter aircraft to have a crew member other than the pilot. Acceptance of the role of the RIO has often been limited due to its break with the traditional single-seat fighter aircraft. Such begruding acceptance of the "man in the back seat" has been more pronounced among squadron personnel who have transitioned from single-seat aircraft. Until the team concept is accepted by both members, ineffective crew coordination will most likely continue within certain crews.

Violations of flight discipline were more numerous in the F-4. Failure to properly wear survival equipment and the performance of unauthorized maneuvers constituted the major categories of such violations. Again, it is suggested that such differences reflect the operating characteristics of these two aircraft. Proper use of survival/flight equipment is more critical in the F-4. Violations, whenever they occur, are more likely to manifest themselves in an

15

..

رهي ۽ سد

injury. Again, the F-4 is more demanding and provides little tolerance for human errors. Performance of quauthorized maneuvers most likely reflects differences in both the aircraft and the pilot. Obviously, the F-4 is designed for acrobatic maneuvering, while the P-3 is not. Parily due to tradition, the fighter pilot is more likely to engage in such displays of irrational individuality. For the same reasons, there may be some tendency among squadron commanders to overlook such violations which reflect combat aviation's history. Flight discipline, like crew coordination, represents a problem in the F-4 community which is in part due to its heritage.

and the second

While possible design deficiencies accounted for a sizeable number of errors in the P-3, it is encouraging to note they were involved in relatively few major accidents and no fatalities. As indicated, several design changes were implemented in order to eliminate certain service and braking problems. In the F-4, possible design deficiencies were cited concerning the inadvertent actuation of certain cockpit controls. Again, the design of controls in the F-4 is more critical due to the normal operating envelope of the aircraft. A human factors appraisal of the ordinance and canopy jettison systems appears to be warranted.

The last remedial area, training, presumably subsumes all those errors not included under the other three categories. They include certain procedural errors as well as most perceptual-motor errors. Ultimately, the problem is one of a search for better training methods. For example, how does one best train the psychomotor coordination necessary for proper glide slope control? Two solutions are possible. First, the amount of training can be increased. In other words, the training syllabus can be lengthened. Second, the search for better training techniques can be continued. The use of flight simulators represents a promising area for training research.

An alternative to better training procedures is that of better selection methods. Under the assumption that better pilots will commit fewer errors, is it possible to improve the quality of the incoming aviator material? Should certain individuals be assigned to one pipeline rather than another? Improved selection and training methods are necessary if human error is to be appreciably reduced.

The value of the present study lies in its definition of those problem areas which should be emphasized in training. A re-education of flight crews concerning these potential errors may be of value. The most significant gains should be realized in replacement air group training. Those aviators who are first introduced to training in a particular aircraft are the most susceptible to

effect change. Emphasizing the consequences of these potential problem areas may promote an awareness which may be instrumental in reducing future mishaps.

Despite their value in the study of human error, the techniques used in this study have certain limitations. First, not all mishaps are reported. Second, the technique is dependent upon the reports of people who are influenced by such factors as motivation, perception, recall, and the desire to look good. Third, some of the causes of a mishap are based on conjecture as a result of the aircraft being destroyed or the deaths of the crew members. Fourth, the accident reports, though based on trained and experienced opinions, are nevertheless subjective and open to error. Fifth, the content analysis of the reports depends upon the subjective evaluations of the investigators in terms of error classification. Sixth, there was no possible way to relate human error statistically either to opportunity of the personnel to perform the error, to aircraft flight time, or to number of mission sorties. Lastly, the number of errors recorded in the commonality analysis does not truly reflect that one error is more important in one aircraft than in another, simply for the reasons stated above.

At each of the above phases, the possibility of error exists. It is likely that the pilot's human error becomes confounded with the researcher's human error.

- 1. Flanagan, J. C. The critical incident technique. <u>Psychological Bulletin</u>, 1954, <u>51</u>, 327-358.
- 2. Lane, N. E. A review of naval aircraft mishaps with human engineering design deficiencies involved. Paper presented at 1970 Scientific Meetings of Aerospace Medical Association

APPENDIX A

朝日本の「あい」

ia i 1244

ERROR A - VIGILANCE ERRORS FOR P-8 AND F-4 AIRCRAFT (SEVEN AND FIVE YEAR TOTALS RESPECTIVELY)

A_

1.0

	:	Human	Major	Fatali-	Humen	Major -	Fatali-	
Flig	ght Segment I: Servicing/Pre-flight/Post-flight		Accidente			Assidents		
A.	External parts loose or open, poor preflight " inspection-discrepancies not noted.							
,	1. Doors or panels.	9F	**	•-	6CR			
	2. MAD boom tail cons.	1P	**	••	**	••		
	3. Tiedown strap buckles in bomb bay.	10	••	••	- ICR/	 1	••	
	4. Radome assembly.	••	· ••	**	112	ĩ	••	
	5. Zolb ballast.	~#	40	**	1CR			
	TOTAL:	11P	ra		8CR 1P	1	**	
B.	Internal parts loose, poor preflight inspection-							
	discrepancies not noted. 1. Ejection seat not locked in place.		••	**	1P	**		
	2. Parachutes.	11	••	••	~	••	••	
	TOTAL:	1T	•••	••	1 P	.4	**	****
0.	Parts not removed from sircraft, poor preflight inspection-discrepancies not noted.							
	L. Cooling air scoop plug assembly.	1 P	**	••				
	2. Tire worn.	**	**		1CR		••	
	3. Thrust neutralizers.	48 	4 %		LILL ICR		و و میں 1999ء میں	
	TOTAL	1.15	••	••	2CR	••	**	
D.	Inadequate clearance between parts, poor pre- flight inspectiondiscrepancies not noted. 1. Parachute flare dispenser damaged when	1P						
	bomb bay doors were closed.		44 •** ••• •*****************************	•• •	4 8	**	64 L	
	TOTAL	1P	**	**	**	**	46	
E.	Inadvertent actuation of cockpit controls. 1. Throttle lover inadvertently struck causing flame emission from tailpipe.		48		1P	4.0	4.5	
	TOTAL	**			112	**	<u>سوبات</u> سی رمستیسی م ه	
	TOTAL ERROR SEGMENT I	13P 1 T	••	••	10CR 3P	1	••	
F	light Segment II: Start/Taxi/Shutdown							
A	 Poor monitoring, poor supervision Failure to notice wings not folded after landing, poor checklist monitoring. 				1R	4-	84	
	2. Refuel probe extended while maintenance-		••	**	iP			
	man on wing checking radar scope, knocked	**	••		ĨŔ,	**	A.	
	off wing. 3. Refuel probe extended catching R10's	٣						
	finger, pilot not monitored.	**	**	**	1R		\$6	•
	TOTAL:		بر <u>محافظ مح</u> دين الم 44		8R		**	

ne se de la companya La companya de la com La companya de la com

، محمد به منه میکند. مرکز محمد میکند : مرکز محمد از محمد : محم

			, , , , , , , , , , , , , , , , , , , ,	*.	P-3 Alrer	ift a sec	den en e	F-4 Aire	raftan an	
					Major Accidents	Patali- ties	Human Errors	Major Accidents	Fatali- ties	
1	Flight S	egment II (Continue	d)							
	B. Misi 1. S	interpretation of har Signals of taxi direct	id signals. or, collision	• •	•••	• •	1P	5 4		
			TOTAL:	• •	• •		19	••	••	
	1. 1	dvertent engine inger Sufety pins (face cur pins) ingested into e	tain, seat pin, gear		••	• •	3P	••	••	
			TOTAL:	•••	4 .	# 4	<u> 3P</u>	• •	••	
		TOTAL ERROR SI	GMENT II:	••	••	••	5P 3R	••	••	i i
	Flight	Segment III: Takeof	f/Landing			•		:		
		or monitoring, poor Gear up indication checklist monitorin	not noticed, poor	1P			2R			
	2.		takeoff, poor check-	••	••		2R 1P		••	2 }
	8.	T.O. checklist not e done, pilot not chal			2		1R 1FL			
	4.	Poor supervision, fa of A/C in time to pr	ilure to take control event mishap.	<u>5P</u>			•••	6 •		
			TOTAL:	6P	••		5R 1P 1FL			
		or instrument scan								
	Ŀ	Altimeter Indicator (a) Break for landin	g at field/ship, ground/	••	••	••	2P	2	8	
			ring field approach,	••	••		2R 1P	1	2	
		collision. (c) 75 ⁰ heading cha approach, collis	ion.	••	••	• •	1R 1P 1R	1	2	
		(d) Wave-off from (on up-wind turi	ield landing, collision				1P	1	2	
		(e) Bolter, did not i	rotate, collision.	• •	• •		1P	i	ĩ	
	2.	cupied with em Angle of Attack and	after takeoff, preoc- ergency, collision. d Airspeed indicators.	••	• •	••	1P 1R	1	••	
		ceaft traffic, sta	reoccupied with air- ll. roach to field, stall.		••	••	1P 1P 1R		••	
		descent, ramp s	to carrier, high rate of trike.	4 8	× 6. 4	••	1P 12	1	• • •	
	4.	Failure to recognize	pitchlock condition.	<u>1</u> F	سينبد أسافت ورقتك كالكاف	• •	<u> </u>	بر بر 1990 - میلیونششین	6 . 	
		· · · ·	TOTAL:	1F	E ••	· · · · • •	10P 7R	9	10	· · · · · · · · · · · · · · · · · · ·

ς.

	<u>م</u>				Α.		
and the second	. P.	-3 Alroraft		F-4	Alreraft		
	Human Errors	Major Accidents	Fatali- ties	Human Errors	Majur Accidents	Fatali- ties	
C. Inadvertent actuation of cockpit controls. 1. Canopy jettisoned by arm brushing cock-							
pit release lever. 2. Autopilot actuated, aircraft over-rotated on cat shot, stalled.	• • • ·	••	•••	2P 1P	 1	••	
TOTAL:	••	• •	• •	8P	1	• •	
TOTAL ERROR SEGMENT III:	6P 1FE	• •	••	14P 12P 1FL	10	10 .	
IV. Flight Segment IV: Inflight.							
A. Poor instrument scan							
 Altimeter indicator. (a) Water collision while en route to des- tination or running in on a night sur- 				2P			
face contact. (b) Bomb pattern, recovery too low, dam-	18	1	8	2R	2	4	
age from bomb. (c) Bomb pattern, aircraft too low, over-	••	••	••	8R 2P	••	••	
stressed on pull-out or water collision. 2. Air combat maneuvering, low fuel warning	••	•••	••	2R 2P	1	2	
light illumination, flameout, 3. Airspeed and angle of attack indicators.	••	••	••	ÎR 3R	2	. • •	
 (a) Bomb pattern, aircraft stall. 4. Disorientation, overall scan. 	••	••	••	1 P	1	2	-
(a) Holding pattern in turn, stall.5. Cabin pressure climbed unobserved.	 1fe	••	••	1 P	1	••	
 6. Inflight refueling, refuel pressure gauge not scanned. 		••	••	••	• •	••	
		• • 		<u></u>	• •	* * 	
TOTAL:	1P 1FE	1	8	9P 11R	7	8	
 B. Poor monitoring, poor supervision; 1. Poor supervision of trainee. 2. Inadequate monitoring of another aircraft's 	1FE	••	••	••	••		
fuel, flamcout. 3. Failed to question flight leader's erroncous	••	••	••'	2FL 1P	••	••	
position.		• •	••	<u>1R</u>	• •	• •	
TOTAL:	1FE	••	••	2FL 1P 1R	••	••	
 C. Misinterpretation of hand signals. 1. Misinterpretation of hand signals between wing and lead aircraft while in formation, 					1 · ·		
collision.	د د مربعی به میسد	• •	•••	1P	• •		
TOTAL:	••	••	••	1P		* *	

pelledet Charles to the state of the state

. No a

÷.

	P-3	Aircraft			4 Aircraft	• • • • • •	•
·	Human I Errors A		Patali- tios	Human Errors	Major Accidents	Patali- ties	
. Poor external visual lookout, aircraft collision. 1. Bomb pattern, another F-4.	••	••	••	1P 1R	••	• • ,	
2. Cliv.sout, KC 130 and F-4.	••	* •	••	1 P 1R	3	5	
3. En route, F-8.	••	••	••	1P	2	1	
4. Inflight refueling, A-8 mid-air on break- away from tanker.	• •			1R 1FL 1P	2		-
TOTAL:	••	••		4P 1FL 8R	7	6	
 Navigation Equipment, Inadvertent/incorrect actuation of cockpit controls. Wrong TACAN channel selected, wrong position computed, flameout in both aircraft. 				1P 1R	2	••	
2. Navigation error due to movement of AHRS control from slave to free position.	3P					••	
TOTAL:	3P	• •	• •	IP 1k	2	• •	
 Ordnance switches, inadvertent/incorrect actuation of cockpit controls. Rocket launcher/POD, wrong wing station selected, jettisoned. Missile fired, inadvertent actuation. Bomb dropped, inadvertent actuation, air- craft's wing damaged by bomb fragments. Rocket launcher dropped, switch in drop position. Sonobuoy inadvertently released while chute pressurized, airspeed above maxi- mum recommended for release. AGU 12 B-rails jettisoned during ditching drill. Wrong switch selected on bomb run, bomb not released, preoccupation with correct selection, ground collision. 	 1P 1T 1P 2P 1T	··· ·· ·· ·· ··	 	5P 2P 2P 1P 10P	 	••	-
 Fuel/engine switches, inadvertent/incorrect actuation of cockpit controls. External fuel tank jettisoned, fuel tank switch mistaken for fuel transfer switch. Inflight refuel probe extended. Main fuel tank valve switch closed or selected "OFF", engine shutdown. Feather switch bumped, engine feathered. 	 2FE 1CM	 N	•••	1P 27 1P	•••	••	
TOTAL:	2FE	• •	••	4P			
	ICM.	N		-		• .	•

	P-3 Alroraft			74		
	Human N Errors Ad	elor xoldent	Pateli-	Human Errors	Major Accidents	Patell- tine
II. Canopy jettisoned, inadvertent actuation of cockpit controls.						
 Used lever to pull/steady/turn body. Brushed lever with arm to change radio 	, 	••	••	4R	••	••
frequency or manipulate switch on missile control panel.	a 1		••	1 <u>P</u> 1R		
TOTAL:	••	••	••	5R 1P	••	
2. Engine fire extinguisher, inadvertent/incor- rect actuation of cockpit controls.						
 HRD bottle discharged on simulated engine fire, wrong circuit breaker pulled. Fire extinguishing unit discharged into 	1 FE	••	••	••	••	••
wrong engine during transfer.	<u>1P</u>	• •	••	••	• •	
` TOTAL:	IP 1FE	•••	••	••	••	••
 J. Electrical switches, inadvertent actuation of cockpit controls. 1. AC bus circuit breaker popped from being brushed against. 	2CMN	1 3		• •		
TOTAL	2CMN	••	• •		••	
 K. Prop control, inadvertent actuation of cock- pit controls. 1. Power levers moved during prop indexing for a pitchlock. 	1P	••			•••	••
TOTAL:	IP		4 4	• •	9 1	• •
TOTAL ERROR SEGMENT IV:	8 p 5fe 1t 8cmn	1	8	81P 21R 8FL	16	14
TOTAL ERRORS (ALL FLIGHT SEGMENTS:	27P 6FE 2T 3CMN	1	8	58P 36R 4FL 10CR		24

4

% __________

.

i

· -

APPENDIX B

ERROR B • PROCEDURAL ERRORS FOR P-8 AND F-4 AIRCRAFT (SEVEN AND FIVE YEAR TOTALS RESPECTIVELY)

\$-1

	· · · · ·	P-3	Airarati		P-4	Aircraft	
		Human Errors	Major Accident	Fatali - a tios	Human Errors	Major Actidents	Fatali- <u>Itles</u>
ligh	t Segment 1: Servicing/Pre-flight/Post-flight						
A.	Improper survival/ejection procedures						
	 Helmet chinstraps cut off. Helmet not brought in for check, earphones 	••	••	••	1P	• 11	••
	wiring loose, visor screws missing. 3. Passenger no: equipped with flight boots or		••		19	••	••
	flight suit.	• •	••		2P		••
	 Passenger allowed to have suitcase on lap. Alternate seat ejection guard set "up", determined not to be used. 	••	••	••	1P 1P	••	••
	6. Leg straps out off survival vest.		•••	••	1R 1R	**	••
	7. Survival vest not worn.		••	••	10	••	· • •
	8. Ejection seat leg restraints not used.		• •	••	2P		
				-	ĨR		
	9. "G" suit not worn.		••	••	2P	• •	••
	10. Failed to carry required sign-1 devices-				2R		
	flares, strobe light, emergency radio. 11. Reflective tape not worn on helmet.		8 /	••	1P 1P		
	TOTAL:	••	• •	••	18P 5R	••	••
B,	Improper servicing procedures.	1					
	1. Low oil in prop filler reservoir,	72FE	••	••	• •		••
	2. Overservicing caused prop oil reservoir leak,	1FE	••	••		••	• •
	3. Overservicing caused engine oil tank leak.	<u> </u>	• •	••		• •	• •
	TOTAL	74FE	••	••	••	••	••
C.							
	cedures.	4	15				
	 Straps grabbed, blade tripped. Did not wait five minutes with O psi prior to unloading mechanism, huma finad 	10RI 10RI		••	••	• •	••
	to unloading mechanism, buoy fired. TOTAL:			_ <u></u>		••	• •
n	Improper briefing procedures, perfinent infor-					- •	
υ,	mation not communicated,						
	1. Not briefed for carrier break at field, use to				1 834		
	1500' vice 800' break, collision, 2. Not briefed as to proper formation position	••	••	••	1FL	••	
	for wing aircraft, collision. 3. Not briefed properly concerning lead change,	• •	••	••	1FL	• •	• •
	collision.	••	••		1 FL	••	- •
	4. Passenger not briefed properly for indight ejection, used seat vice face curtain ejection,						
	thought he was too tall for curtain ejection.	•••	• •	• •	<u> 1P</u>	• •	• •
	TOTAL:		••	••	8FL 1P	· • •	• •
E.	Improper instrument/fight planning procedures 1. Faulty flight planning concerning distance						
	and fuel, flameout,	••	••	••	2P	••	••
	2. Failure to be aware of hazards in area,						
	collision with mountain.	* *	# P	• •	<u> 1P</u>		• •
	TOTAL				8P	••	

- C.

ı

				•		
		P-3 Alrer	eft	<u>.</u>	4 Airgraft	• • •
	Human	Major Accident .	Fatali- ties	Human Errors	Major Accident	Fatali- ts ities
F. Improper post-flight maintenance procedures. 1. Engine not visually inspected after shutdown.	* *	••	••	1CR		••
 Downing gripe (fire warning light illumi- nation) not reported on yellow sheet. 	••	••	• •	1P	••	••
TOTAL:			••	1P 1CR	••	
G. Poor judgment, flight should not have been flown.						
 Pilot and passenger not NATOPS qualified to fly F-4. 	••	••	••	2P	••	••
 Impaired thinking due to heavy drinking, hangover, fatigue, collision. 	••	••	••	2P	1	2
TOTAL:		••	• •	4P	1	2
H. Parts not properly secured by aircrewman, not checked for security.					i	
1. Loose prop oil filler cap,	79FE 1FE	••	••	• •	••	••
 Loose engine oil tank filler cap. Loose fuel tank cap. 	IFE	••	•••		·	••
TOTAL:	81FE		• •	••	••	••
TOTAL ERROR SEGMENT I:	155 FE 20RI		••	22P 5R 1CR 3FL	1	2
ight Segment II: Start/Taxi/Shutdown.						
A. Checklists not complete						
 Pitchlock reset circuit breaker not pushed in. Wings not folded after randing. Allocated action to bablish flight care 	1FE ••	• • • -	••	2P	••	••
 Abbreviated pre-taxi chocklist, flight con- trols not checked. 	••	• *	••	1P	••	••
4. Canopy improperly secured, tape not checked for alignment.	••	• •	••	մը 2R	••	••
 Post-land checklist, throttles in idle vice cutoff. 		••		1P	••	••
5. AFCS engaged, pre-taxi checklist.	••	• •	• •	<u>IP</u>		• •
TOTAL:	1 FE	••	••	11P 2R	••	••
 B. Poor ground engine operating procedures. 1. Power added without direction, man 				. *		
injured. 2. Engine not secured prior to tow, collision.	••	••	••	1P 1 1P	1	* *
 Compressor stall/overtemperature due to engine operation in low RPM/high ambient temperature. 	2P	••	• -		. -	
TOTAL:	2P	•••	••	 2P		**
1414 (A.C.)						

.

8-2

÷ --

o de suborde de la serie de

.

(Area) 14(1) (PC-1)

la

· · · · ·		P-3 Airers	<u>ft</u>	<u><u><u></u><u></u><u><u></u><u></u><u></u><u></u><u></u><u></u><u><u></u><u></u><u></u><u></u><u></u><u></u><u></u><u></u><u></u></u></u></u></u>	Aircraft	
· · · · · · · · · · · · · · · · · · ·	Human Errors	Major Accidents	Fatali- tios	Human Errors	Major Acsidents	Fatali- ties
C. Poor judgment, flight should not have been flown.				ه المتشرق عب		
 Flight should have been cancelled due to takeoff delay; inadequate/faulty starters, fuel starvation, collision. 	••	••	••	1FL		••
🔭 TOTAL:	• • • •			iFL		
 D. Improper refueling procedures. 1. Unauthorized actions by pilot during hot refueling, refuel crew distracted/confused. hose removed prior to shutoff, fire. 	• •	a •	•••	1P	4 6	•
TOTAL:	••	••	••	1 P	••	••
 E. Poor communication procedures, pertinent information not communicated. 1. RIO not notified of refuel probe extension, 	,			1 P		
finger caught. TOTAL:		B B	4 6		• •	•••
IOTAL:	••	• •	••	1 P	••	••
TOTAL ERROR, SECMENT II:	1 FE 2 P	••	••	15P 1FL 2R	1	••
sht Segment III: 'Takeoff/Landing.						
 Improper Emergency Procedures. Hydraulic failure, aircraft landed prior to LSO on radio. 				1P		
 180 too close for single engine landing. Failure to select optimum runway for field arrestment, runway selected was shorter and 	••	••	••	îP	••	• •
 had a crosswind. 4. Bird ingested during landing rollout, engine should not have been secured, aircraft 	••	• -	••	2P	••	••
swerved. 5. Engine problem, single engin - approach not	• •	• •	••	1P	••	••
performed.	••	• •		1P	••	
 6. Morest cable snap, engine not shutdown. 7. Drag chuie streamered on landing, tailhook 	••		••	1P	••	••
not dropped.		••	••	1P		••
 Blown tire, now gear steering not used. Fire warning light illumination, warning 	••	••	••	<u>2</u> P	ŝ	••
light circuit breaker and possible engine maifunction not checked.		••	••	1P 1R	• '•	••
 Flameout on takeoff, external stores not jettisoned. 	••			1 P	••	• •
 Bridle failure on take off, failed to follow proper procedures. 	••		••	1P	• •	11 B
12. Gear did not retract on takeoff, landing cir- cuit breaker not pulled.	••	• •	a 4	1P	* *	••
13. Engine secured during takeoff, afterburner not maintained on good engine.	••	••	••	1P	••	••
14. Takeoff aborted, tailwind not considered.	ی منابع روسینی ا	• •	ة م منابقة مريسين التكاري	19	ی بندان او بر ایر بندان او بر او	• •
TOTAL	a •	* •	••	16P 1R	1	••
		-	• •	•		en de Sala. National de
and the second	8-3	.e.angan te	्र इ.स. २३ व्	n n nor Nort de la	، د ښېله ورون	یا در
	· · · · ·	· ··· · ·	· · · · · · ·		and a second second Second second s	en an in Anna The State

.

		P-3 Aircraft	•	F-4 Alr	erett	
	Human Errors	Major Achidents	Fatail- ties	Human Brrors	Major Accidents	Patali- ties
B. Inproper Instrument/Navigation Procedures 1. Aircraft below minimums on approach a	ind					
waveoff. 2. Did not maintain assigned altitude.	• • • -	••	••	1P 1P 1R	••	• *
 Radar altimeter not turned on. Instrument departure not performed, at 		, уг а	••	1 P	••	• 1
tempted to remain VFR.	••	••	••	1P	1	••
TOTAL	••	••		1R 4P	1	••
C. Improper survival/ejection procedures. 1. Visor up on ejection.		••	••	1P 1R	••	••
 Gloves not worn on ejection. Late ejection from an engine failure. 	* *	• •	••	2P 1R/21	 P	8
TOTAL:	••	••	••	5P 2R		3
 D. Drag chute not deployed, improper procedured in a takeoff or a landing. 1. During an aborted takeoff. 2. During landing. 	ures 	• • • •		1P 8P		••
TOTAL:	••	••	• •	9P	2	••
 E. Checklists not complete. 1. Gear up landing. 2. Harness not locked on landing. 3. Wings folded on takeoff. 4. Flight controls not checked for takeoff, locked controls. 	1P 	1 	•••	2P 1R 1P 2P	1 	
 5. Engine run-up not complete. 6. Flaps up on takeoff, aircraft over-rotate 	d	- •	••	1P 4P		8
TOTAL:	1P	1	• •	10P 1R	5	8
F. Improper procedures used in a takeoff or la ing, landing lights not turned on when visib was poor.	nd- ility			1P	1	1
TOTAL:	••			1P	1	1
G. Improper maintenance/troubleshooting pro- cedures. 1. Low HP on No. 1 engine, possible arcr						
malfunction not checked. 2. Anti-ice light illumination, cause not in	1P	• •	••	* •	- •	••
gated. 3. Possible brake problem noticed, not in-	3P	• •	• •	* * 1 B	••	• •
vestigated. 4. Engine instruments not checked. catap officer saluted, engine failure on takeof		• • • •		1P 1P		••
TOTAL:	4P	* *		2P	1	1

15

The second s

	<u>!</u>	P-3 /siraraft	-	<u> </u>	4 Airoraft	
	Human Errors	Major Accidents	Fatall- tice	Human Errors	Major Accidents	Patali- ties
Aircraft controls released/raised too quickly on take-off, improper procedures used in a take-off						
or landing.						
 Flaps raised prematurely, collision Brakes released prematurely, after burner 	••	••	••	1 P	1	••
selected, wing aircraft thought lead had com- menced take-off, collision. 3. Gear raised prematurely, tires blew upon	••	••	••	1P	••	••
retraction due to an inadequate cooling period.	₩ 10P	••	••	••	••	••
TOTAL	10P	5 s		2P	1	4 1
Poor communication procedures, pertinent in-						
formation not communicated,	4 2323					
1. Failure to notify pilot of pitchlock.	1 FE	••	••	iP	••	•••
 Proper verbal ejection command not stated. RIO ejected, pilot not told. 		••	• •		••	1
4. Ship not informed of engine difficulty.			••	1 P		•••
5. Towar not notified of field arrestment						
desired.			·· •	1 P	••	• •
6. Wave-off lights for No. 1 aircraft, No. 2						
with low fuel state wayed off without check-						
ing with LSO, collision.				<u>1P</u>	1	• •
TOTAL:	1FE	4 8	••	4P	1	1
		t		1 R		
 Overweight landing attempted, improper procedures used in a take-off or a landing. Overweight landing necessary due to diminiahing weather, rollout not computed. Unauthorized overweight landing, tire failure. Unauthorized overweight approach to a landing, stall, hard landing, fire. 	1P 1P	 		 1P	 1	•••
TOTAL	2P	• •	• •	1 P	1	
 Wave-off not executed when aircraft in poor situation, improper procedures used in a take- off or a landing. 						
1. Section landing, wing aircraft had an exces-						
sive sink rate.	••	••	••	2P	1	e + +
2. Aircraft set up to land on wrong runway.	••	••	••	12	••	••
8. Morest cable snapped.	••	* *	• •	1 P	• •	• •
4. Tire blew on touchdown.		••	••	<u>1P</u>		••
TOTAL:	••	••	••	5P	2	••
 Performance of <i>vas</i>uthorized action. LSO waved aircraft off due to being high, 					•	
pilot disregarded and landed.	د د	• • منصب بنی مینطنی		1P	1	
TOTAL	••	••	••	1 P	1	**
TOTAL ERROR, SEGMENT III:	17P 1FE	1	an 🖝	60P 6R	17	· 9

		P-3 Aircraft			F-4.	Airoraft	
		Human Error	Major Accidents	Fatali- tios	Human Error	Major Accidents	Patali tiés
ight Segr	nent IV: Inflight.						
1. 1	roper emergency procedures. mproper stall recovery, failed to raise fleps,						
2. 5	drag chute deployed prematurely. moke in cockpit, front canopy not jetti-	••	• =	••	1P	••	••
	oned. Fre warn light illumination, did not land	••	••	••	1P	••	••
i 4. E	nimediately. Ingine secured prior to determining if actual	••	••	••	2P.	••	••
1	nalfung Sun, erroneous reading on TIT gauge and nonexistent fuel leak.	2P	••		••	••	• •
1	ailure to secure engine with low bleed air preseure.	1P	••	••		• •	••
6. F	ailure to disconnect when inlet discharge gage indicated 0 differential.	1FE	••	• •	4 a	••	
	TOTAL	8P 1FE	• •	••	4P	• •	••
1. N	roper survival/ejection procedures. lecks on exposure suits open during ejection,	••	• •		1 P		• •
2. E	exposure from cold water jection lever on seat pan not pulled far				1R		
- 8. J	nough, no ejection. ace curtain not pulled far enough, no	••	• •	• •	2P	• •	••
	sjection. ligh speed ejection, face curtain not used.	••	••	• •	1P 1R	••	•••
	ate ejection from an engine failure, uncon-	•••	•••	••	4R		18
	rolled flight, or stalled aircraft.				6P		U
6. ł	lelmet visor up, eyes damaged from a bird strike,	••	••	••	IP IR	• •	••
	leimet chinstraps loose, helmet lost on ejection.		••	•	3R		
	2 mask not worn or not attached to both ides of helmet.	••	••	••	1R 1P	••	••
	Bloves not worn during ejection, hands						
10. H	ourned. ISSK and raft not deployed during descent,	••	••	• ,•	1R		* •
-11. S	tard landing. urvival kit lost during ejection, not secured	••	••	••	1 P	••	••
	o torso harness.	••	••	• •	1R	• •	• •
18. K	taft not inflated, drowned. OCK fittings not unfastened or released	••	••	••	1R	••	1
(luick enough, entangled in parachute.	•••	• •	8 8 	2R	• •	• ••
	TOTAL:	••	• •	••	13P 16R	••	10
- 1. I	klists not complete. FR penetration descent, pitot heat off, no irspeed or altimeter indications.			• •	18		••
2. F	IRD bottle discharged on simulated engine ire, circuit breaker not pulled.	2FE	• •				
	TOTAL:	2FE			1P	• •	• •

۰.

. .

B-6

an state and state

 pertinent information not communicated. I. Failure to tell pilot and TACCO of inflight maintenance on schobuoy chute. I. ICS malfunction, RIO ejected, thought pilot said to eject, nothing wrong with aircraft, ejected without checking aircraft or pilot. Failed to advise replacement pilot of proper stall recovery technique. RIO disoriented, pilot asked to rollout, pilot thought something was wrong because of RIO b ing excited, "G's" pulled on aircraft. Inexperienced wing flying complicated maneuver, lead failed to brief wing of proper position, collision. TOTAL: 		P-3 Alrei	<u>111</u>	4	F-4 Alra	raft	. ·
	Human	Major Accidents	Petall-	Human	Major Accidents	Patali- tios	1
D. Poor communication procedures,			:	. ·	• • • •	· .	
pertinent information not communicated.	i t	•	Ĩ	ł	1 1 1	• • • •	
	IOR	D''			••		
2. ICS malfunction, RIO ejected, thought pilot							
said to eject, nothing wrong with aircraft,				+		•	
ejected without enecking aircraft or pilot.	• •	••		1R	••	.	
				= 1R	••		•
4. RIO disoriented, pilot asked to rollout,						•	
of RIO by ing excited, "G'a" nulled on air.		*					÷
	••	• •		1 R	• •	••	
5. Inexperienced wing flying complicated man-		1				·	
	•	••		1 P			
-	IOR	D •	**************************************				-
IOTAL	IUN		••	- 1P	•••	••	
E. Improper instrument/navigation procedures.			•				
rain, to use all available navigational aids			:		, .		
	4P	1 .	12	4P	3	* *	
ing speed and fuel checks, flameout.		,		īfl			
				JR			
 Other navigation equipment not used to check wrong T.' CAN readouts, wrong chan- nel selected. 	•••	• •	••	1P 1R	• • ;	••	
TOTAL:	4P	l	12	5P 4R	3	4 #	
	•			ÌFL	•		
F. Performance of unauthorized actions.	, ,	, ļ		•			
1. Unauthorized/unscheduled low level flight,		•	• .				
flathatting, reckless flying.	••	• •	••	3P	2	4	
2. Aircraft rolled while performing authorized				1 P		0	
low level pass by tower. 3. Acrobatic maneuvers at too low an altitude	••	••	•••	1FL		2	
and too close to clouds.				1P	•	•	
4. Unscheduled/unauthorized ACM.	6 - 4	8 8	• •	18	1		-
TOTAL:	••	••	••	6P	4	8	
				1FL			
G. Improper engine operating/restarting procedures.							
1. Engine secured in icing conditions, 2 gener-			•				
ators overheated. 2. Lack of knowledge concerning engine re-	1 P	••	• •	••		• •	
start procedures.	••	••		1P	• •		
8. Engine restart of decoupled engine.	1P	••	• •	*,*		••	
 Prop decoupled due to excessive airspeed on engine restart. 	1 P -				i i i	46	
5. During engine restart, prop rotated with oil	* *				: . i	· · ·	
shutoff valve closed and oil tank shutoff cir-	2FE	1. j. j.					
cuit breaker not reset.		•	•• <mark>•</mark>	ata#*. 	••• 	••	
			1				۰,
	8-7			and on the Bythe part			

- G. Improper engine operating/restarting procedures. (Continued)
 - During engine restart, feather button not released and released prior to fuel and ignition "ON".

TOTAL:

- H. Improper ordnance handling/release procedures.
 1. Violations of SOP for flare dropping, drops
 - continued after problems arose.
 2. Aircraft damage due to bomb/napalm delivery below recommended altitude.
 - 3. Bomb delivery at low altitude, aircraft collision with trees.
 - 4. Improper dive recovery, turned left vice pullup, bomb fragmentary damage.
 - Rocket pack jettisoned, bullpup selected purposely on weapon selector and pickeled, controls mismanaged.
 - 6. Improper sonobuoy handling, failure to disarm chute.
 - Improper sonobuoy handling, failure to secure valve and bleed trapped air prior to buoy removal or inflight maintenance.
 - 8. Flight entered hot fire area, aircraft struck by dummy missile.

TOTAL:

- I. Improper maintenance/troubleshooting procedures. 1. Failed to use stop/cut switch when overspeed
 - noted on target reel launcher system. 2. Crewman entered electrical load center with power on, panel came in contact with
 - generator.
 3. Failure to depressurize R/T unit prior to removal during inflight maintenance, crewman struck in head.
 - 4. Disregarded deicer warning indication, deicing equipment used intermittently.
 - 5. Vacuum cleaner hose in wrong hatch, fitting lost in slipstream.

TOTAL:

- J. Improper refueling/fuel transfer procedures.
 - 1. Cross-country, internal tank used before external tank, transfer malfunction, no transfer, flameout.
 - 2. Prop decoupled during fuel chop due to low sirspred and HP.
 - 8. Refuel probe extended in excess airspeed.
 - 4. Violated SOP, tight wing position following inflight refueling.

TOTAL.

•	P-3 Alrer	att	F.4	<u>.</u> ,		
Humen Error	Major Addidenta	Potoli- tios	Human Error	Major Accidents	Fotali-	
2FE	••	••	••			
4FE 8P	•	••	1 P	••	••	
1P 1P	1 	18 ••	2P 1R	••	••	
••	••	••	1P	••	••	
••	• •	••	1 P	* *	. ••	
••	••	••	4P	••	• •	
IORE)	••	••	••	••	
40RE)	.	1P 1FL	, 1	1	
2P 5ORE	1	18	1FL 1R 9P		1	
••	••	••	1R	• •	••	
1CMN	۰. ا	••	••	•	•••	
1CMN	1		• •	••	· · · · · · · · · · · · · · · · · · ·	
1 P	••		••		••	
1CMN		•••	• •	• •	• •	
3CMN 1 P	4	••	18	••	••	
1						
••	••	u 4	1P	1	• •	
1P	••	••	1P	••	••	
••	•••	••	1P -		••	
, 1P			8P ·	1	م <u>يستويند.</u> م م	

9-4

 1			P-3 Aire	raft.		F-4 Altoref	· · · · · · · · · · · · · · · · · · ·	
n an bran ∫ar bran bran		Human	Major locidents	Patell-	Humen Error	Mejor Accidents	Patali- ties	÷.
К.	Improper procedures within a thunderstorm		,			÷		
	1. Entered thunderstorm area without ascertain- ing storage complete.	1 P	••	• •	••	••	••	
	 Thunderstorm area entered without using radar. Failure to circumnavigate thunderstorm area. 	1P 1P	••	••	• •	••	••	
	TOTAL:	8P	• •	• •				•
· • • •	TOTAL ERROR, SEGMENT IV:	8CM 17P 7FE 60R I	_	25	43P 25R 8FL	9	19	
	ICTAL ERRORS (ALL FLIGHT SEGMENTS)	164FE 80RI 36P 3CMM		25	140P 38R 1 CR 7 FL		80	

APPENDIX C

ERCOR C - PERCEPTUAL-MOTOR ERRORS FOR P-8 AND F-4 AIRCRAFT

(SEVEN AND FIVE YEAR TOTALS RESPECTIVELY)

			· · · ·			•	• • • • • • •	*
· .			· ·			· · .		· '… •
·.		· . · .	-P-3 Airon	nft ¹		Aironaft		an a a a a
		Human Nrror	Major Accidents	Fetali- ties	Human Error	Major- Accidents	Fatall- ties	
Flight	Segment I: No discrepancies noted.		N.					
· · ·	Segment II: Start/Taxi/Shutdown					,		
•	Aircraft collisions on taxiiway/flight line, mis-							
	judged sale distance or speed.				•••			,
	1. Another aircraft. 2. Revetment.	3P 1P	••	••	2P 1P	1	••	
	3. Indicator Light.	îP	••	••	ÎP	••		1
	4. Saw horse	1P		••	112	••	••	
	5. Chockstand	1P	• •	• •		* •	••	
	6. Fire bottle 7. Starting unit	1P	••	••	1P	••	••	
	8. Blast fence				ÎP	••	••	
	9. Snowbank	2P	B 4	••	• •	••	• •	-
	TOTAL:	10 P			7P	1	••	
В.	Aircraft taxied off taxiway, ramp or into carrier							
	1. Catwalk	••	• •	• •	1P	••	••	
	2. Taxiway 9. Barry (Cald)	1P	••	• •	2P 1P	••	• •	
	8. Ramp (field) TOTAL:	<u></u> 1P	• •		<u> </u>			
	IUTAL:	16	• •		41	••	••	
С.	Inadequate clearance between aircraft, misjudged safe distance. 1. Close proximity and reverse thrust of one						,	
	aircraft caused damage to another.	<u>1P</u>						_
	TOTAL:	1P	• •	• •	يليو هو. ماليا م	••	• •	
	TOTAL ERROR, SEGMENT II:	12P	• •	••	11P	1	• •	
rugni	Segment III: Takeoff/Landing							
А.	Poor power/nose on glide slope (combination of							
	both controls)							
	 High nose attitude, poor power, high sink rate. 	1 P	1	6	8P	8		
	2. Poor power/nose control, landed fast at field.				8P	••	••	
	3. Rough power/nose control, could not get							
	aboard, barricade necessary.		••	••	1 P	* *	••	•
	4. Field landing, lead went high, poor power/							
	nose control, poor lead, wing landed hard due to a high sink rate.				1FL	••		
	TOTAL:	112	1	6	1FL		<u> </u>	-
	IVIAL:	ir	, 1	U	12P	0	••	
					· .			
В.	Poor elevator control,					,		
	 Aircraft started high, nose lowered, high sink rate on glide slope. 				21 P	. 2		
	2. Throttle malfunction, high all the way, passed		••	••		-	•-	
	over wire during field landing.	• •	••	••	1P			
	3. During field takeoff failed to recognize locked			7. 1		•		1
	controls, AFCS was engaged.	• •		6.9	1P	• •	-y #	,
	 Over-rotated nose using aerodynamic braking during landing rollout. 	1P					••	
	5. Over-rotated nose on take-off, stall.				8P	2	1	
	6. Failed to rotate nose off catapult.				<u></u>		<u> </u>	
	TOTAL:	1P		••	29P	Ő	3.	πin isisi Ma
. AF 1	and the second	n in the s		· · · · · ·		بيفهده بأسلوط	eare de la companya d	a di san ing
· · · · ·		1-0-						
· · · · ·		ι.		1	i i	u.	×	

1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 -1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 -1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 -

	P-3 Aircraft		F-4 Alroraft			
	Human Error	Major Acoldents	Fatali- ties	Human Error	Major Assidents	Fetali- ties
 Poor power control. Poor power control, high sink rate. Poor power, pilot induced pitchlock by rapid 	4P	••	••	9 P	7	. 2
power manipulation into reverse, high sink rate, swerve on landing. 3. Poor power control, low on final, collision.	8P	1	••	••	••	••
with drydock, seawall or landed short at field.	2P	••	••	8 P	2	••
 Pitchlock induced, rapid manipulation of power into reverse during aborted takeoff. Maximum power added too rapidly during takeoff torsus floaned over equains 	3P	. 1	••	••	••	••
takeoff, *orque flopped over causing fluctuating engine RPM. 6. Improper power reversal technique, swerve	1 FE	••	• •	••	••	••
developed during landing rollout. 7. Bolter, slow to add power, water collision.	2P	4 a 4 a	••	 1P	 1	••
8. During field arrested landing, power added, thought wire missed when wire was engaged.	••	• •	••	· 1P	••	••
 Throttle not closed, aircraft fast on landing rollout. Inadvertent engine shutdown during field 	••	* *	••	8P	••	•• त
landing, throttles retarded to cutoff.			••	<u>1P</u>		<u></u>
TOTAL:	14P 1 FE	2	••	18P	10	2
 Poor elevator control pilot induced stall during high performance man- euver, or the break to land due to poor elevator control/slow airspeed/high nose attitude. Maintained high rate of climb on high per- formance field attends attill and high per- 				1 P	1	2
formance field takeoff, stall, collision. 2. Field broak to land, aircraft over-controlled, inverted, stall, collision.	•••	••	••	1P	1	2
TOTAL		а С. С. С	* *	2P	2	4
2. Poor control of brakes, poor braking technique during takeoff aborts/landing (due to drag chute not deployed, braking at high speed, braking too early, and/or heavy braking).						
 Drag chute not deployed, aircraft too fast. Poor braking. 	 11P	••	••	4P 9P		* *
TOTAL:	11P	• •	••	13P	3	••
 F. Poor control of brakes, poor braking on landing rollout (due to no or little braking until too late). 1. No braking, morest cable snapped followed by heavy braking. 2. No braking and chute not deployed on wet 	••	••		1P	••	- a
runway, hook skipped, followed by heavy braking.	••	••	••	1 P	••	, • •
 Landed with blown tire off centerline, oppo- site brake not used, sircraft left runway. 	• 4		• 1	1P	1	4. ••
TOTAL:		\$ a '	4 4	3P	1	

. . - 1.

deres if the orth

an hTrade Contra a

	P-3 Alroreft		F			
	Human Error	Major Accidents	Fatali- ties	Human Error	Major Accidents	Patali- tiss
Poor control of brakes, brakes inadvertently ap- plied along with rudder during takeoffs, tire						
blow. 1. During simulated engine failure, swerve developed.	7P			••		
2. Four-engine takeoff aborted, engines reversed.	iP	••	••	••	• •	••
 Catapult shot. Field takeoff, swerved off runway. 	••	••	••	1P 1P		•••
TOTAL:	88	• •		2P	1	• •
Poor control of brakes, brakes inadvertently ap- plied along with rudder during landings, tire blew.						
 Regular four-engine landing, five mishaps needed a crosswind correction. 	18P	••	• •	r =	••	••
2. Regular two-engine landing on field.		••	• •	2P	• •	• •
 Improper reversal technique on four-engine landing, swerve developed. Four-engine landing, differential reverse power 	1P	••	••	••	••	••
used to correct back to centerline, swerve developed. 5. Two-engine-out landing, swerve developed	1 P	••	••	••	4 4	••
when engines were reversed, two mishaps required a crosswind correction.	1âb	••	€ 41	••	••	••
6. One-engine-out landing, swerve developed with engine reversal.	<u> 1P</u>	••	* •			
TOTAL:	39P	• •	••	. 2P		••
 Poor rudder control. Regular two-engine takeoff, swerve developed, lost control, departed runway. Regular two(F-4) or four (P-3) engine land- ing, over-corrected rudder, swerve developed. 	••		•••	2P	1	••
left runway (all F-4 mishaps landed in cross- wind or crab/skid).	1P	1	- 1	4P	2	
 Bird ingestion, engine secured on rollout, swerved Regular two-engine landing, landed off center- 		••	• •	1P	• •	••
line, rough rudder correction back to center- line, blew tire/sheared gear.	••	••	••	3P	••	••
 Two-engine-out landing, swerve developed during engine reversal. 	2P	••	••	••		••
 Simulated engine failure on takeoff, swerve/ skid developed. 	3P	••	••	••		
TOTAL:	<u>6P</u>	<u>l</u>	1	10P	3	••
Poor aileron control.						
 Regular four-engine takeoff, crosswind cor- rection used, prop contacted runway. Landed off centerline, struck carrier catwalk 	1P	••	••	• •		••
on bolter.	••	••	••	1P	••	••
 Regular four-engine takeoff, lost control, wing struck runway. 	1P	• •		• •	• •	••
TOTAL:	2P	• •		1P		• •

,

.

- K. Misjudged safe speed and distance on landing rollout.

 - Overran runway. Attempted to furn off duty runway at high speed, gear collapsed. Ž.

TOTAL:

- L. Misjudged safe speed and distance on section takeoff causing a midair. 1. Wing aircraft overtook lead, midair after
 - liftoff.

TOTAL:

TOTAL ERROR, SEGMENT III:

Flight Segment IV: Inflight.

- Poor elevator control pilet induced aircraft stall or overstress during violent or unusual flight mannuvers due to poor elevator control/slow sirspeed/high nose attitude.
 - 1. During "SAM" radar breaking, tactical maneuverling.
 - 2. During dive bomb set-up, dive recovery, bombing pattern, tactical maneuvering.
 - 3. During ACM departure and maneuvering, tactical (1 mishap included overstressed aircráft).
 - 4. During missile firing and aircraft interception, tactical maneuvering.
 - 5. Authorized, low level, highspeed pass, non-tactical maneuvering.
 - 6. During wingover acrobatic maneuver, nontactical maneuvering.
 - 7. Evasive action to avoid mid-air collision while flying straight and level, non-tactical maneuvering (1 mishap included overstressed aircraft).

TOTAL:

- B. Misjudged safe speed and distance during formation, inflight refueling, or tactical maneuvering.
 - 1. During ACM, became disoriented or did not recognize a dangerous situation, causing midair or water collision.
 - 2. During form, tion flying, aircraft too close, wing flying incorrect position, mid-air collision.
 - 3. During inflight refueling, poor relative move-ment while being requeled, drogue damaged.
 - 4. Poor closure rate during rendezvous for formation flight or inflight refueling, mid-air on joinup.
 - 5. During missile firing and interception, poor closure rate on flare, midair.

ى بى بى بى د ئىپ يەتى سىكىسەتخىرىي يېچىق تىن

6. Poor depth/altitude perception during bombing, aircraft too low, damage from napalin explosion or collision with trees.

TOTAL.

	P-3 Aircra	<u>ft</u>	<u>F-4</u>			
Human Error	Major Accidents	Fatali- ties	Human Error	Major Accidents	Patali- tius	
1₽	••		1P		• •	
••		••	1P	••	••	
1P	••	• •	2P	* ¢	• • .	
	••	a •	18	2		
• •	• •	••	1P	2	••	
83P 1FE	4	7	95P 1FL	31	9	
••			2P	1	••	
••	••		3P	. 5	3	
•••		••	7P	4	4	
	••	• •	1P	1	••	
* •	••	••	1P	1	• • .	
••	••	••	1P	1	L	
••	••	¥ 4	2P	1	2	
••	••		19P	14	10	
••		••	4 P	5	4	
••	••		4P	5	1	
••	••	••	3P	• •		
••	••		5P	2	••	
••	••	••	1P	• -	• •	
••	• •	* *	2P	• •	· -	
	• •		19P	12	5	

		P-3 Aircraft		F-4 Aircraft		
	Human Error	Major Accidenta	Fatali- ties	Human Error	Major Accidents	Fatall- ties
C. Poor elevator control. 1. During dive bomb recovery relaxed pull-out, aircraft too low on recovery, damage from						
bomb explosion.	••	••	••	1P	••	••
2. Used positive "G" on bomb release, bomb collided with aircraft after release.	••	••	••	1 P	••	••
TOTAL:	••	••	• •	2P		••
 D. Poor throttle control. I. Inadvertent engine shutdown during formation rendezvous, high closure rate, throttles 						
snapped closed and were retarded to cut-off.		• •	• •	<u></u> [P	I	••
TOTAL:	• •	••	••	1 P	1	••
TOTAL ERROR, SEGMENT IV:	••	••	••	41P	27	15
TOTAL ERROR, ALL SEGMENTS:	1 F 95P	E 4	7	1FL 147P	59	24

.1