

The Naval Flight Surgeon's



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Pocket Reference to  
Aircraft Mishap  
Investigation

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The Naval Safety Center,  
Aeromedical Division

In conjunction with

Dedicated Aerospace Medicine  
Professionals

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Sixth Edition  
2006

# INTRODUCTION

Aircraft mishap investigation can be extremely difficult, time consuming, stressful, but also rewarding when we recognize that the contributions we make will improve aviation safety. A thorough mishap investigation is absolutely necessary to determine the cascading events causal to a mishap and recommending corrective actions to prevent recurrence. This sixth edition of the Pocket Reference introduces a new improved tool in accident investigation, the DoD Human Factors Analysis and Classification System (**DoD HFACS**) and its taxonomies. The DoD HFACS, has been adopted by the other services, will provide the accident investigator with a proven template that aids in organizing the investigation while providing a detailed analysis of human error for post-hoc mishap data analysis, revealing previously unidentified trends and hazards.

Historical data has shown that human error, by itself or in combination with other factors, is present in about 80% of aircraft mishaps, and is therefore the single greatest aviation hazard. As a member of an Aircraft Mishap Board (AMB), the Flight Surgeon is responsible for doing an exhaustive investigation in an area most likely to yield results: the medical and human-factors portion. Past investigations have shown that human factors are not limited to just pilot error. Human factors extend to aircraft maintainers, air-traffic controllers, the Squadron chain of command, Airwing, TYCOM, and can continue to CNO. The role of an investigating Flight Surgeon is not limited solely to an in-depth analysis of the individuals directly involved in the mishap, it must include all of the individuals and events that, through careful analysis, reveal the entire mishap chain.

How the Flight Surgeons meet their duties and responsibilities of a mishap investigation will affect their appraisal by their peers and seniors in the Navy as an officer, a Flight Surgeon, and a physician, perhaps to a larger extent than anything else he/she may do while on active duty. During an investigation, they should demonstrate the same respect for objectivity and confidentiality that is expected of the Flight Surgeon in his/her role as a personal physician. If, by his/her efforts as a physician and mishap investigator, a Flight Surgeon prevents one aviation mishap in a 20-year Naval career, he/she will have saved the Navy more than his/her entire career pay. While a Flight Surgeon may never have absolute proof that he/she prevented a mishap, they must always do their best to prevent damage, injury, or death.

Developing and maintaining sharp mishap-investigation skills is difficult, since most Flight Surgeons investigate mishaps infrequently. Consequently, it is easy to commit errors due to lack of experience and the rapid pace of the mishap investigation. And, as most mishaps occur at inconvenient times, to say the least, preparedness is

paramount. This reference was compiled to help the Flight Surgeon avoid some of the common pitfalls encountered in these infrequently, but chaotic situations.

The Flight Surgeon is both the Human Factors and Medical expert for the AMB. It is incumbent on the Flight Surgeon to prepare for this role and be able to provide on scene guidance to protect the team from biological, chemical, physical and environmental hazards. We have included a number of sections discussing biological and material hazards encountered during an investigation. Some hazards are not covered in this text. We advise that you work with your local fire/rescue teams and industrial hygiene professionals to better identify and prepare for the specific/unique hazards that your squadron's aircraft will present at the mishap site.

This reference is an adjunct to formal instructions that govern mishap investigation and is not meant to supplant the other references that address aeromedical aspects of mishap investigation. Use this guide as a ready reference in the field to make sure that your data retrieval is complete and that you preserve perishable evidence. It also may serve as a source for obtaining additional assistance.

## Acknowledgments

This is the sixth edition of the mishap investigation pocket reference. This edition is a result of a collaborative effort between contributors throughout Naval Aerospace Medicine. The goal of this edition is to provide both a print and electronic version of vital Aeromedical Mishap Investigation information to all members of Aircraft Mishap Investigation Teams. The electronic version is available on line at the Naval Safety Center's Home Page: <http://safetycenter.navy.mil>.

The Sixth Edition of this reference is available in an Adobe Acrobat <sup>®</sup> format and can be downloaded and printed by any interested party.

The Mishap Investigation Guide has traditionally been issued to all Naval Flight Surgeons as part of their basic training in Mishap Investigation at the Naval Aerospace Medical Institute in Pensacola, Florida. Recognizing the need for the continued publication of this reference, **The Society of United States Naval Flight Surgeons (SUSNFS)** underwrites the printing costs of this text as a service to its members. A printed version of this guide may be obtained by contacting the Society at <http://www.aerospacemed.org>

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## **Additional Mishap Investigation Resources Available on CD Version of this guide**

**AFPAM 91-211** USAF Guide to Aviation Safety Investigation

**AFI 91-204** USAF Safety Investigation and Reports

**TO 00-105E-9** USAF Aircraft Mishap Hazard & Rescue Information

**FAA Order 8020.11B** Aircraft Accident And Incident  
Notification, Investigation, And Reporting

**U.S. Army Accident Investigation Guide**

**DOD 6055.7** Accident Investigation, Reporting, and  
Record Keeping

**NTSB Major Investigations Manual**

# BACKGROUND INFORMATION AND DEFINITIONS

This section will provide the investigator with background information concerning duties and responsibilities of members of the medical department followed by basic definitions and information concerning the Naval Aviation Safety Program.

The goal of all Aviation Safety programs is to identify report then implement plans to eliminate hazards. This section defines the term hazard and provides guidance to Flight Surgeon for reporting hazards that fall into the aeromedical realm.

## **OPNAVINST 3750.6R Instructions to the Medical Department**

1. According to OPNAVINST 3750.6R, the Chief, Bureau of Medicine and Surgery (BUMED) shall:
  - a. Advise and assist in support of medical investigations into naval aviation mishaps.
  - b. Provide pathology services to process tissue from aviation mishaps as directed by this instruction, and **BUMEDINST 6510.2F**.
  - c. Train Flight Surgeons thoroughly in medical pre-mishap planning, medical investigation of aviation mishaps, and their role as members of Aviation Mishap Boards (AMBs).
  - d. Provide all aircrew with timely and complete medical services from properly trained and designated Flight Surgeons.
  
2. Commanding Officers, Naval Medical Facilities shall:
  - a. Train their staff members in the general medical and administrative requirements of this instruction.
  - b. Prepare and keep current a pre-mishap plan, and have ready both personnel and material to support the Naval Aviation Safety Program.
  - c. Train Flight Surgeons and prepare them fully for assignment to an AMB.
  - d. Provide a Flight Surgeon for appointment as an AMB member. If local medical facilities cannot provide, the controlling custodian will.
  - e. Provide facilities, material and personnel support for the immediate treatment and subsequent aeromedical evaluation of individuals from any branch of the Armed Services involved in an aircraft mishap.

3. Flight Surgeons, shall
  - a. Be thoroughly trained in human factors evaluation, medical pre-mishap planning, medical investigation of aviation mishaps, and their role as members of AMBs.
  - b. Be appointed in writing and participate fully in human factors councils and boards.
  - c. Be appointed in writing as a standing member of squadron/s (AMB).
  - d. Participate in pre-mishap planning for squadron and military treatment facility.
  - e. Participate fully in the investigation and reporting of physiologic hazards, human factor hazards or any other hazard with aeromedical implications.
  - f. When requested, immediately perform physical examinations and laboratory studies on individuals involved in an aviation mishap from any military service.
  - g. Participate in all salvage efforts whenever recovery may include human remains.
  - h. Participate fully in assigned mishap investigations and all deliberations of the AMB.
  - i. Provide the senior AMB member an Aeromedical Analysis in HFACS format that coincides with the finding of the Safety Investigation Report (SIR).

**NOTE: AMB duties take precedence over all others.** Any request for medical assistance from an AMB must be treated as a priority and handled with dispatch.

## **Basic Definitions**

### **1. The Naval Aviation Safety Program**

- a. The Naval Aviation Safety Program enhances operational readiness when it preserves the lives and enhances the well being of its members by protecting the equipment and material they need to accomplish their mission. The Naval Aviation Safety Program supports every aspect of naval aviation. Knowledge gained here may assist other safety efforts, yielding benefits and preserving resources far beyond its intended scope. The main document outlining the program is **OPNAVINST 3750.6**.
- b. The Naval Aviation Safety Program succeeds by preventing damage and injury. Potential causes of damage and injury under human control are termed hazards. The goal of the Naval Aviation Safety Program is to eliminate or control hazards.

### **2. Hazards**

- a. A hazard is a cause of damage or injury. The damage or injury either has occurred or has the potential to. In **OPNAVINST 3750.6** the term hazard is used in both senses. The term is also used synonymously with "mishap causal factors" and with "causal factors of damage and/or injury."
- b. Most mishaps result from a combination of two or more causal factors. Without one of them there would be no mishap. All cause factors are viewed as playing equal roles in causing a particular mishap. No attempt should be made to rank causal factors as "direct", "primary", "principle", "contributing", etc. Hazards vary according to the severity of damage and/or injury they are expected to cause and the probability of that severity.
- c. The same logic that applies to mishap causal factors also applies to the causal factors of damage and injury that occur in the course of a mishap.
- d. All causal factors are considered to be "under human control". Thus, as defined, all hazards can be eliminated and all mishaps can be prevented. NOTE: by this logic, environmental (weather) conditions are not hazards.

### 3. **Intent for Flight**

- a. Intent for flight for DOD aircraft is a prerequisite for the classification of a naval aircraft mishap as a Flight Mishap (**FM**) or Flight Related Mishap (**FRM**).
- b. Intent for flight exists when the aircraft or UAV's brakes are released or takeoff power is applied to begin an authorized flight. For catapult takeoffs, flight begins at first motion of the catapult after pilot has signaled readiness for launch. For UAV rocket-assisted takeoff (RATO), flight begins at the first sign of RATO bottle ignition. For UAV pneumatic launches, flight begins at first sign of pneumatic launcher motion after the pilot has signaled readiness for launch.
- c. Intent for flight continues until:
  - i. The aircraft or UAV taxis clear of the runway or landing area, or;
  - ii. Helicopter or vertical takeoff and landing (VTOL), flight ends when the aircraft has alighted at the termination of the flight and the landing gear supports the aircraft weight. Touch-and-go or stop-and-go landings are not terminations of flight.
  - iii. UAV flights end in the net or when captured by another recovery system.

### 4. **Naval Aircraft Mishap**

- a. A naval aviation mishap is an unplanned event or series of events, directly involving naval aircraft or UAVs which result in any of the following:
  - i. Damage in the amount of twenty thousand dollars or more to naval aircraft or UAVs, other aircraft (DOD or non-DOD), or property (DOD or non-DOD).
  - ii. Lost workday injuries - defined as causing the loss of 5 or more workdays (not including the day of injury)
  - iii. Damage incurred as a result of corrosion or fire that happens while the aircraft is awaiting salvage must also be included.

- b. Exceptions to the definition:
  - i. Intentional or expected damage to DOD equipment, property, aircraft, or UAVs, incurred during authorized testing or combat training.
  - ii. Intentional, controlled jettison or release, during flight, of canopies, cargo, doors, drag chutes, hatches, life rafts, auxiliary fuel tanks, missiles, target drones, rockets, conventional munitions, and externally carried equipment not essential to flight.
  - iii. Malfunctions or failures of parts due to normal wear provided: (1) the malfunction or failure is the only damage, and (2) the sole action is to replace or repair the part.
  - iv. Damage due to vandalism, riots, civil disorders, sabotage or felony.
  - v. Foreign Object Damage (FOD) to aircraft engines, air-breathing missiles, or drone engines when not caused by aircrew or maintenance personnel action or bird strike unless an injury is incurred or other aircraft structures suffer more than \$20,000.00 in damages.
  - vi. Occupational illnesses due to repeated exposure to environmental factors associated with the occupational environment. Report these illnesses per **OPNAVINST 5102.1C (NOTAL)** or **MCO 5101.8 (NOTAL)**.
  - vii. An injury sustained during a planned aircraft egress (such as parachute jump or rappelling) if the aircraft or aircrew did not contribute to the injury.
- c. The term "naval aircraft or UAV" refers to those aircraft and UAVs of the U.S. Navy, U.S. Naval Reserve, U.S. Marine Corps, and U.S. Marine Corps Reserve for which the naval aircraft accounting system requires accountability.
- d. A naval aircraft mishap may be considered over when the following conditions are met:
  - i. If there is an aircraft fire, the fire is out and the site is declared safe.

- ii. If there are pyrotechnics etc., they have been secured and the site is declared safe.
  - iii. If there are survivors, the survivors are safely rescued.
  - iv. If the survivors are severely injured, they come under the care of competent medical authority.
  - v. If there are fatalities, the fatalities are either recovered or officially presumed dead.
- e. A Naval aircraft mishap is a signal of a failure of the Naval Aviation Safety Program: It is evidence that hazards were not eradicated prior to their causing mishap level damage and/or injury. In case of a mishap, the hazard detection and elimination, which did not take place in time to prevent the mishap occurrence, must take place afterward to prevent mishap recurrence. Hazard detection after a mishap is accomplished through mishap investigation.
- f. The Naval Safety Center normally assigns a mishap to the reporting custodian and the controlling custodian whose aircraft is involved in the mishap, without consideration for cause factors. The reporting custodian is responsible for investigating and reporting the mishap. In any case where the accountability for a naval aircraft mishap is unclear, the Commander, Naval Safety Center, will make a determination.

## 5. **Damage and Injury**

- a. Damage and injury may be subdivided into mishap damage or injury and other damage or injury.
  - i. Mishap damage or injury. If the total severity of damage and injury meets the minimum established mishap severity criteria, that event is called a mishap. (See **Mishap**)
  - ii. Other damage or injury. Other damage or injury may occur in one of two ways:
    - Damage and/or injury that totals less than established mishap level criteria.

- Damage or injury occurring in the course of a mishap. A causal factor of damage occurring in the course of a mishap is any hazard which causes unnecessary/ avoidable damage, and a causal factor of injury occurring in the course of the mishap is any hazard which causes unnecessary/avoidable injury, etc. For example, a helicopter loses tail rotor authority and makes a theoretically survivable low impact crash (the mishap) but is quickly consumed in fire (other damage) because of non-crashworthy fuel cells. The fire burns the crew (other injury) because they were not wearing the proper flame resistant flight suits. Although there was only one mishap, there are three identified causes of damage and injury (hazards). (See Hazard Reporting)

b. **Physical injuries**

- i. A **reportable injury** is any bodily harm such as a cut, fracture, burn, or poisoning received while involved with naval aircraft or UAVs, so long as these injuries - updated until the final endorsement message has been sent - result from a single or one-day exposure to an external force, toxic substance, or physical agent, and result in a:
  - Fatality, regardless of the time between injury and death.
  - Permanent total disability.
  - Permanent partial disability.
  - 5 or more lost workdays not including day of injury.
- ii. For mishap reporting purposes the defined injuries are fatal injury, permanent total disability, permanent partial disability, lost workday injury - major, lost workday injury - minor, lost at sea and missing/unknown.

c. Injury Classification

- i. **Fatal injury**: An injury occurring during a mishap which results in death, regardless of the length of time between the mishap and sub-sequent death.
- ii. **Permanent Total Disability**: Any injury which, in the opinion of competent medical authority, permanently incapacitates someone to the extent they cannot pursue



gainful employment. In addition, the amputation of, or the loss of use, of both hands, or both feet; or loss of, or blindness in, both eyes, or a combination of any of these injuries as a result of a single mishap constitutes a permanent total disability.

- iii. **Permanent Partial Disability**: An injury which does not result in death or permanent total disability, but, in the opinion of competent medical authority, results in permanent impairment or loss of any part of the body, the loss of the great toe, the thumb, or an unreparable inguinal hernia, with the following exceptions:
  - Teeth.
  - The four smaller toes.
  - Distal phalanx of any finger.
  - Distal two phalanges of the little finger.
  - Repairable hernia.
  - Hair, skin, nails, or any subcutaneous tissue.
- iv. **Lost workday injury**: An injury, which does not result in death, permanent total disability or permanent partial disability, but results in 1 or more lost workdays, not including the day of injury. Lost workday injuries are further divided into major lost workday injury, (5 or more lost workdays) and minor lost workday injury, (more than one, but less than 5 lost workdays). Only a major lost workday injury requires a report; however, if a mishap report is submitted as a result of \$20,000 or more aircraft damage, then include all injury classifications.
- v. **First Aid Injury**: An injury with no lost workdays. Used when individuals are treated and released.
- vi. **No Injury**.
- vii. **Lost at Sea** \*
- viii. **Missing/Unknown** \*

\* Lost at sea and missing/unknown injuries equate to fatality for mishap severity level classification.

## **Mishap Classification**

### **Mishap Severity Classes**

#### **Class A:**

- Aircraft or UAV is destroyed or missing, or
- The total cost of damage to property or aircraft or UAVs is \$1,000,000 or greater, or
- A fatality occurs or there is an injury that results in permanent total disability.

#### **Class B:**

- The total cost of damage to property or aircraft or UAVs is \$200,000 or more, but less than \$1,000,000, or
- An injury that results in permanent partial disability, or
- Hospitalization of three or more personnel.

#### **Class C:**

- The total cost of damage to property or aircraft or UAVs is \$20,000 or more, but less than \$200,000, or
- An injury that results in 5 or more lost workdays.

#### **Hazard:**

- Any occurrence in which the total cost of property or aircraft or UAV damage is less than \$20,000, and
- There are no reportable injuries,
- The event is not an aviation mishap. Report these events as hazards.

### **Mishap Categories**

#### **Flight Mishap (FM):**

- This category encompasses those mishaps which result in \$20,000 or more damage to a DOD aircraft or UAV or, the loss of a DOD aircraft or UAV.
- When intent for flight for DOD aircraft or UAV existed at the time of the mishap.
- Other property damage, injury or death is irrelevant to this classification.

**Flight Related Mishap (FRM):**

- Those mishaps which result in less than \$20,000 damage to a DOD aircraft or UAV.
- When intent for flight existed at the time of the mishap,
- And, additionally, \$20,000 or more total DOD and non-DOD damage or a reportable injury or death occurred.

**Aircraft Ground Mishap (AGM):**

- Those mishaps in which the intent for flight did not exist,
- But a DOD aircraft or UAV was lost or more than \$20,000 damage was sustained by a DOD aircraft or UAV,
- Or DOD or non-DOD property was damaged in the amount of \$20,000 or more,
- Or a reportable injury or death occurred.

## Privileged Information

1. All naval aircraft mishap investigations are conducted solely for safety purposes. The success of the Naval Aviation Safety Program depends on the submission of complete, open and forthright information and opinions concerning safety matters.
2. Privileged information is information provided under a promise of confidentiality, or information, which would not have been discovered, but for information provided under a promise of confidentiality. The deliberative analyses, conclusions, and recommendations of the AMB are privileged. Also privileged is information directly calculated by the AMB or developed specifically by/for the AMB, if disclosing that information would reveal the AMB's deliberative process. Privileged information will be used for safety purposes only.
3. Photographs of a sensitive nature such as autopsy photographs or other photographs of the deceased and those photographs staged by the AMB that reveals its deliberative process are either privileged or protected in some other way. All other photographs are nonprivileged. However, captions and markings placed on photographs that are indicative of the AMB's deliberative process are privileged. The captions and markings only, not the photographs, are privileged.
4. Endorsements of SIRs are privileged.
5. The Naval Safety Center determines the privileged or nonprivileged status of all information contained in the SIR. All questions concerning privilege should be directed to the Naval Safety Center.
6. The purposes of employing Privileged Information directives are to:
  - a. Overcome any reluctance to reveal complete and candid information pertaining to the circumstances surrounding a mishap.
  - b. Encourage AMBs and endorsers of aircraft SIRs to provide complete, open and forthright information, opinions and recommendations regarding a mishap.

7. The purposes for which privileged safety information shall not be used are listed in OPNAVINST 3750.6R, and on the "Advice to Witnesses" form ([Appendix 6A in 3750.6](#)). That form says Privileged information shall not be used:
  - a. In any determination affecting my interests.
  - b. As evidence or to obtain evidence in determining misconduct or line-of-duty status of killed or injured personnel.
  - c. As evidence to determine responsibility from the standpoint of discipline.
  - d. As evidence to assert affirmative claims on behalf of the government.
  - e. As evidence to determine the liability of the government for property damage caused by a mishap.
  - f. As evidence before administrative bodies, such as Naval Aviator/Naval Flight Officer Evaluation Boards (USN) or Field Flight Performance Boards (USMC).
  - g. In any other punitive or administrative action taken by the Department of the Navy.
  - h. In any other investigation or report of the mishap about which I have been asked to provide information.
  
8. The rationale for having privileged information is as follows: If aircraft mishap investigators were unable to give an assurance of confidentiality, or if their promises were hollow, then input from witnesses, AMB members, endorsers and others might be incomplete or false. In order to continue the revelation, development, and submission of privileged information in aircraft safety investigation reports and endorsements, faith must be kept with the assurances of the limited use to be made of this information. Should privileged information be used for any purpose other than safety, credibility of future assurances would be lost.
  
9. In addition, it should be noted that:
  - a. Witnesses shall not provide statements to AMBs while under oath. Requiring them to do so is prohibited.
  - b. The AMB witness shall be advised, in writing, of the purposes for which their statement is being provided and the limited use to be made of the statement.
  - c. AMB members shall not, nor may they be requested to, divulge their own opinion or any information, which they arrived at, or to which they became privy, in their capacity as a member of an AMB.

- d. The exercise of command influence to edit, modify, or in any-way censor the content of SIRs is contrary to the spirit of the program and is prohibited.
10. Any individual having knowledge of the content of an aircraft SIR is prohibited from releasing that information, except per **OPNAVINST 3750.6**. Should any individual be contacted either formally or informally for such information, immediately contact the Naval Safety Center for guidance. This includes requests made under the Freedom of Information Act (FOIA).
11. **NOTE: Unauthorized disclosure of privileged information is a criminal offense punishable under Article 92, Uniform Code of Military Justice (UCMJ).**

## Hazard Reporting (SAMPLE HAZREP)

The primary mode for HAZREP reporting now is going through using the [Web Enabled Safety System \(WESS\)](#). This is online reporting using the Safety Center Web site. If online capability is not available, one can obtain an offline CD and mailing this back to the Naval Safety Center. CD can be obtain by calling 757-444-3520 x 7048 or 7148, [Cynthia.young@navy.mil](mailto:Cynthia.young@navy.mil)

1. A hazard is a **potential** cause of damage or injury that is under human control. The Naval Aviation Safety Program identifies and eliminates hazards before they result in mishaps. If this were completely successful, which it isn't, there would be no mishaps. Therefore, the following paragraphs explain how to detect and report hazards before a mishap occurs.
2. Each individual has an obligation to others in naval aviation to report hazards. The use of AMBs in the investigation and reporting of hazards is strongly recommended. When a naval aviation hazard has been detected a Hazard Report (HAZREP) should be submitted.
3. Purposes: There are four purposes for hazard reports, all of which are intended to eliminate hazards:
  - a. To report a hazard and the remedial action taken, so others may take similar action.
  - b. To report a hazard and recommend corrective action to others.
  - c. To report a hazard so some other organization may determine appropriate corrective action.
  - d. To document a continuing hazard in order to establish risk severity.
4. Hazard Detection: Analyzing, observing near-mishaps and incidents, conducting safety surveys, and reviewing command plans, policies, procedures and instructions will aid in detecting hazards before a mishap occurs. Operational Risk Management (ORM), applied in the planning stages of an operation, will identify hazards at the earliest possible opportunity. Individuals or commands with direct, first-hand knowledge of the circumstances surrounding a potential problem are most effective in hazard detection.
5. Submission Criteria
  - a. General Submission Criteria: A hazard is anything possessed of the potential to cause damage or injury. Submit a HAZREP whenever a hazard is detected or observed per [OPNAV 3750.6R](#)
  - b. Special Submission Criteria:
    - i. Whenever electromagnetic interference is encountered

- ii. Whenever unintentional incidences of Out-of-Control-Flight occur.
  - c. Reporting of Hazard Containing Human Factors: (See [Human Factors HAZREPS](#)).
  - d. Related Aviation Reports: Incidents that are reported in other formats may require a HAZREP to assist in data analysis.
  - e. Submission by an AMB investigating a Mishap.
  - f. Severe hazards identified during the SIR, which require immediate attention. Promptly submit a Hazard Report.
  - g. Hazards that are not causal factors in the mishap under investigation. Report such findings as a HAZREP, and not in the SIR.
6. Each of the following Identified Hazards requires a specific format:
- a. Bird/Animal Strike Hazard Report. ([Report Form](#)) ([SAMPLE](#))
  - b. Near Midair Collisions Hazard Report (NMAC). ([SAMPLE](#))
  - c. Physiological Episodes Hazard Report. ([See Physiologic Episode Hazard Reporting](#)) ([SAMPLE](#))
  - d. Embarked Landing Hazard Report. ([SAMPLE](#))
  - e. Air Traffic Control Hazard Report. ([SAMPLE](#))
7. Anonymous Hazard Reporting:  
Activities or individuals reluctant to identify themselves or their command may post, or E-mail, Hazard Report messages with COMNAVSAFECEN as the sole addressee.
8. HAZREPS are for "general use" (vice "safety purposes only," such as SIRS) and shall not contain privileged information.
9. DEADLINES: HAZREP deadlines vary:
- a. There are no time limits for submitting HAZREPS. Try to forward reports of hazards with a severe RAC within 24 hours of detecting the hazard. ([See Appendix M Risk Assessment Code](#)) Submit all other HAZREPS within 30 days following detection of the hazard.
  - b. Air Traffic Control HAZREPS. ([See 3750.6 for details](#))  
Gather information from tape recordings of air traffic control (ATC) communications or radar video in a timely manner. ATC erases these tapes after 15 days unless investigators request otherwise.



## Human Factor HAZREP (SAMPLE)

1. Naval Aviators have done a commendable job of detecting, analyzing, understanding, and correcting mechanical defects and faulty design features in the aircraft they fly. We have, however, been considerably less successful at understanding and combating those failings of a human kind, which continue to constitute upwards of 80% of the cause factors in Naval Aviation mishaps.
2. These human factors - personal and professional stress, physiological related impairment, lapses of attention, confusion, and willful violations of flying regulations, to name but a few, stand as the last great barrier between today's commendable mishap rates and the next breakthrough in Naval Aviation Safety. Our ability to accomplish the mission of Naval Aviation in the future will depend in large measure on how well we understand and control these aspects of human behavior in our aircrew and maintenance personnel today.
3. A Human Factors Hazard Report need embarrass no one. Where the anonymity of an individual or organization is a concern, send the HAZREP from a senior command, or use the provisions available in the paragraph covering Anonymous Hazard Reports. But, above all, never fail to report.
4. The requirement to analyze and report human factors in the WHO/WHAT/WHY format is now a requirement in HAZREPS.
5. A Flight Surgeon should be included in the investigation and reporting of Human Factors Hazards.

## Physiological Episode HAZREP (SAMPLE)

1. Physiological episode hazards are often under reported and history has proven these events to be significant factors in aviation mishaps. The Flight Surgeon or Physiologist is often the only member of the safety team notified of such events. It is incumbent on these individuals to notify the rest of the Command Safety Team and be a part of the investigation of these events. The HAZREP format is outlined in **3750.6R paragraph 419**.
2. A physiological episode can be considered to have occurred whenever any of the following conditions existed without a defined naval aircraft mishap:
  - a. Hypoxia, proven or suspected.
  - b. Carbon monoxide poisoning or other toxic exposure.
  - c. Decompression sickness because of evolved gas (bends, chokes, neurocirculatory collapse), or severe reaction to trapped gas resulting in incapacitation.
  - d. Hyperventilation.
  - e. Spatial disorientation or distraction resulting in unusual attitude.
  - f. Loss of consciousness for any cause.
  - g. An unintentional rapid decompression, exposing personnel to cabin altitudes above FL 250, regardless of whether dysbarism or hypoxia occurs.
  - h. Other psychological, pathological or physical problems manifest during or after actual flight or simulated flight in any aviation physiological or water survival training devices. Reporting trapped gas expansion, hyperventilation, and hypoxia episodes in the hypobaric chamber or GLOC episodes in the centrifuge are not required unless the event occurred outside the training protocol Recompression therapy for simulator training will be reported Under this instruction.
  - i. Training devices or simulators that cause personnel injury or fail to function as designed. For example: if a student experiences hypoxia because of faulty equipment, a Physiological Episode HAZREP would be required.

# PREMISHAP PLANNING

Premishap Planning is a critical step in safety planning for all aerospace medicine professionals who may be involved in aircraft accident investigation. Planning with local fire and rescue agencies, hospitals and other safety professionals can help decrease response times in the event of a mishap thus increasing the possibility of rescue of survivors. Additionally this planning will provide insight into the hazards present at a mishap site and decrease the chance that responders may sustain acute or chronic injuries.

An aerospace medicine professional's skills and insight are critical in the development of premishap plans for all aviation units and facilities that support aviation operations. This section provides guidance for aeromedical topics important in premishap planning.

## Aircraft Mishap Board

1. Each naval FM, FRM, and AGM shall be investigated and reported in accordance with **OPNAVINST 3750.6** by an aircraft mishap board (AMB).
2. Precedence: Mishap investigation and reporting responsibilities of AMB members shall take precedence over all other duties.
3. Membership: Minimum of 4 of the following:
  - a. Flight Surgeon.
  - b. Aviation Safety Officer (Safety Officer course graduate, if available).
  - c. Officer well-qualified in aircraft maintenance.
  - d. Officer well qualified in aircraft operations.
4. Standing Board:
  - a. Each aircraft reporting custodian (squadron) maintains a standing AMB appointed in writing, to immediately assume the mishap investigation responsibilities of the AMB when a mishap occurs.
  - b. Officers on exchange duty from other services (USA or foreign) are authorized to serve on AMBs but may not be the senior member.
  - c. Members shall maintain a thorough knowledge of Naval Aviation Safety Program (OPNAVINST 3750.6), the Guide to Mishap Investigation (**NAVAIR 00-80T-116-1, -2, and -3**), the squadron's safety program, and the squadron's premishap plan.
  - d. The board may be replaced entirely, in part, or not at all.

5. Required replacements for members of the Standing Board:
  - a. Personnel who were directly involved in a mishap shall not serve on an AMB conducting an investigation of that mishap.
  - b. For mishaps involving aircraft manned by an aircrew, at least one member of the AMB shall be a pilot NATOPS-qualified in the model aircraft involved in the mishap under investigation.
  - c. A member who has a personal interest in a mishap, which might conflict with the objective and impartial performance of AMB duties, shall not serve on an AMB conducting an investigation of that mishap.
  - d. Under no circumstances may an expected endorser of an SIR serve as a member of the AMB investigating the mishap, which will be the subject of that report.
  - e. AMB members shall not be assigned as members to any other investigation (e.g., JAG) of the same mishap.
  - f. The appointing authority, at the recommendation of the senior member, may make replacements and additions to the board.
  - g. Individual board members who feel their expertise is not needed for a given mishap investigation may be excused from active participation (but not the AMB itself) at the prerogative of the senior member.
6. Senior Member:
  - a. He shall be a Naval Aviator or naval flight officer.
  - b. He shall be senior to the pilot in command and mission commander involved in the mishap being investigated.
  - c. On all class A FM or FRM investigations, the senior member will be appointed by the aircraft controlling custodian from sources external to any reporting custodian involved in the mishap (if practical, outside the endorsing chain).
  - d. On all class A FM or FRM investigations, the senior member will be grade 05 or higher and a graduate of the Aviation Safety Officer Course or Aviation Command Course or have other suitable training or qualifications approved by the aircraft controlling custodian.
7. Additional Members: In unusual or complex mishaps, the AMB may benefit from having officers with specific expertise as members. In such cases the senior member should request the appointing authority assign these additional members (an

Aerospace Physiologist, in the event of a suspected physiologic episode or Aviation Life Support System (ALSS) concerns, or a Flight Deck Officer in the event of a significant event involving flight deck personnel) to the AMB.

8. Privilege: The privileged status of the information the AMB acquires is one of its most important tools in obtaining complete cooperation from witnesses and in determining the cause of the mishap. Each AMB member should understand that the information derived from his or her work is of a privileged nature and may be used only to improve flying safety within the Navy.  
(See Privilege)

## Aeromedical Safety Officer (AMSO)



1. The Aeromedical Safety Officer or AMSO can be located at the Wing (USN or USMC) or Group (USMC only) level. AMSOs for the most part are Aviation Physiologists. (Appendix C: AMSO phone numbers)
2. An AMSO should be included as an AMB member or technical-advisor-to-the-board in all Class-A mishaps where physiologic events occur or ALSS equipment is involved. A board that does not utilize the AMSO is often creating additional work for its members and may overlook important physiologic or ALSS issues. At a minimum, an AMSO can provide assistance in the following areas of expertise:
  - a. Aviation Life Support Systems.
  - b. Physiological issues.
  - c. OPNAVINST 3710 / 3750 / 4790.
  - d. Aeromedical Analysis preparation.
  - e. Human Factors.
  - f. Assist with the Human Factors Engineering (HFE) investigation (See Appendix X).
  - g. Augment the Flight Surgeon in his investigative efforts.

## Premishap Plans

Thorough squadron and medical facility premishap plans and regular premishap drills will greatly improve the response to a mishap. The squadron and supporting medical facility must have their own written premishap plan.

1. A good premishap plan includes:
  - a. Contingency arrangements with appropriate activities for:
    - i. Rescue.
    - ii. Fire fighting.
    - iii. Explosive ordnance disposal.
    - iv. Logistic support.
    - v. Site security.
    - vi. Photographic coverage.
    - vii. Medical support (military and civilian) that is compatible with the mass casualty plan and other premishap plans.
    - viii. Coordination with PAO for the release of information and handling of news media.
    - ix. Coordination with area law enforcement officials and coroner offices. (See Appendix Y)
    - x. AMSO assistance.
    - xi. Wreckage location, security, recovery, movement, preservation, reconstruction, disposal and release.
    - xii. Notification of key personnel.
  - b. AMB training.
  - c. Periodic drills of the premishap plan.
  - d. Contingencies for deployments.
  - e. Checklists to guide the actions of all cognizant personnel (SDO, CO, AMB members).
  - f. Reference to **OPNAVINST 3750.16** for the contingency of FAA or NTSB involvement.
  - g. References to **OPNAVINST 3750.6** (particularly the concept of privilege).
  - h. Reference to written agreements concerning the retrieval of remains and jurisdiction of autopsies. (See Appendix Y)
  - i. Policies for the collection of biological samples.
  - j. Adequate coverage of aeromedical concerns, including the specific Flight Surgeon's (by name and his alternate) designation in writing as a member of the AMB and an adequate description of the Flight Surgeon's responsibilities.
  - k. The listing of all other AMB members and outlines of their duties.

- l. A mishap investigation kit, with an accurate list of contents that highlights items with a short shelf life. (See Mishap Kit)
  - m. Describe the proper handling of post-mishap hazards: ordnance, ejection seats, liquid oxygen (LOX) bottles, canopy jettison cartridges, high-pressure tires, composite-fiber materials, etc.
  - n. Include guidance with respect to the collection of adjunct data (e.g., log books, flight schedules, NATOPS jackets, medical and dental records, DAPA, FAP, Psychology clinic records) including perishable data, such as weather data, tower tapes, ATC tapes and radar tapes.
  - o. Ensure completion of **Emergency Data Sheets** by all aircrew
2. In addition, as part of his premishap planning the Flight Surgeon should:
- a. Be thoroughly familiar with the aircraft, life-support systems, squadron mission and fellow squadron members.
  - b. Be an active member of his squadron's AMB and be thoroughly familiar with his squadron premishap plan.
  - c. Work with the Safety Officer to ensure adequate PPE supplies, planning and training for the AMB on Hazards at any mishap site including:
    - i. Biohazards.
    - ii. Respiratory hazards including composite fibers.
      - Fit check AMB for respirators.
      - Obtain appropriate respirators.
    - iii. Obtain MSDSs for known HAZMAT.
    - iv. Environmental Hazards.
      - Heat.
      - Cold.
      - Disease vectors.
      - Noise.
      - Abrasion / laceration hazards.
  - d. Periodically review the local medical facility's mass casualty plan and pre-mishap plan to ensure their adequacy and see that they are tested with regular drills.
  - e. Ensure that the local lab is prepared to handle post mishap lab collection efficiently. (See Lab Specimen Collection)
  - f. Identify local key personnel (such as AMSO and Tech Rep) and have their phone numbers at hand.
  - g. Identify the local coroner, determine jurisdiction, and have important phone numbers and letters of agreement concerning jurisdiction on file. (See Appendix Y)
  - h. Have the names and phone numbers of key personnel at the Naval Safety Center and AFIP readily available. (See



Appendix A, B, C, D).

- i. Identify nearest trauma and burn center, hyperbaric chamber, and back-up facilities.
- j. Review SAR and EMS procedures and equipment.
- k. Provide semiannual training to EMS personnel on:
  - i. Protection of EMS from Hazards at a mishap site.
  - ii. Treatment of ejection patients including spinal immobilization of all ejection patients.
- l. Review medevac (air and ground) procedures and equipment.
- m. Ensure that the team's immunizations comply with **BUMEDINST 6230**.
- n. Ensure you have a current passport.
- o. Ensure the adequacy of the MTF aeromedical mishap investigation kit. (See Mishap Kit)
- p. Along with the Safety Officer, ensure the adequacy of the squadron premishap plan (and test it with regular drills) and mishap investigation kit.
- q. Maintain a working knowledge of **OPNAVINST 3750.6** and his command's Aviation Safety Program.
- r. Review all of the above for deployments and detachments.

## Bloodborne Pathogens

1. During a mishap investigation, exposure to blood and bodily fluids is a possibility. The risk of bodily fluid exposure leading to infection by a bloodborne pathogen is becoming ever more significant. The Occupational Safety and Health Act (OSHA) has addressed this hazard potential in **29 CFR 1910.1030** and names aircraft mishap investigators as being "occupationally exposed to bloodborne pathogens". The purpose of this regulation is to limit the occupational exposure to potentially infectious materials, which could lead to disease transmission and illness.  
[http://www.osha-slc.gov/pls/oshaweb/owadis.show\\_document?p\\_table=STANDARDS&p\\_id=10051](http://www.osha-slc.gov/pls/oshaweb/owadis.show_document?p_table=STANDARDS&p_id=10051)
2. To comply with these federal guidelines the Navy updated **BUMEDINST 6280.1A - "Management of Infectious Waste"** instruction. This instruction outlines who is potentially exposed, how to handle, and how to package biohazardous materials.
3. The bloodborne pathogens of most concern include the Human Immunodeficiency Virus (HIV), the Hepatitis B & C Virus (HBV & HCV), Lyme disease, and Tetanus. Although HIV infection is the virus most feared, the HBV is more infectious and poses a greater threat. This is exemplified by the fact that HIV survives in dried blood for less than 24 hours, whereas HBV can survive in a dried state for one or more weeks. In remote or extended on-scene mishap investigations Lyme disease and community acquired infections may become the primary health concern for mishap-investigation personnel.
4. Four hazard control methods should be used to protect investigators and reclamation personnel from exposure to biohazards at the mishap site:
  - a. Familiarity with potential on-scene hazards.
  - b. Understand the risks of disease transmission and comply with protective practices.
  - c. Learn new investigation/reclamation habits BEFORE you get to the scene. Avoid habits that could lead to inadvertent contamination.
  - d. Provide annual refresher training for mishap investigators and reclamation specialists.
5. Engineering Controls:
  - a. Control entry into the mishap site by designating a biohazard area with a single entry/exit point.

- b. Establish a decontamination site at entry/exit point.
6. Work Practice Controls: (OSHA 29 CFR Part 1910.1030)
  - a. Avoid moving or bending sharp metal with bare hands.
  - b. Move fabric slowly to avoid aerosolizing pathogens and/or dust.
  - c. Walk cautiously over mishap material to avoid slips or falls. Walk around, versus over, the mishap wreckage.
  - d. Prohibit eating, drinking, or smoking in or near the mishap site.
  - e. If acceptable to the engineering investigator, decontaminate aircraft evidence and non-disposable tools with a 10% bleach solution for at least 10 minutes. (Caution: This solution can be corrosive to metals, especially aluminum. Consider whether disinfecting will destroy mishap evidence).
  - f. Wash hands with soap and water after removing personal protective equipment.
  - g. Cleanly package evidence in approved leak proof shipping containers and label as biohazardous material for transportation.
7. Use of Personal Protective Equipment (OSHA 29 CFR Part 1910.1030).
  - a. Handle all mishap material with gloves. Wear leather outer gloves to prevent punctures and cuts to the skin.
  - b. Wear Nitrile or latex inner gloves to prevent fluid contact with the skin.
  - c. Wear eye and face protection.
  - d. Wear puncture-proof footwear, preferably water proof and washable. Consider disposable over-boots.
  - e. Wear disposable outer Biohazard suits (Hazmat suits). Tape wrists and ankles.
8. Premishap Planning.
  - a. Protect yourself first, ...investigate second.
  - b. Anticipate handling of biohazardous materials and PLAN accordingly. You and your mishap response team must ensure that a "hazardous control plan" which clearly identifies personnel duties and specific procedures for handling potentially infectious waste is part of the pre-mishap plan.
  - c. Ensure mishap responders' immunizations are in compliance with BUMEDINST 6230.

- d. Initial annual training for mishap investigators in the subjects of biohazards, protection, and workplace practices. Make this chapter a topic in your annual unit AMB training.
  - e. Procure Biohazard suits, bags, and labels for proper I.D. and to mark off hazardous areas. Many commercial companies sell these Hazmat items. (See Mishap Kit).
  - f. Don't mix personal equipment with mishap-investigation equipment.
  - g. Have a bleach solution available to disinfect non-disposable investigation tools.
9. References:
- a. **Occupational Safety and Health Act (OSHA) 29 CFR 1910.1030**
  - b. **BUMEDINST 6280.1A - "Management of Infectious Waste"**
  - c. FAA Video "Aircraft Accidents and Bloodborne Pathogens: A Hazardous Combination" a 2 part movie available online at - <http://www.cami.jccbi.gov/National-Resource/CAMI21st.html>

**PLAY FAA VIDEO PART I**

**PLAY FAA VIDEO PART II**

## Composite-Fiber Material

1. Composite-fiber material is not something that should significantly alter a squadron's mishap response. Like many other substances in the mishap debris, it is to be understood and dealt with accordingly.
2. Technically, any non-homogenous material (e.g., plywood) could be called a composite material. However, in aviation the term has specific connotations. Advanced aviation composite structures consist of light, strong, stiff fibers, embedded in a "matrix" material. Composites offer two principal advantages: a significant reduction in aircraft weight, and outstanding resistance to fatigue, which lowers the lifetime cost of aircraft. The structural properties of composites, such as stiffness and tensile strength, often exceed those of high-strength metals. However, the materials - although very strong - usually are quite brittle (they tend to shatter on impact).
3. The reinforcing fiber most commonly used in aircraft structures is graphite, i.e., carbon. Bismaleimide (BMI) and boron fibers (such as kevlar) have seen some limited applications.
4. Epoxy is the matrix material that is used most. When epoxy burns, it readily releases the reinforcing fibers. Even after the visible flames are out, "smoldering combustion" can continue as long as unburned epoxy remains.
5. Results of studies to date seem to indicate that composite fibers pose no more danger than fibrous glass particles, and involve only short-term skin, eye, and respiratory irritations. However, their carcinogenic potential is unknown. Prudence requires the utilization of personal protective equipment. (See paragraph 11)
6. The following naval aircraft contain some composite material (with total composite material weight/percentage of structural weight in parenthesis):

V-22 (55%)	F-16N (176 lb./1.5%)	H-53E
AV-8B (1317 lb./26%)	H-46	S-3
F/A-18 (1000 lb./9.8%)	F-14A/D	EA-6
SH-60B/F	E-2C Radome	

7. In addition, helicopter rotors and fixed-wing propellers usually include some composite-fiber material.
8. Boron fibers pose only one major concern. When released from the epoxy matrix, whether by cutting, shattering or burning, the fiber becomes an extremely fine splinter. This splinter can easily be driven into the skin causing the same type of irritation as any metal or wood splinter. The best treatment is prevention: wear heavy leather gloves and use caution when handling broken parts with exposed fibers. Avoid walking through burned or damaged debris.
9. Graphite (carbon) fibers liberated by burning are reduced in size from their original form. A small percentage of the total fibers liberated are of a respirable geometry that may be deposited deep in the alveoli and theoretically may pose a threat similar to asbestos. Currently no scientific data supports this theory. Due to the potential hazard however, respiratory and skin-protection precautions are recommended by all services when working with burned composites.
10. Safety Officers should determine if their aircraft contain composite-fiber material and identify specific composite fiber components. Premishap plan training should include identifying the location of composite fiber components and their proper handling, depending on the presence or absence of fire.
11. In mishaps where burned composite fibers have been released due to fire, the following precautions should be taken:
  - a. All unnecessary personnel should be prevented from approaching the crash site. Personnel should be restricted from the area downwind of the fire/crash site.
  - b. While aircraft wreckage is still burning or smoking, only fire fighters and rescuers equipped with Self-Contained Breathing Apparatus (SCBA) will be in the immediate vicinity of the mishap until the fire chief advises the commander that the area is fire-safe. Advanced fire fighting techniques, equipment, and protection may be required, although the specifics are beyond the scope of this section. The on-scene commander will determine who is authorized to enter the mishap site, and when they may enter. Although proximity suits and SCBA should be adequate protection, fire fighters must be aware of the potential puncture/abrasion hazards associated with crash/fire-damaged composites.

- c. Once the fire is out and the wreckage has cooled, fire-damaged composite fibers should be sprayed down with a fixant, such as Polyacrylic Acid (PAA) (also known as B.F. Goodrich Carboset XI-11). If not available, acrylic floor wax will serve as an acceptable substitute to contain the release of composite-fiber material.
- d. One application of fixant does not permanently render the site "safe". Any time wreckage or dirt contaminated with burned composite material is moved, fibers can be liberated and repeat applications of fixant may be required.
- e. Personnel required to enter the mishap area should wear adequate protection. Personnel working with any burned composite materials or within 25 feet of such material shall wear the following protective equipment:
  - i. **Respiratory Protection:** wear NIOSH approved full-face or half-mask respirators with dual cartridges for organic vapors (for protection from jet fuel) and for dust, mist, and fumes (for airborne particulate fibers and other dust). All personnel must be fit tested and properly trained in the use of respirators. The use of full-face respirators is recommended because they will eliminate the need for safety goggles.
  - ii. **Eye Protection:** Non-vented safety goggles that minimize particulate/fiber entry, shall be worn when a half-face respirator is used. Safety glasses with side shields are not recommended within the 25 ft boundary area of the mishap site.
  - iii. **Skin Protection:**
    - **Coveralls** - Tyvek hooded coveralls are required (Tyvek suits coated with 1.25 mil polyethylene will provide additional protection against fuel and biohazards). The coveralls should have a zipper front, elastic sleeves, legs, and drawstring hood. External booties will eliminate possible boot contamination and reduce dermal contact potential. They are recommended when available. Any openings or attachment points, especially at the ankles and wrists, should be sealed with duct-tape to keep out particulates.
    - **Gloves** - Puncture resistant leather gloves shall be worn as a minimum. Optimally, Nitrile gloves shall be worn as an insert to the leather glove to protect against bloodborne pathogens, solvent residue, and fuel spills. The installation industrial<sup>30</sup>

hygienist will determine any additional specific protection requirements.

**Caution:** Do not wear Nitrile rubber gloves when handling burning or smoking composite materials.

- **Boots** - Steel-toed shoes/boots should be worn.
- f. Likewise, if personnel are breaking or cutting either burned or unburned composite parts, the same personal protective equipment (PPE) requirements apply.
  12. Once fixant has contained composite fiber material, the use of NIOSH approved industrial dust masks, gloves, safety goggles and Tyvek coveralls are considered sufficient for work around the crash site where composite-fiber material is not being stirred up.
  13. Burned composite-fiber material that requires EI analysis should be treated with a fixant and wrapped in heavy-duty plastic wrap before packaging for shipping.
  14. Composite material that is not required for investigation purposes or for which analysis is complete should be wrapped in plastic, labeled as DO NOT INCINERATE, and disposed of at an approved hazardous material waste site.
  15. All mishap-site personnel should be provided with a suitable shower facility prior to going off duty. To remove composite fiber from the skin, sprinkle talcum powder over the affected area and rub gently with a nylon stocking until the fiber is snagged.
  16. The Flight Surgeon assigned to the AMB should contact the nearest Naval Medical Command Industrial Hygienist. The Flight Surgeon, in turn, will be provided with the latest information and procedures concerning composite fiber hazard mitigation. The Flight Surgeon should also review the references concerning composite material in the **reference section** of this guide.
  17. Personnel involved in cleanup or handling of large quantities of wreckage should wear the same PPE as noted above for those entering a composite-material mishap site that has not been treated with fixative.
  18. **View Real Media .rm video on Composite Material** requires Real Player from <http://www.real.com/>



## Aeromedical Mishap Investigation Kit

1. An aeromedical mishap kit should be maintained at all Military Treatment Facilities that support flight operations. This includes ships that support high tempo flight operations. The Flight Surgeons / AVTs should be responsible for inventory. The Mishap Investigation Kit should be compact, portable (should fit in a backpack) and ready for immediate use. The precise contents will depend on the geography, aircraft type and mission and should be designed for the worst-case scenario. The clinic kit is designed to augment the mishap kit kept by operational units.
2. Each Flight Surgeon should keep a small "go kit" of personal items.

Medical/Recovery	References/Forms
Surgical gloves & Masks	MTF Pre-mishap Plan
Scissors, Forceps	Inventory of kit with <u>expiration dates</u>
Scalpel & Blades	This mishap investigation reference
Tissue collection kits (min 4)*	Index cards
Plastic bags (various sizes)	3750.6 Appendix N forms
Anti-Microbial hand soap	SF 523: authorization for autopsy
Anti-Microbial towelettes or	SF 600 forms (progress notes)
Waterless instant hand cleaner	Grounding notices (down chits)
Body bags and liners - due to size keep separately from portable kit	Clearance notices (up chits)
	OPNAVINST 3750.6 w/appendices
	Toxicological exam forms (AFIP Form 1323)
	Memorandum Notebook (small)
	Aeromedical Questionnaires
* Post-Mishap Tissue Collection Kit - 1 prepackaged bag for each person containing at least: 3 Red tops, 2 Purple tops, 2 Gray tops, 1 Urine cup, Betadine swabs, Sterile 2x2s, Tourniquet, Venipuncture syringe, Needles, Labels, Lab chits, Blood drawing instructions, 1 AFIP Form 1323 form per patient.	

Analysis Kit	
2 Mini-Audio Cassette Recorders w/counter	8 Mini Audio Cassettes
Digital Camera 35 -105 Zoom/Macro	Lensatic Compass
Or Camera: 35mm (35-105 Zoom/Macro)	Camera Flash
Color print/slide film-many rolls	Ruler (clear plastic)
Pens, Perm Magic Markers, Paint Markers	Graph Paper (polar, grid)
Tape Measure (100 ft long)	**Red Flagged Wire stakes
Fresh and Spare Batteries*	Tags
*NOTE: <b>DO NOT</b> store batteries inside electronic equipment as they will leak and damage equipment.	
** Role of 100 wire Surveyor's stakes available at hardware store for a few dollars.	

<b>Other Items Often Useful at the Mishap Site</b>	
Medical bag	First-aid kit
Rubber bands, strip ties	Water 5 gallon cooler
Fluid sample bottles	Purchase forms (SF 44)
Air navigation plotter	Inspection mirror
NATOPS manual	Whiteboard and markers
Aircraft Maintenance Manual	Magnifying glass
Protractor	Calculator with trig functions
Calipers	Chem lights
Dusting brush	

3. The following list contains examples of the PPE. Equip clinic mishap kits with sufficient stock to protect 10 personnel. Be prepared to reorder immediately for high casualty mishaps.

<b>Personal Protective Equipment (PPE)</b>	
*Disposable over boots	Steel Toed Hard soled boots
**NITRILE 6 mil long cuff gloves	Leather Gloves assorted sizes
Biohazard Warning signs	Warning flagging Tape
Duct Tape	Ear plugs
Safety Goggles	NSN 4240-01-433-8719
Tyvek <sup>®</sup> disposable coveralls w/Hood and booties (w/Olefin coating) (CANARY SUIT)	NSN 8415-01-254-0667
Dust mask	NSN 4240-00-629-8199
Respirators (FIT CHECK REQUIRED)	(See Pre-mishap planning)
Half-mask Small	NSN 4240-01-312-8702
Half-mask Medium	
Half-mask Large	NSN 4240-01-086-7670
Dust and Mist filter	NSN 4240-01-230-6895
***Chlorine bleach solution	Plastic bucket / basin for disinfecting
* Disposable over boots may prevent biohazard contamination of shoes.	
**Nitrile gloves resist chemicals better than latex but must be worn under leather gloves when abrasion/puncture is possible.	
***Household Chlorine bleach diluted 1:10 with clear water is recommended for disinfecting biohazard contaminated items.	

4. Consider the following items for a personal go kit:

<b>Personal Items</b>	
Water (canteen)	Water Purification Tabs
Pocket knife/Multi-tool	Food (MREs/food bars)
Sunscreen	Insect Repellent
Hat with brim / Sunglasses	Mints or gum
Flashlight (bulb, batteries)	Poncho
Heavy Work Gloves	Toilet paper
Passport/Immunization record	35mm Disposable Camera /flash
Note book	Chap stick
Vicks Vapor rub	
Cell Phone - Can be useful if service available at mishap site.	

## POST MISHAP DUTIES

The role of all aeromedical professionals involved in the initial phase of a response to a mishap is to ensure the safe triage, treatment, movement and evacuation of casualties. Our first duty is to preserve life and prevent further harm. This must be done with the knowledge that a mishap site is a hazardous environment and safety on the site is paramount. In addition to the care of the survivors we are responsible for gathering and preserving perishable evidence. This evidence includes interviews and examinations of survivors.

This section provides guidance concerning the many duties of a Flight Surgeon post mishap.

### Immediate Post-Mishap Duties of the Flight Surgeon

1. **Safety Is Paramount.** Do not enter a mishap site to triage or treat until cleared by crash rescue. Mishap sites are hazardous and we do not need additional victims.
2. The first priority is the safe triage, treatment, movement and evacuation of casualties. Always strive to preserve life and prevent further harm.
3. If fatalities occur, determine jurisdiction (See [autopsy and Appendix Y](#)), bodies of deceased personnel should be covered and left where they are for the period required to take photographs or make sketches documenting their posture and relative position within the mishap site before the remains are moved. (See [Photography](#)). Do not move bodies until you are sure you have authority to do so from a local coroner or AFIP. (See [autopsy and Appendix Y](#)). Call the AFIP, the Aeromedical Division at the Naval Safety Center and the local coroner early on.
4. Draw appropriate labs. (See [Lab Specimen Collection](#))
5. Do physical exams. (See [Post Mishap Physical Examination](#)) The services have agreed that the first Flight Surgeon to whom mishap victims are brought shall immediately perform examinations and laboratory procedures required by the Flight Surgeon's service.
6. If possible keep survivors separate until after conducting interviews.

7. Obtain a taped statement and interview from each member of the aircrew (and possibly air traffic controllers or plane captains, etc., as appropriate) recounting the mishap from brief to rescue. (See Appendix I & J and Interviewing). If a tape recorder is not available, obtain a written statement following taped interview guidelines.
8. Distribute the post-mishap aeromedical questionnaires and the 72-hour history forms. (See Appendix K and Q)
9. Notify MTF commander of mishap.
10. Impound flight equipment and medical and dental records, obtain mental health, substance abuse (DAPA) and Family Advocacy patient records.
11. Make appropriate aeromedical disposition for ALL aircrew.
12. Notifying the next of kin is the duty of the Commanding Officer. Usually a Chaplain and if requested, a Flight Surgeon accompanies the CO.

## Post Mishap Physical Examination

1. Requirement:  
Immediately post mishap, a physical examination, of all crewmembers and if indicated, passengers, and anyone else who may have been a causal factor of the mishap, shall be performed. All branches of the armed services have agreed that the first Flight Surgeon to whom mishap victims are brought shall immediately perform examinations and laboratory procedures required by the Flight Surgeon's service.
2. The exam should be as complete as the examinee's condition and other circumstances permit, with special emphasis on those areas that may be pertinent to mishap causal factors. Documentation can be made on **Chronological Record of Medical Care (SF 600)**, **Physical Examination Forms (SF 88 and 93)**, or a civilian / military emergency room treatment record. Attempts should be made to gather the following minimum information.
  - a. History: A complete medical history is essential. Note all changes from the last recorded history and note if changes were present before, or as a result of, the mishap. Be sure to make note of any medical waivers, medications, herbal preparations, nutritional supplements or other alternative medicine modalities used. Have patient complete **72-hour history** as soon as practical. (See **72-Hour history**) A history of activities beyond the prior 72 hours may be indicated if there are concerns of long term fatigue. USAF requires a 14-day history in addition to the 72-Hour history.
  - b. Physical examination:
    - i. Vital signs - complete, include height and weight (out of flight gear).
    - ii. HEENT as complete as possible, include distant and near visual acuity with and without corrective lenses worn during the mishap (if possible). Audiograms if indicated.
    - iii. Cardiopulmonary exam - complete, ECG and CXR only if clinically indicated.
    - iv. Abdominal examination - complete.

- v. GU/Rectal - if clinically indicated.
  - vi. Spine and Extremities - do a complete exam, document all injuries and limitations in range of motion. (Note if they were pre-existing)
  - vii. Neurological Examination - required and should be as in-depth as possible.
- c. Labs: See [\(Survivor Laboratory Specimen Collection\)](#)
  - d. Radiography: Perform radiological studies: as clinically indicated, after all ejections, bailouts, & crashes with or without suspected back injuries, full spinal radiographs are required.
3. Medical Photography: Obtain photographic documentation of all injuries. Utilize a medical or base photographer if possible. [\(See Photography\)](#)
  4. Make the appropriate aeromedical dispositions. Remember, the Flight Surgeon's history and physical exam have priority over any other interviews.
  5. Submission: Submit all history and physical examinations as an attachment to the Aeromedical Analysis.
  6. Submit copies of last two history and physical examinations along with copies of all BUPERS waiver letters as an attachment to the Aeromedical Analysis.

## Survivor Laboratory Specimen Collection

- In all class A and B mishaps, and when deemed necessary in class C mishaps, biological sampling should take place. Immediately after a mishap, sufficient blood and urine should be taken for the determination of blood alcohol, glucose, carbon monoxide, drug screen, hematocrit and hemoglobin and urinalysis. **Lab results** are factual evidence and are **not privileged** information. Ensure chain of custody is maintained using **AFIP Form 1323** for each individual. Results for each individual tested will be recorded on a separate Appendix N **FORM SIR 3750/3** and submitted as an attachment on side A of the SIR

- AFIP requests that the following specimens be collected:

Serum:	14-20 ml (no preservatives, red top)
Blood:	14-20 ml (NaF, gray top)
	14-20 ml (EDTA, purple top)
Urine:	70 ml is optimum (no preservatives)

- However, as a practical guide, as soon as possible after a mishap collect from each of the aircrew (as well as anyone else who may have been a factor in the mishap) at least: 2-3 red tops, 2 gray tops, 2 lavender tops, 100 ml urine.

- NOTE: Prepare skin with Betadine or soap & water.

### **DO NOT USE ALCOHOL.**

Locally run	AFIP run	Held frozen > 90 days
Serum glucose	EtOH level	Drug screen
CBC	CO level	
UA (routine & micro)	Drug screen	
SMA-18		
1 gray top	7-14 ml, 1 gray top	1 red top (serum)
1 purple top	7-14 ml, 1 purple top	
Urine	5-10 ml 1 red top (serum)	10 ml urine
1 red top (serum)	70 ml urine (no preservatives)	

\*DO NOT use SST / CORVAC / Tiger Top tubes for blood collection; the serum-separating gel has been shown to absorb certain classes of drugs.

4. The JAG investigator will want the "objective" lab results and he/she is entitled to them, but you are not required to provide them yourself.

5. AFIP routinely screens for:

Amphetamines	Opiates	Propoxyphene
Barbiturates	Phencyclidine	Salicylates
Cocaine	Cannabinoids	Acetaminophen
Methaqualone	Benzodiazepine	Phenothiazines
Antihistamines	Nicotine	Ibuprofen

6. The actual number of substances examined exceeds 35,000. Despite this impressive capability, substances are still missed because of their short half-life, limited tissue distribution, etc. However, the chances of recovery are substantially improved if the toxicology investigation is directed. Therefore, if there is a drug that you would like tested for, specify that on the AFIP Form 1323 (Toxicological Examination -- Request and Report Form) and call AFIP to discuss your request. AFIP also recommends that a brief summary of the patient's health status and the mishap be enclosed. This information can help the toxicologist select special procedures to supplement the routine analysis.
7. Each specimen should be individually labeled with name and SSN, wrapped in an absorbent packing material and then placed in a heat-sealed or zip-lock plastic bag; blood and urine should be packaged separately. Next, place all specimens and paperwork (paperwork should be sealed in a separate plastic bag) from a single individual in another heat sealed or zip-lock plastic bag; do not package different types of specimens together nor package more than one set of patient specimens in each bag. The blood and/or urine should be packed, unfrozen, in a shipping container of sturdy cardboard, plastic or metal construction, sealed, and then sent by the fastest means possible to the AFIP, such as Federal Express<sup>®</sup>, U.S. Priority Mail or U.S. Second-Day Mail. **DO NOT** send package(s) by Registered, Certified, Air Freight or "Return Receipt Requested" as this will cause significant delays in the delivery of the specimens. Each individual's set of specimens submitted must have an accompanying **AFIP Form 1323** and any other documentation pertinent to the case (paperwork should be sealed in a separate plastic bag).



8. Note that failure to submit a properly completed **AFIP Form 1323** for each sample will delay processing, may result in an incomplete analysis of the submitted specimens and may cause test results to be returned to the wrong address. Address packages as follows:

Armed Forces Institute of Pathology  
ATTN: Division of Forensic Toxicology  
Bldg. 54  
6825 16th Street, NW  
Washington, DC 20306-6000

9. Note: AFIP is not equipped to run a CBC, SMA-6, UA, etc.
10. AFIP cannot bail you out if you or your lab errs.
11. Additional information concerning AFIP forensic toxicology can be obtained online at:  
<http://www.afip.org/Departments/oafme/tox/tox.html>  
Or in the: **AFIP Guide to Collection and Shipping of Toxicologic Samples, March 2002** .
12. Per **SECNAVINST 5300.28 paragraph 3a(4) and paragraph 4**, biological samples collected following an aircraft mishap are considered command directed tests and can be used for administrative purposes but not for disciplinary purposes.

## Other Flight Surgeon Duties

1. Ascertain and document all injuries of crew, passengers, and other personnel involved in the mishap.
2. Coordinate with AFIP, know autopsy jurisdiction, (See [Autopsy and Appendix Y](#)) and help provide support for the AFIP team, (such as helicopter transport to the mishap site) and assist at the autopsy. See that dental comparison and fingerprinting are done, arrange for dry ice and have the NATOPS manual for the aircraft involved on hand.
3. Ensure all victims are free of firearms, pencil flare, smoke markers, or any other hazardous ordinance. You should work with EOD.
4. For fatalities, obtain full body radiographs in and out of flight equipment with emphasis on hands, feet, head and neck (AP and lat). Order special views whenever indicated (e.g., sinus series and obliques of the neck). (See [Autopsy](#))
5. Submit lab specimens etc. to AFIP as appropriate. (See [Survivor Lab Specimen Collection & Fatalities Without AFIP](#))
6. Collect the post-mishap aeromedical questionnaire form ([Appendix K](#)). In the case of fatalities, the [72-hour history](#) must be constructed from friends, coworkers & family of the deceased. Do not limit your history to the required 72 hours. Delve as far back as necessary. The spouse or friend interview guide in [NAVAIR 00-80T-116-3](#) is very good. Don't procrastinate.
7. Maintain close follow-up with those involved to monitor any changes in their medical condition and to obtain further elaboration on the mishap events.
8. Be sensitive to the psychological trauma a mishap may inflict on all, including those participating in remains recovery; counsel or refer as appropriate.
9. Participate fully in the AMB investigation and drafting the SIR, including the [SIR enclosure forms](#). (See [AMB & SIR](#))
10. Complete the Aeromedical Analysis (AA). (See [AA](#))

11. Together with the Safety Officer, submit the SIR enclosure forms and the AA. (See Appendix P)
12. Call NAVSAFECEN's Aeromedical Division as needed.

## Flight Surgeon Duties at the Mishap Site

The role of the Flight Surgeon at the mishap site is that of a professional investigator as well as that of a preventive medicine specialist. We must strive to gather data without damaging items that may provide additional information about the cause of the mishap. In addition we must ensure the health and well being of all personnel in and around the mishap site.

This section provides guidance on the duties of a Flight Surgeon at the mishap site.

1. **Safety Is Paramount.** Do not enter mishap site to triage or treat until cleared in by crash rescue. Mishap sites are hazardous and we do not need additional victims.
2. Care of survivors is the first priority. (See [Immediate post mishap duties](#))
3. The wreckage should be disturbed as little as possible in the process of removing survivors, but remember survivors come first.
4. Ensure that all compressed gas or pyrotechnic-actuated equipment (such as ejection seat cartridges, tip tank ejectors and all ammunition) have been safetied. Wait until cleared in by EOD.
5. Work with AMB and an Industrial hygiene specialist as needed to ensure the members of the AMB and recovery team are protected from all identified HAZMAT including bloodborne pathogens, composite fiber respiratory hazards, abrasion/laceration hazards, petrochemical hazards, and hydrazine to name a few. (See [Bloodborne Pathogens and Composite Fiber section](#))
6. Keep your hands in your pockets for the first walk-through.
7. Bodies of deceased personnel should be covered. (See [Immediate post mishap duties and Autopsy](#)) Moving bodies across county and state lines without permission is almost always illegal. (See [Appendix Y](#))
8. Body parts and any identifying personal articles should be tagged to identify their exact location. (See [Appendix S](#))

9. As a rule, body fluids from fatalities should NOT be collected on-the-scene. The autopsy is the proper time and place for the collection of body fluids for lab testing.
10. Ensure you work with EOD to remove pyrotechnic devices and firearms prior to moving the body. Do not remove flight equipment from the body before radiographs are taken prior to the autopsy.
11. All inquiries by the news media will be handled by the public affairs officer (PAO) or the senior member of the AMB only.
12. In remote sites the AMB Flight Surgeon may be the only medical care available. Ensure that contingency plans are in place for prevention and treatment of medical condition. The site should have basic first aid supplies and communications equipment to coordinate evacuation of injured personnel. Medevac contingencies should be planned.

## INVESTIGATION TOOLS

This section provides guidance to identify, gather and preserve perishable information. Some of the tools used are discussed in earlier sections.

### MISHAP INVESTIGATION TIPS

1. Safety is paramount. There has already been a mishap; do not have another while investigating the first.
2. Clues to the causes of the mishap are available from the first day; many deteriorate with time. Do not delay an investigation awaiting better conditions.
3. Avoid building a theory on a scrap of information. Look for multiple indicators.
4. Learn as much as possible from (exploit) the wreckage at the crash site before moving anything.
5. Do not rely on memory to retain your observations. Make notes, take photos, use a tape recorder.
6. Don't take shortcuts; you may unknowingly destroy clues.
7. Keep an open mind. Premature investment in a particular scenario/conclusion will taint evidence collection by steering the pursuit to that which supports the preconception.
8. Don't focus on one cause; a mishap is usually the convergence of multiple conditions (hazards).
9. Component or structural failures generally result from:
  - a. Inadequate design strength.
  - b. Excessive loading.
  - c. Loss of strength through wear, fatigue or corrosion.
10. Direction of flight can be inferred from the axis of wreckage distribution, fuel splash, ground scars and dirt throw. A fire pattern on ground is less reliable: it might start with a fuel splash, but is likely to wander according to surface wind, availability of dry foliage, or combustible fluids flowing with the slope.
11. Do not improve (wash, clean or brush off) dirty items before examination.
12. Do not alter positions of control dials, switches or mechanisms that until readings/positions are recorded. Photograph them.
13. Nuts and fittings can lose torque as result of impact shock or (in fire) heat. They are unlikely to spin off as result of either.
14. Hangar layout (wreckage display) is essential to a thorough investigation.
15. Items with high-mass for small surface area (generator, battery, engine, etc.) may break lose and travel great distances, usually continuing in the direction of flight.

16. Guidelines for working in committee:
  - a. Brainstorm to generate as many ideas as possible.
  - b. Utilize the HFACS template as a guide for evaluating all levels of events leading to the mishap.
  - c. No new idea should be considered too far out.
  - d. An idea is not personal property. Using or building upon other's ideas is to be supported.
  - e. Constructive criticism.
17. You need not work in isolation. Use resources. Call the Naval Safety Center with questions.
18. Don't give up.

#### **WRECKAGE** Evaluation, Recovery and Preservation

1. Safety of the investigation and recovery team is paramount.
2. Before evaluating the wreckage site, ensure that fires are out and ordnance (including escape systems) are disarmed, removed or isolated by qualified personnel.
3. The first walk-around should be with hands in pockets. It is a reconnaissance.
4. The wreckage should not be moved or disturbed for the first 24 hours unless to protect life or property, to facilitate essential military or civil activities, or to protect wreckage from loss or further damage. The purpose of the delay is to allow investigators to assess, plan, then proceed deliberately.
5. Ensure site security.
6. Work with the local Industrial Hygiene specialist to identify and diminish potential hazards (biological, respiratory).
7. Ensure personnel entering the mishap site are attired in appropriate PPE.
8. The Naval Safety Center investigator (if assigned) or the SIB Senior Member controls the wreckage and real evidence.
9. Photograph extensively. Film is cheap. ([See Photography](#))
10. The SIB should obtain fluid samples (fuel, oil, hydraulic) early for analysis.
11. Components (engines, ejection seats, hydraulic components, etc.) should not be dismantled in the field without a cognizant field activity (CFA) engineer present to direct disassembly. Field disassembly runs a high risk of losing vital detail: it will disturb the context of the installed part and spoil opportunity to conduct functional tests of the part as-found.
12. Utilize the Human Factors Engineering Guide (Appendix X) as a tool to investigate any element of aircraft or personal gear design, and aircrew/passenger-related indicators that suggest impaired performance, error in decision-making or operation, or other human-machine interactive variable.

13. Record (photograph) position of switches and instruments early.
14. Tag and identify parts before moving them.
15. Make or obtain wreckage diagrams. ([See Diagrams of Wreckage](#))
16. Do not reassemble broken pieces. Mating fracture surfaces risks altering (smearing) the texture of the fractures, making subsequent examination difficult.
17. If wreckage is underwater, photograph or video the scene before bringing up remains.
18. Submerged wreckage should be removed as soon as possible and anticorrosion measures taken (rinse with fresh water, coat with light oil).
19. During aircraft recovery where human fragmentation occurred, a medical representative should be on site to manage disposition of remains that might be located as wreckage is moved. (See Handling Fatalities without AFIP Assistance and Appendix S Search and Recovery of Remains)
20. Examination of the damage, its extent and distribution, at the crash site may reveal:
  - a. Angle of incidence.
  - b. Speed.
  - c. Attitude.
  - d. In-flight fire versus ground fire.
  - e. In-flight structural failure.
  - f. Aircraft configuration and integrity at impact.
  - g. Engine operation.
  - h. Whether ejection occurred.
21. The following may be evident from field examination or might require component shipment elsewhere for engineering investigation:
  - a. Position of flight controls, engine controls at impact.
  - b. Instrument readings.
  - c. Presence and type of contamination.
  - d. Ejection attempted, sequence interruption and cause.
  - e. Component operating at impact.
  - f. Electrical sources of fire ignition.
  - g. Type/source of combustible material.
  - h. Temperature profile of heat-distressed items.
  - i. Light bulb illumination at impact.
  - j. Trim settings.
  - k. Engine condition, or malfunction.
  - l. Thrust (demanded versus actual).
  - m. Propeller pitch.
22. Composite fiber materials deserve special attention. (See Composite Fiber Materials)
23. When all concurrent investigations (e.g., JAGMan investigation) have been completed, the senior member will release the wreckage and real evidence to the reporting custodian.



## INTERVIEWING

A successful interview is one that elicits information from a witness, sufficient for investigators to appreciate the event/subject as well as the witness did on beholding it (observer) or living it (involved in the sequence of events).

Avoid basing analysis or conclusions on a single interview. Various, seemingly unrelated, possibly contradictory contributions from multiple witnesses can reinforce or contradict other evidence the board acquires. Evaluation of the whole body of evidence must wait until later deliberations.

In the meantime, you will want to get witness contributions while they are fresh.

1. **Whom to interview:** In the broadest sense, anyone who might shed light on people, equipment and events culminating in the mishap. Usual subjects are:
  - a. Aircrew, passengers.
  - b. Air traffic controllers, plane captains, maintenance personnel, schedulers, operations, etc.
  - c. Witnesses who might have seen/heard events leading to, during, or after the mishap. Local authorities and news media responding to the event might have witnesses' names. One witness might lead to another: ask them.
  - d. Peers, friends and families of mishap personnel.
  - e. Rescuers and other first-responders.
  
2. **When to interview:**
  - a. As soon as possible after the mishap, before memories fade or are shaped by witnesses conferring with others. Witnesses should be interviewed singly. Although you cannot hold them in isolation, neither should you create opportunities for them to confer (waiting room scenario).
  - b. The board is small; witnesses can be many. Prioritize them according to their likely value and schedule accordingly.
  - c. Follow-on interviews with select witnesses might be needed to confirm, clarify or elaborate.
  
3. **Where to interview:**
  - a. An eyewitness is best interviewed at the spot where he/she viewed the mishap, to stimulate state dependent memory.
  - b. If not there (for eye-witnesses) and for all others, a quiet and private place.
  
4. **How to interview:**
  - a. Be prepared.
    - i. Plan the interview so it flows smoothly. A prepared list of questions is not necessary, but areas of concern should be addressed. (See [Appendix I & J](#)).
    - ii. Read a witness' written statement, if one has been provided. Be aware some people have limited writing ability.
    - iii. Witnesses shall not provide information under oath.
    - iv. Ideally, interviews would be one-on-one. Two-on-one is efficient for the board (while one asks a question, the other can take notes). Many-on-one is distinctly uncomfortable for the witness and will likely inhibit him/her. If two-on-one, make sure the second party is sitting where the witness can see them, but inconspicuously placed.

- b. Have a tape recorder and omni directional microphone ready. Make sure the combination works ahead of time, and load fresh tape and batteries.
- c. Stage the interview.
  - i. Dress as you expect the witness to be dressed.
  - ii. Arrange seating for conversation. Avoid a 'long, green table' setup. Sit level with the interviewee. Do not allow anything (desk, table, etc.) to come between you and the witness. If a table is necessary, sit at the corner with the witness.
  - iii. Make sure you will not be interrupted. No calls. No knocks on the door.
  - iv. Have an aircraft model and a whiteboard. The witness may be able to demonstrate by manipulation or diagram what he lacks words to convey.
  - v. Have coffee, water, etc., and offer them. Giving something instills trust and encourages the witness to talk freely.
- d. Style.
  - i. Your uniform, rank and official capacity are potentially intimidating. Allay discomfort, embarrassment, anxiety or shyness on the part of the interviewee. Approach the interviewee as an equal, especially with junior enlisted. Consider calling the witness by first name or using other informal manners.
  - ii. Avoid jargon and terminology that may confuse or intimidate.
  - iii. Do not assist the witness with terminology. The statement should be in words the witness understands.
  - iv. Do not interrupt the witness.
  - v. Observe non-verbal communication.
  - vi. Tolerate silence. Allow the interview to go as long as the witness needs.

5. **Opening the interview.**

- a. Introduce yourself, shake hands. Be friendly; make eye contact.
- b. State your function, the interview's purpose, who will hear the information and its confidentiality (if privileged).
- c. Tell the witness why their input is important to the investigation.
- d. Obtain sufficient identifying details (name, rank, position, telephone number) to ensure follow-up can be made easily.
- e. Have a witness directly involved in the mishap read and sign the "(Promise of Confidentiality) Advice to Witness" form (3750.6R Appendix 6A). Use (3750.6R Appendix 6B) "Advice to Witness" form for a witness not directly involved in the mishap; this form does not promise confidentiality and may be released under FOIA requests. Do not delay interviewing if forms are not at hand.
- f. Ask the witness' consent to using the tape recorder. If the witness objects, remove the tape and put the recorder/microphone aside, unused. If the witness consents, engage the recorder and put it out of the line of sight between you, so the witness is not distracted by its presence. With recorder running, state the date, name the personnel present at the proceeding, remark whether the interview is privileged and (if applicable) ask the witness if he understands the concept of privilege. Use a separate tape for each major witness.

6. **Begin**

- a. Start with questions the witness can answer easily ("are you well after the excitement?," vocation, aviation acquaintance, vantage point). The purpose is as much to allow the witness to become comfortable with talking as to elicit information.

b. If tape is running, concentrate on the witness, not your notes. If tape is not running, priority remains with keeping the witness engaged and talking. With two interviewers, one asks while the other takes note of highlights.

7. **Narrative**

- a. Use open-ended questions like, "What first drew your attention to the aircraft and what happened after that?"
- b. Do not interrupt. Let the witness talk.
- c. Reward the witness when he signifies his narrative is complete by expressing appreciation for his time and effort.
- d. There is no requirement for repetition, but if you want to hear the narrative again or from one point to another, invite the witness to do so. Bear in mind: he may wonder if you were paying attention.
- e. If you consider it helpful, you can play the tape for the witness to stimulate recall.

8. **Questions**

- a. After the narrative, specific questions are appropriate.
- b. Pose questions at the witness' level of acquaintance, as indicated in the preceding narrative.
- c. Questions become more specific as the interview progresses, but be careful not to get ahead of the interviewee. As questions move from general toward specific, jeopardy of leading the witness increases.
- d. Do not inform or educate the witness by providing detail or understanding he did not bring to the interview. Recognition memory exceeds recall memory; recall might be enhanced if the proper recognition cues are provided. Those cues should be gleaned from the witness' own account, not provided by the interviewer. See the progression of follow-up questions below as a means to elicit cues.
  - i. General: So, "the helicopter began to spin?" Please describe that again with as much detail you can recall.
  - ii. Less General: Now, "just as it began to spin, "what do you remember about this portion of the helicopter?" (pointing along the tail section of the model).
  - iii. Specific: So, about the moment the helicopter began to spin, can you remember anything about this area? (pointing to the tail rotor of the model).
  - iv. More Specific: Did you notice whether or not the tail rotor was spinning?
  - v. Note: The two general questions do not lead, and the information revealed by them is more likely to be accurate. With the specific question the witness may feel pressure to remember "something" and may report details he did not observe. The more specific question is leading and can contaminate the memory of the witness. It should be avoided or held to the last.
- e. Near the end of the interview ask the witness to try to think of anything he might have missed or would like to add.
- f. The closing question should be, "What do you think caused this mishap?" This question, when the witness is most comfortable with you, might give clues as to his biases.

9. **Points to consider:**

- a. Establishing a witness' credibility is important, but do not play the heavy. Avoid antagonism in the interview.
- b. Immediately after the interview write down your impressions, thoughts and concerns. Note your assessment of the witness' credibility.

- d. Transcribed witness statements do not have to be signed. A participating board member may attest to its accuracy as a record.
- e. Consider hypnotic or drug-assisted interviews only if critical safety-related information cannot be obtained any other way and the subject agrees voluntarily. Written permission must be obtained from CNO (N-88).
- f. A witness might regard the interview as a forum to voice opinions or grievances unrelated to the mishap. Do not engage a witness on moral or legal responsibility of the crew, Navy, or government. Steer the witness back to observations related to the mishap. This is an interview, not a free-ranging discussion; your purpose is to determine cause so like events can be prevented.
- g. Exaggeration can color an interview after a witness has repeated the story several times (fish story analogy). A witness might inflate or temper his account as result of peer pressure, or in response to interviewer's style (how questions are posed, nonverbal cues as answers are received). Witnesses tend to fill in blanks in their observations/memory after they have had time to apply logic or to adopt details from others.
- h. A witness' location (vantage point) might explain differences from others' accounts.
  - i. A witness downwind of a mishap may hear sounds not audible to an observer upwind.
  - ii. Sound deflected by walls or buildings may cause the witness to erroneously report direction, origin, or dynamic level.
  - iii. Background noise at a vantage point might mask sounds noted by observers elsewhere.
  - iv. A witness looking toward the sun sees a silhouette, while a witness whose back is to the sun may note color and other detail.
- i. A witness can confuse the sensory inputs of seeing the fireball of the crash and hearing the explosion of the crash. This confusion may make them think there was an inflight fire when there was not.
- j. A witness can transpose observed the order of events: recalls significant detail, but places them out of sequence (e.g, a distant witness beholds crash/flash/...boom and reports boom/flash/crash).

## PHOTOGRAPHY

Photos record evidence and are later employed for analysis and to illustrate reports.

At this writing, evidence standards for JAGMan investigation require traditional (film) photography. Digital or film photography are adequate for safety and engineering investigations.

### 1. **Privilege and Photography.**

- a. A photograph which records the as-found condition of an object or scene is real evidence, factual and *nonprivileged*. The same is true if scene is viewed from another angle or if an object is subsequently rolled/turned to expose its various sides (bear in mind you're altering the as-found condition, and the day is young). The same applies to subsequent views of aircraft and component disassembly, all the way down to microscopy and SEM. As-found or as-revealed: real evidence.
- b. Placement of a known object (ruler) or label ('north,' 'left wing,' '#1 engine') in the view for scale, clarity or orientation does not make a photo privileged.
- c. Captioning or marks which are speculative or reflect Board deliberative process will make a photo *privileged*.

d. A photo staged or arranged to illustrate a hypothetical condition or association is speculative on the Board's part and *privileged*. There is no prohibition on taking such photos. Simply observe that speculative content is not real evidence and requires limits on distribution.

e. Photos of injuries, fatalities and autopsy photos are *sensitive* information and are not for general distribution; these are usually included only in the Aeromedical Analysis.

f. An Aeromedical Analysis is a privileged document as a whole. Consequently photos within an AA are *privileged*, regardless of the image.

g. PLAT tapes are classified.

h. The SIB should have custody of negatives.

## 2. **Who shoots.**

a. The A Team. When possible, use an experienced photographer (photographer's mate). The product is superior, and the division of labor takes a load off the Board.

i. The photographer is a helpmate to accompany you and shoot as you direct; he is not an investigator or mind-reader.

ii. Tell him what objects/features are of interest. Give him a name for what he's shooting (he's keeping a log, but might not know an object's nomenclature). Ask for a wide shot to precede each detail/close-up shot.

b. The B Team. *Anyone* can point-and-click. Amateur photography beats none at all. Mishap site conditions are subject to change with time, weather and human activity. Do not forego timely photography for professional photography.

## 3. **What to shoot.**

Short answer: Just about everything. Longer answer follows. An investigation is occasioned by a mystery. A crash scene and evidence on it will change with each passing day, due to exposure to elements, vegetation's recovery and human activity. Until the investigation far along (weeks after the event), many things are of equal interest and their (original) conditions must be documented before changes occur. So...photograph anything for which the location, condition, number (or other descriptor) are curious.

## 4. **How to shoot.**

a. Number and identify pictures in a log as they are taken, noting location or subject. If privileged or sensitive, so note.

b. Overshoot and under-print. Film is cheap.

c. Use color film/imaging.

d. Consider using a small white-board (or notepad, or index card) to write captions on and place it in the foreground of pictures as they are taken.

e. A contact sheet (8x10) can hold up to 30 prints (thumbnails) so shoot 30 exposures on a 36-frame roll to keep things simple.

f. Use flash for fill-in (light in dark places), but avoid night photography unless you have auto-focus capability.

j. Use/place recognizable objects in the scene as size references when possible. In wide shots, the presence of a person may be sufficient. In close-ups, a hand or portion of a ruler works well.

k. The first shot of each roll should be of a color scale.

l. Consider taking photographs of a witness as he/she demonstrates what was seen (using an aircraft model). Likewise, a photo of an eye-witness at his/her vantage point shows field-of-view.

m. A military photo lab is preferred for security of film development. If you must use a commercial developer, give preference to one

which develops on-site with short turn-around; wait for your product and observe the proceedings to ensure all copies are delivered to you.

n. Although hundreds of photos may be taken, your report should include only those needed to illuminate the evidence for a reader.

5. **Equipment:**

- a. Conventional (film) photography:
  - i. 35mm SLR camera.
  - ii. ~35-110 mm zoom/macro lens.
  - iii. Electronic flash.
  - iv. Film, color print, 100-200 ASA, 6-10 rolls.
  - v. Field expedient (the show must go on): obtain a disposable camera from big-box or convenience store enroute to the crash site.
- b. Digital Photography
  - i. One megapixel or higher image resolution
  - ii. Zoom/macro capability
  - iii. Flash
  - iv. Universal/non-proprietary image format (e.g., .JPG)
  - v. Frequently backup to enduring media such as CD.
- c. Miscellaneous supplies:
  - i. Spare batteries.
  - ii. Ruler (6-12 inch).
  - iii. Notebook/pad (for photo log, and captioning shots)

6. **Scene coverage (ground):**

- a. Show enough background to provide orientation. Several pictures in a sweeping sequence can provide panoramic orientation. A wide shot, medium shot, and close-up may encompass the scene, if you have sufficient look-down on the site. Otherwise, shoot the big picture from four compass points.
- b. Bodies, ALSS (multiple views) in position before moving (the former are sensitive, but not privileged). Photograph large body part specimens close-up and in relation to the majority of the wreckage or mishap scene. Be sure the numbered tag is showing. (See Appendix S)
- c. Several views of major wreckage and parts.
- d. Detailed views of selected components:
  - i. Cockpit: instruments, switches, breakers, controls
  - ii. Flight control surfaces, actuators.
  - iii. Engine(s): inlet, discharge, accessories, connections.
  - vii. Fuselage skin: soot pattern, deformation, rupture.
  - viii. Equipment with curious damage.
- e. Ground scars, gouges and impact marks; include tree/obstacle strikes (if any) before ground impact.
- f. View from the vantage point of each eye-witness.

7. **Aerial coverage (usually by helo):**

- a. Overall area (will aid diagramming, plotting wreckage).
- b. Views from flight path into crash site
- c. Consider retracing the flight path using a video camera (same time of day if possible).

8. **Survivor coverage:**

- a. Multiple views in full flight equipment; close-up of damage to flight equipment.
- b. Views of injuries out of equipment; close-ups, if helpful.
- c. Views of survivor reenacting the mishap.

9. **Special Photography**

- a. Ultraviolet and Infrared Photography:
  - i. Special lighting (UV) and color filters (#12 yellow) might reveal features not visible to the eye.
  - ii. Infrared photography has been used for:
    - Wreckage in heavy foliage, or shallow water.
    - Identification of ground scars, tree strikes.
    - Fuel, oil spill patterns.
  - iii. These might require special film, a developing process other than the commonly-used available C-41 process.
- b. Photo Micrographs:
  - i. Ultra close-up pictures with high magnification. Typical documentation for scientific examinations.
- c. Stereo Photography:
  - i. If three-dimensional depth is important.

10. **Autopsy coverage:**

- a. AFIP might bring a photographer's mate.
- b. AFIP recommends bracketing all exposures.
- c. Total body photographs from all directions before removing flight equipment.
- d. Close-up views of damage to flight equipment and associated injuries (with and without a ruler).
- e. Close-up views of all exposed skin while in flight equipment (with and without a ruler).
- f. Total nude-body photographs from all directions.
- g. Close-ups of all wounds, anomalies and other findings.
- h. Other views as indicated.
- i. Photocopies of each exposed radiograph.
- j. Autopsy photographs are to be held by the Flight Surgeon member only and shared only when they are the subjects of AMB deliberations.
- k. Autopsy photographs are sensitive and not for routine distribution.
- l. Autopsy photographs and photos of victims that demonstrate useful information are mailed only to the Naval Safety Center, Code 14, Aeromedical Division (See AA and AA Distribution). Only in the case of AFIP not being directly involved in the autopsy will AFIP need copies of the photographs mailed to them along with the autopsy report.

**DIAGRAMS OF WRECKAGE**

Diagrams are helpful as records (the mishap site will change, wreckage will be relocated, ...) and analytical tools.

1. Use appropriate technology for the scale of the task. If distances are short, use a tape measure. If distances are great, use GPS.
2. There are multiple ways to depict wreckage distribution. Use one suited to the context of the site and wreckage.
  - a. A Polar Diagram is suited to wreckage distribution roughly concentric around the main impact point. Use the main impact point as the center and trace out, using a compass and tape measure (or walking wheel) to measure direction and distances. Use polar graph paper if possible.
  - b. A Linear Diagram is suited to wreckage distribution with a prominent long axis (typically flight path vector).

c. A Grid Diagram might be used if wreckage is widely scattered (multiple ground impacts, midair collision, inflight breakup). Establish a centerline line (cardinal compass points or flight path vector) and a baseline perpendicular to this line. Trace out from the flight path line, parallel to the baseline, at 25 to 50 foot intervals.

3. On diagrams, consider the entries below. (Note: to the extent any of these are deductive, the document becomes privileged.)

- a. Magnetic north.
- b. Impact points (ground and vertical obstructions).
- c. Flight path, wreckage vector.
- d. Scale and elevation.
- e. Significant aircraft parts.
- f. Crew locations.
- g. Ground fire limit.
- h. Ground markings.
- i. Witness location.
- j. Wind velocity, direction at mishap.
- k. Direction of the sun/moon at mishap.
- l. Direction to nearest airport, NAVAID, town, landmark.

4. Aids to site diagramming:

- a. GPS registration of salient points.
- b. Survey: Sea Bees, public works civil engineer.
- c. Sketch terrain cross section (for site with vertical development).
- d. Aerial photography.

#### **AVIATION LIFE SUPPORT SYSTEMS INVESTIGATION ASSISTANCE**

1. ALSS investigation is complex because it involves interfaces between personal flight equipment, life support systems, escape systems and survival equipment. Each of the preceding is a separate technical area, supported by engineering and technical personal at scattered locations. A mishap investigation usually requires concurrent attendance by several engineers/technicians to consider the combined systems as a committee.

2. Naval Air Systems Command's (NAVAIRSYSCOM) systematic approach to examining ALSS in aircraft mishaps is called the Mishap Investigation Support Team. MIST (led by an onsite coordinator) will provide factual data to the concurrent investigations (SIB, JAGMan) concerning the operation of the total egress system including factors that might have contributed to injury or fatality of aircrew. The MIST will provide a human factors engineering (HFE) evaluation and report of the ALSS. This report is non-privileged and is included as a Side A attachment to the SIR. For further information on HFE without MIST team assistance, see (Appendix X: Human Factors Engineering Investigation).

3. Mishap data from MIST investigations has proven essential to saving lives and provided the Naval Air Systems Team with information on ALSS involved in mishaps for inclusion in their database, for trend analysis, and to justify improvements.

4. MIST involvement in a mishap investigation is recommended if the aircrew experienced problems with ALSS resulting in serious injury or fatality. ALSS includes ejection and crashworthy seats, parachutes, propulsion systems, night vision devices and personal flight equipment. The Naval Safety Center



(NSC) Mishap Investigator detailed to a mishap investigation will contact the MIST coordinator for assistance. If a NSC investigator does not attend and MIST assistance is needed, contact the Naval Safety Center Code 13 or the MIST Coordinator below.

5. The NAVAIRSYSCOM MIST Coordinator is Mr. Mitch Mackenzie, based at NAWC-WD China Lake, California. He can be contacted at DSN 437-6132, Commercial (760) 939-6132, Cell (760) 382-9195, Pager 877-442-0384 (leave a commercial number).

6. Instructions for disposition of ALSS equipment are in paragraph 608 of OPNAVINST 3750.6R. For additional clarification contact the Naval Safety Center, Code 13.

### **FIRE INVESTIGATION**

1. Clues to the origin, progress and cause of fire can be gleaned from patient examination of wreckage. The task is made difficult by destruction of some parts as result of fire. Key questions are:
  - a. Was there an inflight fire?
  - b. Was there a ground or post-impact fire?
  - c. Where did fire start; what ignition and fuel were available at the location?
2. To start a fire, three conditions must exist: combustible material, oxidizer, ignition. To sustain the fire, ignition must be continuous or there must be enough heat to constitute a continuous ignition.
3. Flammable liquids (fuel, oil, hydraulic) burn as vapor. A mist (e.g., pressurized fluid escaping from a small orifice) behaves as a vapor, so it is possible to have fire conditions at temperatures lower than a liquid's flash (vapor) point. (See Appendix L)
4. Sources of ignition can include:
  - a. Hot surfaces (engine components, overheated equipment, bleed air duct, aux power units, inflight galley ...)
  - b. Electrical arc (short, static discharge, lightning)
  - c. Friction spark
5. Note the wreckage distribution for missing parts. Parts may have been burned off and may be lying along the flight path. If so, these would give evidence of fire inflight.
6. Note the state of fire extinguisher bottles and condition of fire detectors.
7. Note metal fractures that have been subjected to heat. Parts that fail at elevated temperatures leave clues that a structural engineer or metallurgist will recognize.
8. Note the status of self-locking nuts held by nylon that may have melted away.
9. Safety wire should remain following a normal ground fire.

10. If an inflight fire is contained by within the aircraft, it may be indistinguishable from a post-impact fire. A fire which burns through the structure/skin gains exposure to the slipstream. This creates two effects:

- a. It can increase the intensity of the fire. Inflight fires can burn in excess of 3000° F due to ram air replacing oxygen depleted in combustion. If melted components have a melting point above those typical in ground fire, inflight fire should be suspected. Temperature of ground fires is about 1600° to 2000° F. (See Appendix L)
- b. It will develop a fire pattern which flows with the slipstream.
  - i. Molten metal from an inflight fire will be splattered by the slipstream and found distal to the fire source; metal liquified by ground fire will drip with gravity and puddle.
  - ii. An inflight fire's soot pattern follows the airflow, which is usually the slipstream. The soot pattern of a ground fire usually flows upward and with the surface wind. (Soot does not adhere to surfaces hotter than 700°F.)

11. More on soot or char:

- a. Soot on fractured/torn edges indicates deposit after fracture.
- b. Scratches, scuffs and smears in soot/charred paint indicate damage after soot deposit/heat damage.
- c. Shadowing effect reveals airflow direction. Soot traveling with airflow deposits on the upstream side and flanks of an objects; the lee side will be clean. This applies all the way down to items as small as rivet heads.

12. Wreckage buried at impact (crater content) should not be exposed to post-impact fire; evidence of fire damage would indicate inflight fire.

13. Sometimes, the extent of aircraft destruction or the wide scatter at the site complicates appreciation of a soot pattern in the field. This is compounded when there has been a subsequent ground fire. Wreckage layout (2- or 3-dimensional) is helpful to evaluate signs of fire.

## Diagrams of Wreckage

1. Diagrams are helpful in many mishap investigations and are necessary for those without survivors, witnesses, or with suspected structural failure, in-flight break-up, or with midair collisions.
2. Depending on the type of mishap, there are three primary ways in which wreckage may be diagrammed:
  - a. **Polar Diagrams** are suited for mishaps in which the primary velocity vector is vertical, and thus the wreckage scatter pattern is roughly concentric around the main impact point. Use the main impact point as the center and trace out, using a compass and tape measure (or walking wheel) to measure direction and distances. Use polar graph paper if possible.
  - b. **Tear Drop Diagrams** are a variation of polar diagrams and are most effective if the scatter pattern falls along the main flight path vector.
  - c. **Grid Diagrams** are most effective if the scatter pattern is widely dispersed. Establish a line along the flight path vector, and a baseline perpendicular to this line prior to the first impact point. Trace out from the flight path line, parallel to the baseline, at 25 to 50 foot intervals.
3. On diagrams, consider including the following:
  - a. Date and time of mishap.
  - b. Type aircraft and registration number.
  - c. Magnetic north.
  - d. Point of initial contact.
  - e. Flight path vector.
  - f. Safety equipment.
  - g. Scale and elevation.
  - h. Significant aircraft parts.
  - i. Ejection seats.
  - j. Crew locations.
  - k. Ground fire limit.
  - l. Ground markings.
  - m. Witness location.
  - n. GPS registration of salient points.
    - i. Impact point.
    - ii. Furthest wreckage cast.
    - iii. Major components.
  - o. Prevailing wind velocity and direction at mishap.
  - p. Direction of the sun at mishap.
  - q. Phase of the moon at mishap.

- r. Degrees moon above the horizon at mishap.
  - s. Direction of the moon at mishap.
  - t. Direction to nearest airport.
  - u. Direction to nearest town.
  - v. Direction to nearest landmark.
  - w. Direction to nearest navigational aid.
4. Things to consider:
- a. Enlisting assistance from Sea Bees or public works surveyors in making diagrams.
  - b. Using terrain contour (cross section) diagrams if these might aid in investigation and evaluation.
  - c. Using aerial photography.
  - d. Using sketches.
- (See Appendix S)

## **Wreckage Evaluation, Recovery and Preservation**

1. Safety of the Investigation and recovery team is paramount.
2. Before evaluating the wreckage site, ensure that fires are out and ordnance, ejection seats, and CADs are disarmed, removed or isolated by qualified personnel.
3. Ensure Site security.
4. Work with the local Industrial Hygiene specialist to ensure that potential hazards including biological, respiratory - from fuels, hydrazine and composite material, and any other potential hazards are identified.
5. Ensure personnel entering the mishap site are attired in appropriate PPE.
6. The senior member of the AMB normally controls the wreckage and real evidence unless a Naval Safety Center investigator has been assigned, in which case the investigator controls wreckage and real evidence.
7. The first walk-through should be with your hands in your pockets. It is reconnaissance.
8. The wreckage should not be moved or disturbed for at least 24 hours except to protect life, limb, or property, to facilitate essential military or civil activities, or to protect the wreckage from loss or further damage.
9. Photograph with impunity. Film is cheap. (See [Photography](#))
10. The Naval Safety Center investigator or the maintenance member of the AMB will direct personnel to obtain perishable samples (fuel, oil, hydraulic fluid, soil, etc.) early.
11. Major components (engines, ejection seats, hydraulic components, etc.) should not be dismantled in the field without either a Naval Safety Center investigator or a designated cognizant field activity (CFA) engineer on site directing such disassembly. To ensure a quality engineering investigation, these experts are required and normally will not open or remove components except at the Naval Air Depot (NADEP) where the proper tools are located, laboratory facilities are available and

the disassembly can be conducted and recorded accurately.

12. Utilize the Human Factors Engineering Guide ([Appendix X](#)) as a tool to the investigation of any element(s) of aircraft or personal gear design, as well as aircrew/passenger-related indicators that may suggest impairment of performance, error in decision-making or operation, or other such human-machine interactive variable.
13. Record the position of switches and instruments early and always be suspect of the switch position while analyzing the mishap evidence. Photographs are adequate for this purpose.
14. Tag and identify parts prior to moving them.
15. Make or obtain detailed wreckage diagrams. ([See Diagrams of Wreckage](#))
16. Never allow anything to touch the fracture surfaces of broken parts. Never put broken parts back together again. Preserve the fracture surfaces unaltered for examination by a failure analyst.
17. If the wreckage is underwater, photograph or vide tape the scene before bringing up the remains.
18. If it is under water, the wreckage should be removed as soon as possible and anticorrosion measures taken (e.g., spray with fresh water then coat with light oil).
19. During aircraft recovery effort where human fragmentation occurred, a medical representative should be on site to manage the disposition of human remains that may be located as wreckage is moved. ([See Handling Fatalities without AFIP Assistance and Appendix S Search and Recovery of Remains](#))
20. Examination of the damage, its extent and distribution, at the crash site may reveal the following evidence:
  - a. Angle of impact.
  - b. Airspeed at impact.
  - c. Attitude at impact.
  - d. In-flight fire versus ground fire ([see Fire Investigation](#)).
  - e. In-flight structural failure.
  - f. Aircraft configuration and integrity at impact.
  - g. Whether the power plant was developing thrust.
  - h. If and when ejection was attempted.

- i. Phase of flight at impact (e.g., recovery, stall, spin, inverted).
21. The possible items of evidence that could be determined by the engineering investigation (EI) of the wreckage includes:
- a. Position of flight controls at impact.
  - b. Readings of instruments.
  - c. Causes of contamination.
  - d. Cause of ejection sequence interruption.
  - e. Whether a component was operating at impact.
  - f. Electrical sources of ignition of an in-flight fire.
  - g. Source of combustion.
  - h. Temperature profile.
  - i. Identification of illuminated light bulbs at impact.
  - j. Trim settings.
  - k. Power plant malfunctions.
  - l. Thrust at impact (demanded versus actual).
  - m. Propeller RPM settings at impact.
22. Composite fiber materials deserve special attention. (See [Composite Fiber Materials](#))
23. Once all concurrent investigations (including the JAG investigation) have been completed, the senior member will release the wreckage and real evidence to the reporting custodian.

## **The Autopsy**

1. Each fatal mishap should have three "autopsies":

- Of the man (victim)
- Of the machine (aircraft)
- Of the mission

### **Only the Flight Surgeon participates fully in all three**

2. The Flight Surgeon plays a critical role in jurisdictional issues. The Navy has jurisdiction of the victims' bodies when the event occurs on property that is under exclusive federal jurisdiction (paragraph 3.b. below). However, many bases fall under concurrent jurisdiction, some fall under local jurisdiction, and others may have areas that fall under different jurisdiction within the same base. The Flight Surgeon should establish a working relationship with the local authorities, explore and discuss the options, and preferably reach a formal pre-mishap agreement regarding the jurisdictional issues. The base Judge Advocate as well as the Armed Forces Medical Examiner (AFME) can assist the Flight Surgeon with jurisdiction issues.
3. [Federal Law \(10 U.S. Code 1471 \(1999\)\)](#) gives the Armed Forces Medical Examiner the authority to authorize postmortem examinations subject to the following considerations:
- a. If the jurisdiction is concurrent or exclusively civilian, then the local coroner or medical examiner will have primary jurisdiction. He or she may:
    - i. Retain jurisdiction and perform the autopsy. ([See Autopsy Without AFME](#) and [Appendix Y](#))
    - ii. Retain jurisdiction and request that a representative of the Armed Forces Medical Examiner perform the autopsy under his/her jurisdiction (in military aircraft mishaps the AFME will nearly always agree to do so).
    - iii. Release jurisdiction to the Navy, thereby making jurisdiction essentially federal as the AFME has secondary jurisdiction over all active duty deaths (paragraph 3.b. below). In these cases the AFME will authorize the autopsy.
    - iv. Retain jurisdiction but not perform an autopsy. In these cases the AFME can authorize an autopsy after the body is released (under secondary jurisdiction). While the authority of the AFME is subject to the exercise of primary jurisdiction by the state or local government, it is not limited in those cases where the investigation is incomplete (e.g., an autopsy was not performed by the local coroner or medical examiner).



- b. For exclusively federal jurisdiction, the AFME has the authority to order the autopsy. The Commanding Officer may alternatively sign the [autopsy authorization form \(SF 523\)](#), but this is unnecessary if the AFME is engaged.
4. The Armed Forces Medical Examiner at the Armed Forces Institute of Pathology (AFIP) will, whenever possible, conduct the autopsies on military aircraft mishap fatalities. Requests for their assistance are formally made by the appointing authority to the controlling custodian. However, when such a request is obviously forthcoming, it helps if the Flight Surgeon calls the Armed Forces Medical Examiner and the Naval Safety Center Aeromedical Division as soon as possible so they can "grease the skids." AFME will not launch a team until they are confident the team will have access to the bodies (determine jurisdiction in advance).

<b>Office of the Armed Forces Medical Examiner Phone Numbers</b>	
Commercial	(301) 319-0000
DSN	285-0000
FAX	(301) 319-0635

5. The AFME representative acts as the direct representative of the CNO and controls medical evidence. In an effort to correlate injury patterns and aircraft surfaces and damage, the AFME may visit the mishap site and inspect the wreckage (they often need helicopter support, which the Flight Surgeon should help coordinate). The AFME is entitled to privileged information.
6. Prior to departing from the area, the AFME team will debrief the AMB or sometimes just the Flight Surgeon. They will initially provide a preliminary autopsy report that lists the major injuries and gives a cause of death and method of primary identification. When all medical evidence is gathered and analyzed (typically after 2-4 weeks), a final autopsy report, which describes the injuries in detail and includes the results of ancillary studies such as toxicology and DNA analyses, will be sent to the AMB. A privileged consult report ("blue report") that speculates on the causes of the injuries and death may be provided in certain cases. This report typically covers the following areas of concern:
- Survivability
  - Injury analysis
  - Preexisting disease
  - Toxicology analysis
  - Psychophysiological factors
  - Personal and life support equipment
  - Restraint and egress systems
7. On occasion a local pathologist, either civilian or military, will conduct the autopsies (with advice from the AFME either directly by telephone or through the Flight

Surgeon; [See Fatalities Without AFME](#)). The Flight Surgeon should assist the pathologist in the autopsies and be prepared to lead the inquiry along appropriate lines to obtain the required aeromedical information.

8. Under no circumstances should the Flight Surgeon conduct an autopsy without the benefit of an on-scene pathologist ([See Fatalities Without AFME](#)).
9. Resist pressure to release remains before a site search is complete ([See Appendix S, Search and Recovery of Remains](#)).
10. If dissociated remains are found late in the investigation (after the autopsy or funeral) the Flight Surgeon should take possession of them and call the AFME to determine if they are of use in the investigation. If they are, the AFME will direct their shipment or disposition. If they are not, it is the Flight Surgeon's responsibility to contact the Navy's Decedent Affairs Office and work with them to arrange disposition ([See Decedent Affairs](#)).
11. The objectives of the autopsy of aircraft mishap victims can be summarized in a series of questions:
  - Who died?
  - What was the cause of death?
  - What was the manner of death?
  - What was the nature and sequence of traumatic events?
  - What specific interactions between victim and aircraft structures or components resulted in fatal injuries?
  - If the victim(s) survived the decelerative forces of the crash, why did they fail to escape from the lethal postcrash environment?
  - When in-flight egress systems are available, why did the victims fail to escape?
  - To what feature of the mishap or of the aircraft can the escape?
  - What role, if any, did the victim(s) play in causing the crash?
  - Who was flying the aircraft?
  - Was the pilot incapacitated?
  - Were there physiological or medical cause factors in the mishap?
  - Would any modification of the aircraft or of its equipment have improved the chances of survival of those killed, or reduced the severity of injury to the survivors?
  - Would the incorporation of such a modification have any detrimental effects?

The first three questions are addressed during the course of every medicolegal autopsy since the answers are required for issuance of a death certificate. The remaining questions define the basic subject area of aviation pathology.

12. A distinction is made between the Cause of Death and Manner of Death:

- a. Cause of death: that disease, injury, or injuries that resulted in the death.
- b. Manner of death: the circumstances under which the death occurred.  
These are categorized as:
  - i. Homicide
  - ii. Suicide
  - iii. Accidental
  - iv. Natural
  - In some cases,
  - v. Undetermined

13. Criteria for identification of remains:

<b>Positive (Scientific):</b>	<b>Presumptive:</b>
• Fingerprints • Footprints • Dental comparison • DNA • X-ray comparison	• Visual • Personal effects • Scars • Tattoos • Flight manifest
Identification should be based on at least one, and preferably two, positive (Scientific) methods as delineated above.	

14. Following the autopsy, the prompt release of the remains for preparation and shipment is of major importance. However, resist pressure to release remains identified by less than optimal (presumptive) means.

### **Death Certificates**

- 1. Death Certificates for fatalities that occur in areas of civilian jurisdiction are typically signed by the local coroner or medical examiner, even if the investigation of the death has been turned over to the military. Military investigators will pass pertinent information to the local medical examiner to assist with completion of the death certificate ([See 6000.1A Reporting Births and Deaths](#)).
- 2. If the fatality occurs in an area of military jurisdiction a physician from the AFME or a military physician deemed by the AFME will sign the death certificate.
- 3. The death certificate cannot be signed until positive identification of the victim has been completed. While this seems simple enough, the command, or their seniors, may exert pressure on the investigating team to make a declaration of death based on the “reasonable man theory,” i.e. “We are only missing one plane,” or “We saw him get into the cockpit,” etc. Respectfully resist such

attempts. Identification can usually be made within a week, even in cases of total body fragmentation or charred and/or commingled remains.

### **Decedent Affairs**

1. In the unfortunate event of a fatality, the Flight Surgeon's responsibilities extend beyond identification and recovery of remains. Once the recovery phase is over, disposition of the remains commences. Just as in the hospital, discharge planning begins at admission. Contacting the proper agencies early in the investigation will save you innumerable headaches later.
2. The Navy's Mortuary Office is responsible for managing arrangements following the death of a Service member.

### **The Navy Mortuary phone number is: (888) 647-6676/6628/6629/6644**

3. The Navy Mortuary Office in Great Lakes, IL can assist the command in the following areas:
    - a. Securing a funeral home near the crash site to assist with preparation of the remains.
    - b. Arranging for re-association of any unused tissue samples from AFME
    - c. Coordinating transportation of the remains from the medical examiner's (ME) office to the local funeral home.
    - d. Coordinating transportation of the prepared remains from the local funeral home to the funeral home selected by the Primary Next of Kin (PNOK), if necessary.
- The remains are typically accompanied by an escort, which the mishap squadron should provide.
- Navy Mortuary will also put you in contact with the Casualty Affairs Office (800) 368-3202. They will request that the command fax a death certificate(s) to them.

### **Handling Fatalities without AFME Assistance**

1. It is possible that a mishap with fatalities will not have the benefit of on-scene AFME assistance. However, the AFME will review all military aircraft mishaps, even when an onsite investigation team is not dispatched. The following is a guide for the Flight Surgeon to use in coordination with civilian local medical examiners (and AFME by phone if possible) to collect as much useful data as possible to send to AFIP.
2. Recovery of Remains: In the absence of the AFME, the Flight Surgeon, in conjunction with the local coroner, is responsible for recovery and disposition of remains. An in-depth discussion of this topic is available in ([Appendix S Search and Recovery](#)). Remember if AFME is not on scene, they are available by phone for consultation. During pre-mishap planning an MOU with local authorities will facilitate recovery and investigation ([See Appendix Y](#)).
3. Autopsy: It is imperative in military aircraft accidents, that an autopsy be performed on each of the fatally injured crewmembers. Should the local medical examiner or coroner elect not to perform an autopsy, inform the AFME of this fact at once so that they can assist in negotiations with local authorities. If the local pathologist performs

the autopsy, the Flight Surgeon should be present. It is in this circumstance that the Flight Surgeon functions as the eyes and ears of the aviation pathologist, garnering the pertinent information, which will allow the later reconstruction and interpretation of injury patterns. The section on injury analysis below lists the types of injuries that should be sought.

4. Radiology: Radiologic examination of remains is essential to a complete evaluation of an aircraft crash fatality. Therefore, total body x-rays should be performed on each case. Initial x-rays should be taken with the body “as is”, prior to removal of flight gear. This will allow for identification of personal effects that may have been missed on initial examination, or determining the location of any potential hazards (explosives, etc.) prior to excessive handling of the body. Should any injured areas be incompletely visualized, radiographs of these areas can be performed after the clothing and flight gear have been removed.
  
5. Autopsy Safety: It should be self-evident that universal precautions with respect to biohazards be followed at all times when handling bodies. However, it is also important to remember that the flight gear may contain items that present significant hazards to autopsy personnel. Pencil flares can produce serious injury. More importantly, any firearms carried by the aircrew should be identified. Should these items have been exposed to fire, their explosive characteristics may have been altered and handling may be extremely dangerous. It is often helpful to have an EOD specialist present during examination of flight gear.
  
6. Toxicology: Prompt collection of body tissues and fluids for toxicologic and other examinations is essential so that they may be protected from contamination and physical and chemical change. However, as a rule, these specimens should not be collected on-scene. **NO ONE**, under any circumstances, should attempt collection of body fluids by needle puncture if an autopsy is to be performed. Such attempts may result in contaminated and uninterpretable specimens. Before collecting the specimens, the investigator must ensure that the bodies, or fragments thereof, are properly identified, especially if more than one fatality is involved. If no fluids or organs can be recovered, several hundred grams each of muscle, fat, and red bone marrow can be submitted. In severe crush injuries, and even in some cases of fragmentation of the body, the gallbladder will often remain intact permitting bile collection. Remember that even in the most severely fragmented cases, valuable information often can be obtained from only a few milligrams of blood or tissue. If in doubt, submit as much tissue as practical.

The following tissue and fluid samples are recommended:	
Blood	All available up to 100 ml (indicate source: heart blood vs. peripheral). At least one polyethylene tube, one red top glass tube, one purple top, and one gray top.

Urine	100 ml (no preservative)
Bile	All available
Vitreous	All available
Liver	100 gm
Brain	100-200 gm
Kidney	50 gm
Lung	50 gm
Stomach Contents	50 ml
Skeletal muscle and bone	(100 grams each) equal specimens should also be submitted for DNA analysis.
Spleen	100 grams (for CO and other analysis, especially if blood is unavailable)

7. **Packaging and Preservation:** Each specimen should be individually packaged and heat-sealed in sturdy polyethylene bags. Plastic containers and cellophane laminated plastic bags must not be used for frozen specimens as they will become brittle, crack, and come apart when placed in dry ice for 24 hours or longer. Fluids should be placed in tightly closed, preferably screw cap, polyethylene containers. Additional blood can be submitted in the various glass tubes described above; however, remember that glass becomes very brittle when exposed to dry ice. All of these primary containers should be labeled with the name and social security number of the individual, the type of tissue, date, and name of submitting facility. Avoid contamination of the specimens with solvents that may be found in some inks, formalin or formalinized tissue, alcohol, disinfectants, or deodorants. Make sure that each tissue is individually packaged, since drug distribution studies of different organs are often useful in determining time of ingestion of any drugs. Chemical fixatives, such as formalin, embalming fluids, etc., cause interference to such an extent as to render the tissue nearly useless and the interpretations of results next to impossible. **Freezing is the method of choice in preserving the tissue**, with dry ice being extremely effective in this endeavor. *Note that glass tubes will often shatter and paper labels will not stick when exposed to dry ice.*

It is important that a properly filled-out [AFIP Form 1323 form](#) is submitted with each accident fatality. It is also very helpful to the AFME forensic pathologists and toxicologists if a brief summary of the victim's health status, including any known medications taken, and a brief summary of the mishap including a site description and the condition of the body when recovered are enclosed. Forward this along with the whole body radiographs, and any other relevant paperwork (in its own polyethylene bag) to AFME.

8. **Shipment: Important things to remember:**
- a. All primary containers should be wrapped with sufficient absorbent material to contain any leakage and then placed in a secondary container (a polyethylene plastic bag) and again heat-sealed. A third, large polyethylene bag may now be

used to keep the specimens from one individual together. The frozen tissue and body fluids must now be packed in an insulated shipping container large enough to hold the specimens plus a quantity of dry ice approximately 3 times the weight of the specimens.

- b. The frozen specimens and dry ice should not be packed in containers that seal to the extent that gas is not permitted to escape; gas pressure within a sealed container presents a potential hazard and could cause the container to burst. ***Dry ice must not be placed in a thermos bottle or similar container.***
- c. Do not place fluid containers in direct contact with the dry ice; the freezing fluid may crack the container.
- d. Place organ tissue closest to the dry ice.
- e. The shipment must be made by overnight delivery service (e.g., FedEx). This is the only method rapid enough to deliver the specimens to the AFME as quickly as is necessary to preserve them in their frozen state. Overseas shipments are complicated and specimens are often sent to the nearest military pathologist who, in turn, should work with AFME/AFIP. It is crucial that you pack the specimens with the utmost care, in sturdy containers that are properly labeled, with the correct paperwork.

9. Addressing the Shipment:

- a. The outside of the package must contain the following two phrases:
  - i. **“Clinical/Diagnostic Specimens Enclosed”** and
  - ii. **“Shipment complies with US Domestic and IATA international packaging regulations”**
- b. Also, the word “biohazard” should **not** appear anywhere on the outside of the package.
- c. The package should be addressed to:

Armed Forces Institute of Pathology  
ATTN: Division of Forensic Toxicology  
Bldg. 54  
6825 16th Street, NW  
Washington, DC 20306-6000

10. AFIP Notification/Telephone Numbers:

Commercial	
Tox Div:	(301) 319-0100
Info Desk	(202) 782-2100
DSN	
Tox Div	285-0100
Info Desk	662-2100

11. Notifying AFIP that specimens are about to be shipped contributes immeasurably to expeditious handling of the shipment. The message or phone call should include as much of the following information as possible:

- .a. Aircraft mishap material
- .b. Patient(s) name, rank, social security number
- .c. Method of shipment (air express/air freight)
- .d. Name of Washington, DC area airport to receive shipment
- .e. Name of airline
- .f. Flight number
- .g. GBL/Airbill number
- .h. Contributor's name
- .i. Departure time and date
- .j. Arrival time and date
- .k. Brief description of contents
- .l. Chain of custody
- .m. Other information, if required



12. Information about the Forensic Toxicology Branch can be obtained at their website:

<http://www.afip.org/oafme/tox/tox.html>

Or from the [AFIP Guideline for Collection and Shipping of Toxicologic Samples](#), March 2002

## Aviation Life Support Systems Investigation Assistance

### Mishap Investigation Support Team – MIST

1. Because of the complex interrelationships and interfaces between the Aviation Life Support Systems (ALSS), the Naval Air Systems Command (NAVAIRSYSCOM) developed a systematic approach to the on-site and in-house investigations of the ALSS involved in aircraft mishaps. ALSS includes but is not limited to ejection and crashworthy seats, parachutes, propulsion systems, night vision devices and personal flight equipment. The investigators will provide a comprehensive human factors engineering (HFE) evaluation and report of the ALSS. This report is non-privileged and is included as a Side A attachment to the SIR. For Further information on HFE without MIST team assistance, see ([Appendix X: Human Factors Engineering Investigation](#)).
2. The NAVAIRSYSCOM Mishap Investigation Support Team (MIST) was created to provide factual data to the Aircraft Mishap Boards concerning the operation of the total egress system including any factors that may have contributed to the injury or fatality of an aircrew member. Mishap data discovered from the MIST investigations has proven essential to saving lives and provided the Naval Air Systems Team with information on ALSS involved in mishaps for inclusion in their database, for use in trend analysis, and for justification of improvements.
3. MIST involvement in a mishap investigation is recommended if the aircrew experienced problems with ALSS resulting in serious injury or fatality. The Naval Safety Center (NSC) Mishap Investigator will contact the MIST coordinator for assistance. If a NSC investigator is not present at the mishap, and MIST assistance is needed contact the Naval Safety Center Code 13.
4. The NAVAIRSYSCOM MIST On-site coordinator is Mr. Mitch Mackenzie. He is based out of NAWC-WD in China Lake California and can be contacted at DSN 437-6132, Commercial (760) 939-6132 or Cell (760) 382-9195 (or leave only a commercial number on pager 1-877-442-0384. )
5. Instructions for disposition of ALSS equipment can be found in [paragraph 608 of 3750.6R](#) for additional clarification contact the Naval Safety Center Code 13.

## Fire Investigation

1. Valuable clues to the cause of the fire and the mishap can be gleaned from the fire-damaged parts by the educated eye.
2. For fire to occur, four conditions must exist:
  - a. Combustible material.
  - b. Oxidizer.
  - c. Ignition.
  - d. Enough heat or energy to sustain the reaction.
3. The flammable liquids (fuel, etc.) used on aircraft do not burn as liquids; their vapors burn. (See Appendix L)
  - a. Sources of ignition include:
    - b. Engine exhaust.
    - c. Engine hot section.
    - d. Electrical arc.
    - e. Overheated equipment.
    - f. Air bleed systems.
    - g. Static discharge.
    - h. Lightning.
    - i. Hot brakes or wheels.
    - j. Friction sparks.
    - k. Smoking materials.
    - l. Aircraft heaters.
    - m. Auxiliary power units.
    - n. Inflight galleys or ovens.
4. Note penetrations in the fuselage or wings that may have been caused by high-velocity debris.
5. Note the wreckage distribution for missing parts. These parts may have been burned off and may be lying along the flight path. If so, these would give direct evidence of fire inflight and its origin.
6. Note the state of the fire extinguisher bottles and the condition of the fire detectors.
7. Key questions to ask:
  - a. Was there an inflight fire?
  - b. Was there a ground or post-impact fire?
  - c. Where did the fire start and what was the ignition source and fuel?
8. Note the condition of engine compressors or turbine blades.
9. Note metallic fractures that have been subjected to heat. Parts that fail at elevated temperatures leave clues that a structural engineer or metallurgist will recognize.
10. Note the status of self-locking nuts held by nylon that may have melted away.
11. Safety wire should remain following a normal ground fire.

12. Witnesses often confuse the sensory inputs of seeing the fireball of the crash and hearing the crash explosion. They will be convinced they saw a fire in flight just before the ground impact when there definitely was not one.
13. If an in-flight fire is contained by the aircraft structure, it may be indistinguishable from a ground or post-impact fire. Most in-flight fires, though, eventually burn through the structure and are exposed to the slipstream. This adds oxygen to the fire and creates two significant effects:
  - a. It will increase the intensity of the fire and raise its temperature:
    - i. The temperature of ground fires is about 1600° to 2000° F (except where a localized "chimney" effect occurs).
    - ii. In-flight fires will burn in excess of 3000° F due to the "blowtorch" effect of the slipstream. If melted components have a melting point significantly above 2000° F, in-flight fire should be suspected. (See [Appendix L](#))
  - b. It will develop a fire pattern which follows the flow of the slipstream:
    - i. Note the flow, shape and nature of molten metal. The metal melted in ground fire will drip and collect into pools and rivulets called "slag." The molten metal of an in-flight fire will be splattered by the slipstream and found distal to the fire source.
    - ii. The pattern of soot deposited by hydrocarbon feed fire is a clue to when and where the fire occurred. Soot does not adhere to surfaces hotter than 700°F.
    - iii. The soot pattern from a ground fire typically flows upward and with the surface wind.
    - iv. An in-flight fire soot pattern follows the dominant airflow, which is usually the slipstream.
    - v. Soot on torn edges indicates that the fire forming this soot occurred after the localized damage.
    - vi. Scratches, scuffs and smears in the soot indicate that damage occurred after the soot was formed.
    - vii. Look for the "shadowing" effect of obstructions to the airflow on the soot pattern leaving "clean areas."
    - viii. The portion of the wreckage that is buried at the impact site should not be exposed to post-impact fire; fire damage indicates in-flight fire.
    - ix. Sometimes, the destruction of the aircraft does not permit positive determination of a soot pattern.
    - x. Layout of the wreckage is helpful to evaluate evidence for signs of in-flight fire.

## Mishap Investigation Tips

1. **SAFETY IS PARAMOUNT.** The safety of the public and the investigation and reclamation team, must begin in the Pre-mishap planning stages and continue through the investigation and into final disposition and disposal of the wreckage. Review and update drill with your premishap plan periodically.
2. Most of the clues to the cause of the mishap are available on the first day and deteriorate with time. Do not delay the start of an investigation even if the weather conditions may be uncomfortable.
3. Avoid taking a scrap of information and attaching a theory to it.
4. Learn as much as possible from the wreckage at the crash site before moving anything.
5. Don't rely on your memory. Make notes, take photos, and use a tape recorder to refresh your mind.
6. Don't take shortcuts; you may unknowingly destroy clues.
7. One of the most common faults of accident investigators is "tunnel vision" or jumping to conclusions at an early stage in the investigation. Hence, the search for clues and evidence to support a preconceived assumption overlooks other evidence that may lead in a different direction. All investigators must be on their guard for this as it can unnoticeably slip into the investigative proceedings. Maintain an open mind.
8. Don't focus on just one cause; a mishap is the culmination of a number of apparently unrelated events lining up to create an environment for the mishap to occur.
9. Component or structural failures generally result from one of three reasons:
  - a. Inadequate design strength.
  - b. Excessive loading.
  - c. Deterioration of static strength through the most common, fatigue or corrosion.
10. The direction of flight is often indicated most clearly by the

direction of the teardrop fuel splash and fire pattern.

11. Do not wash, clean or brush off dirty items before examination.
12. Do not touch settings on control dials, switches or anything that can be changed. Record and photograph them. You can never take too many pictures.
13. Nuts and fittings can come loose on impact or after a fire due to the heat and deterioration of seats.
14. The location of witnesses is significant. The exact spot from which a witness makes an observation may explain differences from the accounts of other witnesses in the crash vicinity.
  - a. A witness downwind of a mishap may often hear sounds not audible to the upwind observer.
  - b. Sound is deflected by walls or buildings and may cause the witness to erroneously report direction, sound origin, or dynamic level.
  - c. Background noise level at the point of observation may account for a witness missing significant sounds noted by other observers.
  - d. The witness looking toward the sun sees only a silhouette, while the witness whose back is toward the sun may note color and other details.
15. Peers and the power of suggestion may influence a witness located in a group.
16. Witnesses often confuse the sensory inputs of seeing the fireball of the crash and hearing the explosion of the crash. This confusion may make them think there was an inflight fire when there was not.
17. Another common witness failing is "transposition." The witness reports all the facts, but places them out of sequence with the actual occurrence.
18. Angle of impact may be determined by the flight path through obstacles prior to the point of ground contact or by geometry of the crater. Do not confuse this angle with the aircraft attitude at impact.
19. Guidelines to help avoid problems typical of committees such as the AMB:

- a. Encourage "brainstorming" to generate as many ideas as possible.
  - b. Utilize the HFACS template to provide a guide for evaluating all levels of the mishap and events leading to the mishap.
  - c. No new idea should be considered too far out.
  - d. No idea is to be considered a member's personal property. Using or building upon other's ideas is to be supported.
  - e. There should be only constructive criticism. Have an AMB member play the role of "devil's advocate."
20. Hangar layout of wreckage is essential to a thorough investigation.
  21. If molten metal deposits are found on the hot section components, a minimum operating temperature can be determined based on the melting point of the metal deposits.  
(See Appendix L)
  22. The heaviest items (e.g., generators, batteries, engines, etc.) often travel the greatest distances and will indicate the direction of flight.
  23. Mishap factors are like dominoes. Your goal is to identify all the dominoes and make recommendations to prevent the cascade of mishap events from recurring.
  24. Never put broken parts back together again.
  25. Don't hesitate to call the Naval Safety Center with questions.
  26. Don't give up.

## **Fatigue Avoidance Scheduling Tool, F.A.S.T**

Developed by Dr. Steven Hursh, the Fatigue Avoidance Scheduling Tool (F.A.S.T.) model can predict the joint effects of sleep schedule or sleep potential, sleep deprivation, and circadian variation.

1. The model is capable of interpreting and intervening with respect to the detrimental effects of sleep deprivation. The FAST scheduling tool uses the model to compare schedules in terms of predicted performance effectiveness.
2. FAST allows easy entry of proposed schedules and generates graphical predictions of performance along with tables of estimated effectiveness scores for objective comparison. Optimal schedules may be selected based on average effectiveness for proposed work periods or mission critical events.
3. The tool may also be used for retrospective analysis of fatigue related factors that may have contributed to an accident, error or safety related incident. In this mode, information on the work and sleep schedules of operators prior to the event may be entered into the tool and a projection of performance effectiveness at the time of the event is determined. In combination with other information, this analysis can project the combined effects of time of day and sleep history as a contributing factor to safety related events.
4. An algorithm is included with FAST that can infer likely sleep patterns when only the work schedule or mission demands are known. This AutoSleep feature uses adjustable rules to insert reasonable sleep patterns into a regular or irregular work schedule. Using AutoSleep, FAST can be used to project performance under any anticipated work schedule or to estimate performance at the time of an accident based on work history.

At the School of Aviation Safety in Pensacola, CAPT Nick Davenport has been instrumental in educating our Flight Surgeons and Aviation Safety Officers in the use of the [FAST](#) in their mishap investigations, particularly in the aeromedical analysis by our Flight Surgeons.

The FAST tool equates the percent of effectiveness influenced by fatigue to the corresponding percent of effectiveness influenced by a certain average blood alcohol concentration. For example, an individual with 18.5 continuous hours of wakefulness and 77% FAST effectiveness may be operating to an equivalent average BAC of 0.05. The theory that effects of fatigue may be compared to the effects of blood alcohol to calibrate the severity of fatigue was introduced by Drew Dawson, Director Centre for Sleep Research, University of South Australia.



# BAC Scale

The effects of fatigue may be compared to the effects of blood alcohol to calibrate the severity of fatigue

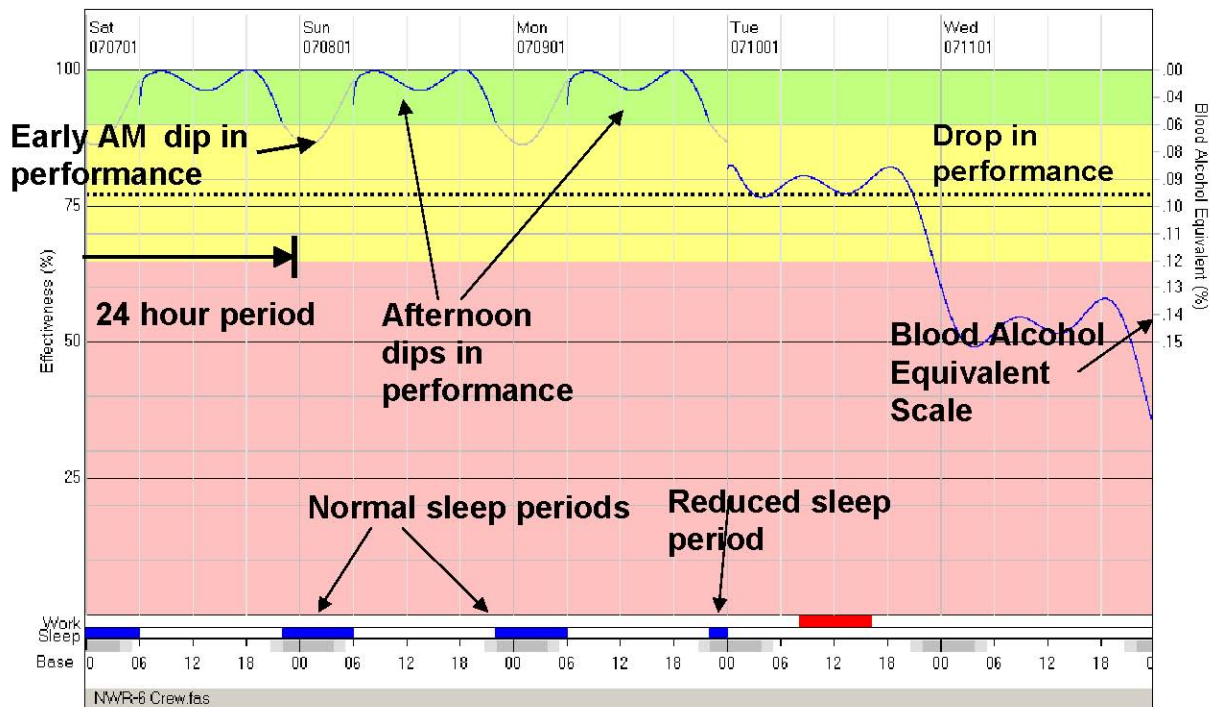
Continuous Hours of Wakefulness	<i>FAST</i> Effectiveness	Blood Alcohol Concentration
18.5	77	0.05
21	70	0.08

Fatigue as predicted by *FAST* and the effects of alcohol are not identical.

Arnedt, J.T., Wilde, G.J., Munt, P.W., MacLean, A.W. "How do prolonged wakefulness and alcohol compare in the decrements they produce on a simulated driving task?" *Accid Anal Prev.*, 2001 May;33(3):337-44.

Dawson, D., Reid, K., 1997. "Fatigue, alcohol and performance impairment." *Nature* 388, 23.

# Fatigue Avoidance Scheduling Tool (FAST)



In April 2006 CAPT John Lee organized a FAST working group conference at the Naval Safety Center. Participants in this meeting included RADM Mayer, Commander of Naval Safety Center, Steven R. Hursh, Ph.D., President, Institutes for Behavior Resources & Professor, Behavioral Biology Research Center, Johns Hopkins University School of Medicine, CAPT Mandel, AIRLANT, Eric Skroch, Northrop Grumman, CAPT John Lee, Command Flight Surgeon, Naval Safety Center, Aeromedical Division Code 14, CAPT Nick Davenport, Command Flight Surgeon, School of Aviation Safety, Naval Aviation Schools Command, James C. Miller, Ph.D., CPE, Senior Research Physiologist, Biosciences and Protection Division, Air Force Research Laboratory, LT Andrew J. Workman, Biobehavioral Performance Branch, Air Force Research Laboratory, J. Hunter Downs III, Ph.D., Chief Science Officer, Archinoetics, Brendan F.P. O'Donnell, Strategic Development, Archinoetics, and Dr. Nita Lewis-Miller Naval Post Graduate School.

From this meeting the potentials and shortcomings of FAST were discussed. It was concluded that FAST is valid tool with good science behind it. It was unanimously supported that our Flight Surgeons are to continue to use FAST in their mishap investigations.

A copy of FAST can be down loaded on the Internet. Go to the website [www.novasci.com](http://www.novasci.com), and click on the FAST button in the left menu choices. Select the "FAST Download & Upgrade" link, which will

give you directions for getting the program. You'll receive a zip file, which when unzipped, will have several files including a SETUP file. Once you install the program, it will give you a registration number and instructions to e-mail that number to the program controller, Brendan O'Donnell. He will send you another file, which when installed in the directory you've installed FAST in, will make the program fully functional. Because FAST development was funded by DoD financial support, our Flight Surgeons have free unlimited license, which will work for several years. If you were a civilian, they'd charge you \$15,000!

# MISHAP ANALYSIS

The analysis of the data from the mishap site, survivor interviews, lab results, and other sources must be pieced together in an organized fashion to produce information, which becomes evidence that is utilized to identify the many causal factors present in a mishap.

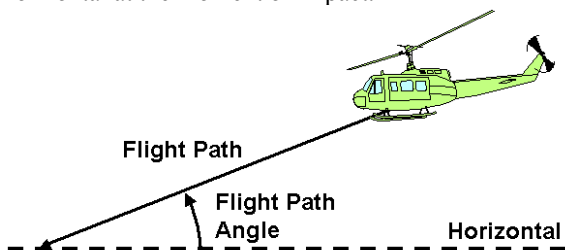
This section provides some tools that can be utilized to help with data analysis and evidence development.

## Crash Survivability

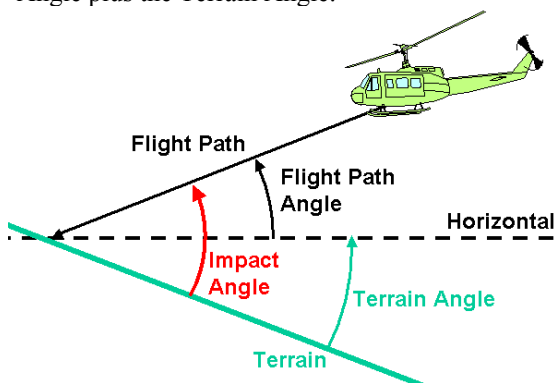
1. Crash survivability focuses on *what happened* during the mishap vice *why the mishap occurred*. It is quite artificial to try to separate the two topics. As Flight Surgeons, you'll be tasked with answering both questions when investigating a mishap.
2. The ultimate goal of a mishap investigation is to determine the cause(s) of the mishap and thus prevent other mishaps. The objectives of Crash Survivability Investigation, while similar, are to:
  - a. Determine the cause of injuries that occur as a result of a mishap.
  - b. Isolate the factors that help to prevent and/or reduce injuries in mishaps.
  - c. Use the knowledge gained from individual mishap investigations.
  - d. Recommend design improvements that will be provide maximum occupant protection throughout a crash.
3. Surviving an aircraft crash generally involves the presence of three factors:
  - a. Tolerable **deceleration forces**.
  - b. The continued existence of a volume of **occupiable space** consistent with life.
  - c. A non-lethal **post-crash environment**.
4. Using known velocities, stopping distances, ground and airframe deformation, gravity constants, etc., the deceleration forces on an aircraft can be calculated. The generated numbers should then be viewed from the perspective of the crew and passengers and their survival. However, the G-forces imposed on the airframe may have only limited similarity to the forces imposed on the aircrew.

## SPECIALIZED CRASH FORCE TERMINOLOGY:

1. **Flight Path Angle** The angle between the aircraft flight path and the horizontal at the moment of impact.



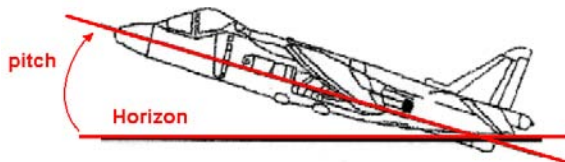
- a. The algebraic sign of the **Flight Path Angle** is positive if the aircraft is moving downwards immediately prior to impact. The sign is negative if impact occurs while the aircraft is moving upwards.
2. **Terrain Angle and Impact Angle:**
    - a. The **Terrain Angle** is the angle at which the terrain slopes up or down at the site of the impact. It is the angle measured between the terrain and the horizontal. If the terrain is level, the Terrain Angle is zero.
    - b. The **Impact Angle** is the angle between the flight path and the terrain. The Impact Angle is equal to the Flight Path Angle plus the Terrain Angle.



- c. The algebraic sign of the Terrain Angle is positive when the direction of flight is uphill and negative when the direction of flight is downhill.

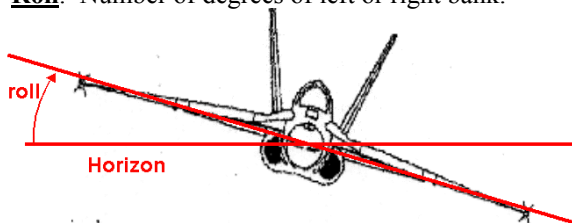
3. **Attitude at Impact** - The aircraft attitude at the moment of initial impact. The factors to be considered in determining the attitude at impact are:

- a. **Pitch**: The angle of the nose of the aircraft above or below the horizon

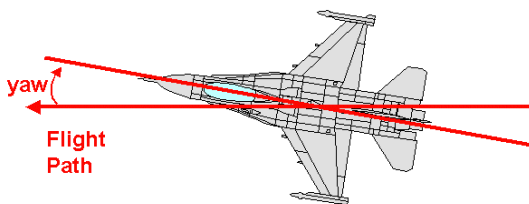


The algebraic sign of the aircraft pitch angle is negative when the nose of the aircraft points below the horizon, positive when above the horizon.

- b. **Roll**: Number of degrees of left or right bank.

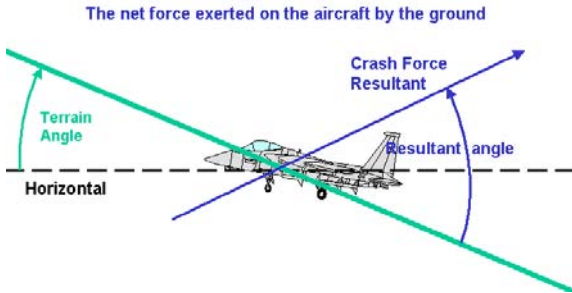


- c. **Yaw**: The angle of the nose left or right of the direction of flight.



- d. Attitude at impact is to be determined as accurately as possible in degrees.
4. **Crash Force Resultant** - The vector sum of the forces perpendicular and parallel to the ground that act on the aircraft at impact.
- a. Perpendicular and parallel crash forces are determined on the basis of perpendicular and parallel velocity components, and stopping distances perpendicular and parallel to the terrain. The Crash Force Resultant can be viewed as an average of all forces the terrain exerts on the aircraft to bring it to a stop producing aircraft damage. (Because the Crash Force

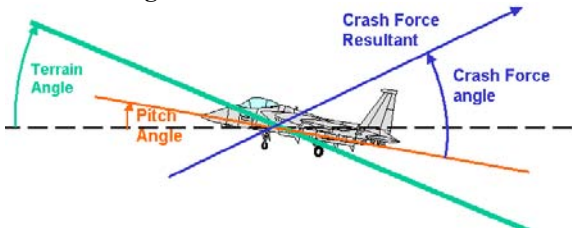
Resultant is a calculated quantity, that depend on velocities and stopping distances both perpendicular and parallel to the terrain, it usually doesn't point directly back along the flight path).



- b. The Crash Force Resultant is fully defined by determination of both its magnitude and its direction. The algebraic sign of the Crash Force Resultant angle is positive when the line of action of the resultant is above the horizontal and negative if the line of action is below the horizontal.

5. **Crash Force Angle** - The angle between the resultant crash force and the longitudinal axis of the aircraft.

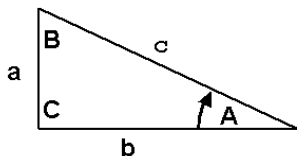
- a. **Crash Force Angle = Resultant Angle + Pitch Angle – Terrain Angle**



- b. The magnitude of the G resultant remains the same, whether the aircraft's nose is pitched up or down. However, the attitude of the plane at impact determines how the **Crash Force Resultant** “penetrates” the plane and the human occupants within. The direction relative to the aircraft's floor changes, determines the direction of the forces felt by the occupants. This angle the Crash Force Resultant makes with the planes axis system is known as the **Crash Force Angle**.

## TRIGONOMETRY REVIEW

### 1. Definitions:



- i. Hypotenuse: the longest side of a triangle
  - (Side 'c').
- ii. Opposite Side: the side opposite to and not touching a specific angle
  - (Side 'a' lies opposite angle 'A').
- iii. Adjacent Side: the side touching a specific angle other than the hypotenuse
  - (Side 'b' lies adjacent to angle 'A').
- iv. Sum of Angles: the sum of the angles of any triangle equals 180 degrees
  - $(a+b+c = 180^\circ)$ .
- v. Pythagorean Theorem: the square of the hypotenuse is equal to the sum of the squares of the other two sides
  - $(a^2+b^2=c^2)$ .

### 2. Trigonometric Functions:

$$\sin \mathbf{A} = \frac{\textit{Opposite}}{\textit{Hypotenuse}} = \frac{a}{c}$$

$$\cos \mathbf{A} = \frac{\textit{Adjacent}}{\textit{Hypotenuse}} = \frac{b}{c}$$

$$\tan \mathbf{A} = \frac{\textit{Opposite}}{\textit{Adjacent}} = \frac{a}{b}$$

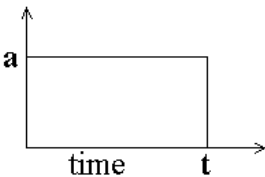


## BASIC AERODYNAMICS

1. Airspeeds - Usually expressed in Knots (Nautical miles per hour)  
1 nm = 2000 yards.
  - a. **Indicated Air Speed (IAS)**: The airspeed shown on the airspeed indicator.
  - b. **True Air Speed (TAS)**: Equivalent airspeed corrected for error due to air density (Altitude and temperature dependent).
  - c. **Ground Speed (GS)**: The rate of the motion of the aircraft over the ground. It is the result of the interaction between the aircraft's speed through the air (TAS) and the wind speed in their relative directions.

## DECELERATION PULSES:

1. One of the most difficult tasks of the mishap board is deciding what was the most likely deceleration pulse shape in a mishap. The deceleration pulse shape chosen by the board will determine the peak G calculated to have occurred in the mishap. The following crash force pulses and the conditions where they are likely found are listed. Also shown are the equations that have been derived for these force pulses. (See Solving Crash Force Problems)
2. **Rectangular Pulse** - Constant deceleration
  - a. Examples include:
    - i. Normal landings with constant braking
    - ii. Wheels up landing on snow or ice



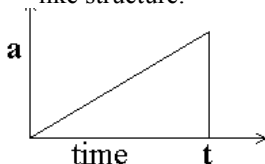
$$G = \frac{(v_f^2 - v_o^2)}{64.4 \text{ s}}$$

- b. This requires unchanging G forces over the period beginning with the initial velocity and ending with the final velocity. An object will sustain the minimum peak G's for a given velocity change if the pulse is rectangular.

3. **Triangular Pulses** - Constantly changing deceleration. These include constantly changing deceleration levels, increasing, decreasing or a combination of both.

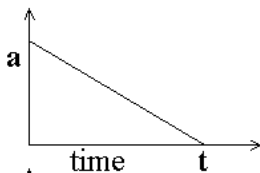
a. Examples include:

- i. **Increasing deceleration** - impacting mud, dirt, or a crash that creates a deep crater, or impacting a spring-like structure.



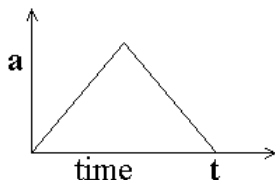
$$G = \frac{4 (v_f^2 - v_o^2)}{96.6 \text{ s}}$$

- ii. **Decreasing deceleration** - Skidding on pavement or impacting an object that gradually gives way, i.e., a tree, or water impact.



$$G = \frac{2 (v_f^2 - v_o^2)}{96.6 \text{ s}}$$

- iii. **Increasing and decreasing deceleration** - Most aircraft impacts, aircraft flying through trees, or shallow angle water entry.



$$G = \frac{(v_f^2 - v_o^2)}{32.2 \text{ s}}$$

- b. The “mid-peak” triangular crash force pulse is most often seen in actual measurements of crash forces, and is probably a good choice for calculating forces if other information is not available to help choose a pulse shape.

c. The time duration of all three triangular pulses is given by:

$$t = \frac{2(v_f - v_o)}{32.2 G}$$

4. **The "Ideal" Pulse Curve:**

When the stopping distance is short, the lowest G level (hence maximum occupant protection) occurs in a rectangular pulse deceleration. Peak G forces are greatest when there is a triangular pulse with increasing deceleration. The most common deceleration pulse encountered in aircraft mishaps is a combination increasing / decreasing pulse shape.

5. Final note on numbers: Numbers are not magical! They imply a degree of scientific precision, which may not be appropriate. This is especially true of crash survivability estimates. The formulae listed above are approximations at best. They are the best means available to estimate the forces acting upon the aircraft and the aviators inside, and give the investigator a starting point, which can then be modified or tempered as indicated by the investigator's experience. [Link to CRASH FORCE ANALYSIS PROGRAM](#)

## **Factors Affecting Crash Survivability**

The acronym "CREEP" is helpful in organizing the important aspects of crash survivability.

**C = Container**

**R = Restraints**

**E = Environment**

**E = Energy absorption**

**P = Postcrash factors**

### **The Container**

1. Basic aircraft structures need to provide an intact shell around the occupants during survivable impacts. If an aircraft is not a good "container" it will tend to collapse inward, denying the occupants enough livable space to survive. Typically this involves: (1) the rearward movement of the engine in single engine aircraft; (2) the downward displacement of engines and transmissions (and other heavy components) in helicopters; (3) the upward collapse of lower structures into the cockpit /cabin area. This deformation or collapse of the occupiable area may result in crushing / entrapment of the occupants.
2. When evaluating the crashworthiness of an aircraft structure, attention should be directed to the anticipated dynamic response under the most probable conditions of impact angle and aircraft attitude. It will be obvious if heavy components have been carried into the cabin. The thoughtful investigator will evaluate the living space remaining after the impact forces have been dissipated, remembering that ductile metals can rebound after they have compromised the occupant's livable volume, leaving few traces of their brief invasion into the aircrew compartment.
3. The preferred container has:
  - a. Crushable structures between the outer skin and the crew / passenger compartments, including a multiple keel belly over the forward 20% of the nose.
  - b. Enough structural stiffness to prevent crushing of occupants by wings, transmissions and rotors. Inward buckling during impact should not occur. Provide an intact floor for seat tie-down even after fuselage fracture.
  - c. Sufficient structural continuity to maintain a protective shell in cartwheel or rollovers, especially during water impacts.

- d. Provide for known fracture sites in long body aircraft and use ductile material at deformation points (at any point where things join the floor, keel, etc.)
4. You don't want to die or be incapacitated in an impact of tolerable deceleration force levels because the container failed.
5. THE IDEAL: provide a habitable space while the rest of the CREEP factors work to attenuate the crash forces and minimize post crash dangers.
6. THE REALITY:
  - a. Tactical Jets - little vertical or longitudinal crush zone available.
  - b. Jumbo Jets / Transport Type Fuselages - New high strength metals are brittle and will shatter rather than bend. Longitudinal structural collapse leads to decreased livable volumes. Buckling or breaking can occur as the underside digs into the ground, bending the cockpit area under the aircraft. If the fuselage fractures, the occupants can spill from the aircraft. Areas of decreased strength should be designed to occur between seat rows, and not under them. As it is now, aircraft often fracture forward and aft of wings. Massive components (i.e. wings, engines, props) may penetrate the cabin, especially shoulder mounted wings that rotate down into the occupiable space.
  - c. Helicopters - Fuselages have too much elasticity and can easily be penetrated by blades. Cockpits collapse and pedals entrap the occupants. Transmissions may collapse into the cockpit / cabin and old style landing gear have been known to penetrate both the cabin/ occupants (H-34). Helicopters have a high probability of rolling over after a crash.
  - d. Small Aircraft - Overhead wings with fuel in the leading edges. Wing struts pass under the seats and engines end up in the pilot's lap. Cockpits collapse and pedals entrap the occupants.

## **The Restraint System**

1. Although a crashworthy structure provides primary protection during a crash deceleration, injuries may still occur when occupants come into forceful contact with the cabin environment or struck by loose objects thrown through the occupiable area. The restraint system used to prevent occupants, cargo, and components from being thrown loose within the aircraft is referred to as the

Tie-Down Chain. The occupant's tie-down chain consists of: seat belt, seat belt anchorages, and the floor. Failure of any link in this chain results in a much higher chance of injury.

2. Injuries resulting from the flailing action of the occupant's body show a peripheral trend; that is, the areas farthest away from the seat belt receive most of the injuries (head and extremities). This tendency is aggravated by loose restraints that allow the head to travel forward excessively, or that allow 'submarining' where the aviator's torso slides under the lap restraint. Not surprisingly, statistics indicate that the head is most frequently the site of serious injury in general aviation accidents. In most cases the lack of adequate torso restraint, allows the head to gain a greater relative velocity than the surrounding cabin during impact deceleration. Termed dynamic overshoot, the unrestrained portions of the body strike objects in its path with a force exceeding that of the overall crash force. This is especially true in the case of aviators sitting in the cockpit environment, facing the instrument panel, flight controls, and many other injurious surfaces. Considering these factors, it is impossible to avoid contact injuries during crash deceleration if adequate seat belts and shoulder harnesses are not used.
3. Injuries attributed solely to transverse G seldom occur in mishaps because structural collapse and or failure of the restraint system usually occurs before the limit of transverse G tolerance (40G) is reached. This is an undesirable situation. Although operational and economic considerations impose limits on the overall fuselage strength, the occupant tie-down chain should be able to restrain the occupants in crashes that do not exceed human tolerance limits. Tie-down failures frequently occur as a result of excessive dynamic loads imposed on seat belts and shoulder harnesses by the occupants. This crash force amplification should be taken into consideration when evaluating the dynamic strength of the occupant tie-down chain (i.e. don't attach a 40 G seat belt to a 4 G seat, which is held to the aircraft floor by a 2 G bolt).
4. Inadequately or improperly secured aircraft equipment and components in the occupiable area also have an injury potential during crash decelerations. Therefore, tie-down and stowage of items such as luggage, cargo, electronic equipment, fire extinguishers, and toolboxes require careful consideration. Overhead luggage bins are a particular hazard, as they frequently fail in aircraft mishaps, releasing deadly projectiles into the passenger compartment.

- a. Seating position:
  - i. Aft-facing.
  - ii. Forward-facing.
  - iii. Side-facing.
- b. Cargo restraints:
  - i. Nets - Best to use Dacron.
  - ii. Lines - Use chains, cables, or webbing; never mix them.
  - iii. Pallets - crash forces can be attenuated by stroking devices that save weight and increase crashworthiness. Inserting a device between pallets that would allow a two-foot stroke after a five G load would reduce the need for a 5000 lbs tie-down system.
  - iv. Litter restraints - need to be modified. Presently poor at best.
  - v. Personnel should always sit behind cargo in the passenger compartment.

## **The Environment**

1. Accident experience has shown that under many impact conditions, occupants who are reasonably restrained within a crashworthy structure, may still receive injuries through forceful contact with injurious surfaces, components, etc. This is particularly true when shoulder harnesses are not used. The type of restraint system installed and the manner used, govern the freedom of movement of the occupant's body during a crash deceleration.
2. The limitations of the restraint system can be used as a guide to determine the extent that the occupant's environment should be made harmless, i.e. an optimum restraint system would negate the need for environmental padding. The injury potential of all objects and structures within striking distance can be reduced by such measures as elimination of sharp surfaces, safe-type control wheels, breakaway features in instrument panels, and the use of ductile or energy- absorbing materials wherever possible.
3. Specific steps that can be taken include:
  - a. When choosing clothing avoid synthetics, wear long sleeves / pants, and have a jacket. Shoes should be kept on (despite what the flight attendants say) and zippers should not replace laces. Flight crews should use cotton underwear, gloves and helmets.
  - b. Helmets deserve more attention than they get. One out of

every three fatalities is due to head injuries. Functions of a helmet include:

- i. Oxygen attachment.
  - ii. Gun site attachment.
  - iii. Infrared sighting device attachments.
  - iv. Communications.
  - v. Noise attenuation.
  - vi. Protection.
  - vii. Night Vision Devices.
- c. Current helmets provide good protection against sharp objects, but less protection against flat objects. Motorcycle helmets rated at 400 G's are too stiff and allow fatal intracranial injuries to occur.
- d. Design features of a good helmet are:
- i. Circumferential anchorage to the neck that will remain in place with up to 400 lbs of deceleration force (it takes 2000 lbs to cause cervical fx's).
  - ii. Fracture and tear resistance external shell with a crushable liner that attenuates peak impact forces to 150 G's maximum.
  - iii. Two lbs maximum weight with a center of gravity near the head's C.G., a shatterproof visor, and minimal external projections.
  - iv. Noise attenuating ear cups.

## **Energy Absorption**

1. Occupant impact injuries are usually associated with "bottoming out" of structures incapable of absorbing or reducing crash forces. Depending upon the nature of the intervening aircraft structure, crash forces transmitted to the occupant's body may be increased, decreased, or unchanged. Vertical forces are usually transmitted to the occupant through the seat, floor, and structures underlying the floor. The dynamic responses of these structures during crash impacts determine how forces acting on the aircraft are transmitted to the occupants. Extremely rigid structures, normally not found in aircraft, transmit the forces without modification. An elastic structure, which has energy-storing properties, can produce amplifications of the deceleration forces on the occupants. Elastic structures include compressible foam rubber cushions, offering little resistance to compression. On compression all the energy is stored in the cushion until the occupant bottoms out. The cushion then rebounds, imparting a greater dynamic force on the occupant. More desirable structures are those that absorb energy. Several designs exist including energy absorbing seats. Energy



absorbing seats progressively collapse, absorbing impact energy at levels within human tolerance ranges, without storing it to later produce a delayed dynamic overshoot. Impact force transmission through energy absorbing seats can significantly attenuate the actual crash forces acting on the aircraft. They are the most basic and best methods for protecting occupants from crash forces.

2. Although crash forces in most accidents act obliquely to the occupants' spines, it is customary to calculate the vertical and horizontal components of the crash force resultant and compare these to known human tolerance levels. A normally seated person, adequately restrained, can tolerate approximately 40 G transverse to the spine ( $G_x$ ), 25 G in the foot-to-head direction ( $+G_z$ ), 15 G in the head-to-foot direction ( $-G_z$ ) and 20 G side-to-side ( $G_y$ ).
3. To improve energy absorption, the goal is to design a structure, particularly the seats, that will undergo controlled deformation thereby reducing stress to a level that the body can safely tolerate. This is accomplished by increasing the time and / or distance over which impact forces are dissipated.
4. Features that enhance energy absorption include:
  - a. Stroking seats that are light, inexpensive requiring minimal maintenance.
  - b. Landing gear that can attenuate a significant vertical velocity. The FAA requires 8 1/2 fps. The Blackhawk / Seahawk (SH-60) can absorb 30 1/2 fps.
  - c. Keel beams.
  - d. Cushions, including helmet liners.

## Post-Crash Factors

1. One of the greatest hazards in an otherwise survivable impact is a post crash fire. Normally these fires develop rapidly, and may severely restrict the time available for evacuation. According to a NACA fixed-wing study, passengers can expect to have an average of 50 seconds to escape large aircraft. In some severe fires, passengers have as little as 7.5 seconds to escape. Studies of fuel spillage in rotary wing accidents indicate that a realistic escape time before incapacitation is 30 seconds. Internal spillage can decrease escape time to as few as 5 seconds. These time elements become even more critical when occupants are trapped in wreckage, disabled or stunned by injuries, or unfamiliar with seat belt release function or the operation of emergency exits.

2. Control of post crash fires is primarily governed by aircraft design. This includes the location of fuel cells and fuel lines in relation to the electrical and mechanical ignition sources and the resistance of fuel system components to rupture under conditions of moderate crash forces or airframe distortion. Other preventive measures include the location of fire extinguishers at strategic points and the installation of automatic or impact-activated emergency fire extinguishing systems.
3. In the event of a post crash fire or ditching, the ability of all the occupants to timely evacuate the aircraft becomes the most important survival factor. Hand or impact-operated emergency light can be critical during evacuations in darkness or subdued light. That the evacuation time is a function of the number, location, size, and ease of opening of both normal and emergency exits should be obvious to even the non-experienced passenger.
4. Post crash factors to increase survivability:
  - a. Cradling of flammable fluids systems to provide maximum impact protection.
  - b. Sufficient emergency exits include standard doors, throw out windows, breakaway hinges and shaped charges.
  - c. Design of aircraft seats / interiors to reduce the current hazards of pyrolyzation of synthetics to HCl and HCN.
  - d. Design crashworthy fuel systems.
  - e. Crash resistant self-sealing fuel cells.
  - f. Fuel lines with breakaway valves that isolate themselves after impact.
  - g. Physically separating the fuel system from likely ignition sources, i.e., hot metal, batteries, sparks, and flames.
  - h. Improving individuals' tolerance to heat by wearing clothes that light in color, with tight weaves, shiny surfaces, minimal fuzz on the surface, and not worn too tight or too loose.
  - i. Natural fibers such as wool are best. Cotton gives reasonable protection, but synthetic fibers should be avoided. An exception is the flight suit. Nomex, which is a Nylon, has good radiant protection.

## Injury Analysis

1. Document injuries carefully and correlate them with the circumstances of the mishap. This information is essential to making any modifications in procedures or in the aircraft that will prevent similar injuries in the future. Among the key questions are:
  - a. Exactly when did the injury occur?
  - b. What was the nature of the force that produced the injury?
  - c. Is the injury the result of mishap forces or an artifact of the post-crash environment?
  - d. Did the injury occur before or after death, or did it perhaps even exist before the mishap?
2. Injury Types: There are 4 major injury types - thermal, intrusive, impact, and decelerative. They can be defined as follows:
  - a. **Thermal**: Following a postcrash fire, the interpretation of the significance of thermal injuries can be one of most daunting tasks to face a Flight Surgeon.
    - i. The following questions are pertinent and will invariably be asked by the AMB:
      - Was there any evidence of an inflight fire or exposure to smoke and fumes inflight?
      - If a postcrash fire occurred, were the resulting thermal injuries the cause of death, or merely an artifact sustained after death?
    - ii. The simplest and best way to assess whether the aircrewman was alive at the time of exposure to any postcrash fire is to examine the airways for the presence of soot. This will appear as black material on the mucosal inner surface of the trachea. To avoid the artifactual introduction of soot into the trachea, it is best to open the airway in situ, after opening the chest cavity during autopsy.

The following provides a framework for interpretation of findings:		
<b><u>Postcrash Fire</u></b>	<b><u>Airway Findings</u></b>	<b><u>Possible Interpretation</u></b>
Yes	Soot present	No inflight fire; crewmember survived crash; postcrash thermal injuries were cause of death
		Crewmember exposed to smoke and fumes from inflight fire which was cause of death; other thermal injuries artifactual
		Crewmember exposed to smoke and fumes from inflight fire; died from thermal injuries sustained in postcrash fire
		Crewmember exposed to smoke and fumes from inflight fire; died from crash forces; other thermal injuries artifactual
		Crewmember exposed to smoke and fumes from inflight fire, died from natural causes (i.e. MI); other thermal injuries artifactual
No	Soot present	Crewmember exposed to smoke and from inflight fire, which may or may not be cause of death-correlate with blood CO levels
Yes	Soot Absent	Crewmember not exposed to smoke and fumes from inflight fire; impact injuries fatal, other thermal injuries artifactual
No	Soot Absent	Crewmember not exposed to smoke and fumes from inflight fire
The above information should be correlated with the results of carbon monoxide levels performed on the toxicology samples. Please refer to the chart on CO level interpretation below		

iii. Common artifactual findings in bodies exposed to fire, which are not necessarily related to the cause of death, include:

- Pugilistic attitude of extremities (contraction of arms and legs).
- Thermal fractures of long bones and skulls.
- Epidural hematomas.
- Splitting of soft tissue.

b. **Intrusive**: e.g., loss of occupiable space due to intrusion of portions of the aircraft and/or surrounding objects such as trees

or wires. Commonly referred to as “crush injuries”.

c. **Impact:** e.g., control surface injuries: injury patterns of the hands and feet may provide evidence of who was controlling the aircraft at impact. Fractures of the carpal, metacarpal, tarsal, and metatarsal bones, with associated lacerations of the palms and soles are suggestive of contact with hard objects, such as the control surfaces, at the time of impact. Tibial shaft and talar neck fractures have also been described. Despite the teachings that have been passed down from Flight Surgeon to Flight Surgeon since the time of the Punic Wars, recent studies have shown that classically described control surface injuries are nonspecific and can be seen in passengers as well as pilots. Therefore, they must be interpreted with caution.

d. **Decelerative:**

Pulmonary contusion	25 G
Nose fracture	30 G
Vertebral body compression (body position dependent)	20-30 G
Fracture dislocation of C-1 on C-2	20-40 G
Mandible fracture	40 G
Maxilla fracture	50 G
Aorta intimal tear	50 G
(Distal - Gx)	
(Proximal - Gz)	
Aorta transection	80-100 G
Pelvic fracture	100-200 G
Vertebral body transection	200-300 G
Total body fragmentation	350 G
Concussion	60 G over 0.02 sec
	100 G over 0.005 sec
	180 G over 0.002 sec
NOTE: This table, as with the other human tolerance table that follows, was derived in laboratories, under artificial and somewhat unrealistic conditions.	

## Human Crash Tolerances

### Human Tolerance To Impacts

1. The ability to withstand deceleration has been studied systematically in experiments of parachuting, ejections, and rocket powered sleds trials. One classic series of rocket powered sled experiments by Colonel John Stapp in the 1950's provided much of the information on injuries associated with rapid deceleration, but the data is incomplete at best. The problem is few volunteers will intentionally suffer injuries to help establish the true envelope of human impact tolerances. As the limits of injury-free deceleration were reached other methods have been used to help fill in some of the gaps. Outcomes of human accidents, cadaver and animal studies, and survivors of long free falls have been extensively studied. As technology improved, anthropometric dummies, and mathematical / computer models have been used. Still it must be remembered that estimates of human tolerance to impacts are just that - estimates.
2. It is known that human tolerance to deceleration is a function of:
  - a. The acceleration pulse rise (rate of G onset).
  - b. The acceleration direction with respect to the body.
  - c. The acceleration duration (from which a velocity change can be computed).
  - d. The acceleration magnitude (peak G).
  - e. The type of seat and restraint.
  - f. The physical characteristics of the aviator.
  - g. The secondary impact of body parts with the aircraft.
  - h. The distribution of force over body parts.
3. It is impossible to isolate each of these factors. We do know that the longer the duration, the greater the magnitude, or the higher the rate of onset, the less likely a person is to survive. For the durations and rates of onset found in most survivable mishaps, the following limits are realistic for a properly restrained occupant:

Eyeballs Out ( $-G_x$ ) (Ex: A carrier landing)

45 G for .1 sec or 25 G for .2 sec

- Colonel Stapp survived a forward deceleration of 35 G's with an onset rate of 493 G/sec. He experienced only retinal hemorrhages. After 38 G's at 1100 G/sec onset he suffered syncope, shock, and 6 hours of albuminuria.

Eyeballs In (+G<sub>x</sub>) (Ex: A catapult shot)

50 G for 0.25sec (500 G/sec onset)

- One accidental exposure of a human subject of 83 G for .04 sec (3800 G/sec) produced shock in the subject, but he survived.
- At about 45 G<sub>x</sub>, the heart rotates in the thorax, causing intimal tears of the aorta. As we cannot restrain the heart, 50 G is the upper limit of G<sub>x</sub> tolerance. A properly restrained human could theoretically survive a deceleration from 150 mph to a dead stop in 0.25 sec.

Eyeballs Down (+G<sub>z</sub>) (Ex: An ejection)

20-25 G for 0.1 sec

- USAF statistics of 175 ejections showed that accelerations from 17.5 to 18.4 G had a 7% incidence of vertebral fractures.

Eyeballs Up (-G<sub>z</sub>) 8. (Ex: Outside loop)

15 G for 0.1 sec

Eyeballs Left or Right (+/-G<sub>y</sub>) 9.

9 G for 0.012 sec

- This value is for individuals restrained only with a lap belt. Lateral limits are poorly defined. Limiting factors appear to be bradycardia and syncope secondary to shoulder strap impingement on the carotid bodies. Exposures to 23 G's (1210 G/sec onset) have been tolerated by providing greater support along the lateral aspect of the body (Metal plates supporting the head, torso and legs).

### **Miscellaneous Points:**

1. There is a "Zone of Unknown Tolerance" when very short stopping distances are involved.
2. You can't restrain the heart, thus  $-G_x$  is limited to 50 G's.
3. Neck fractures develop at 2,000 lbs.
4. Consciousness can be maintained up to 150 G's if the duration of impact is short.
5. Characteristic hand / feet lacerations and fractures usually occur in the individual actually at the controls at impact.
6. Chances for survival are increased with good physical conditioning and with increased muscular contraction at the time of impact.
7. The goal of a crashworthy system is to attenuate the impact forces to the human tolerance levels of 25 G's in the  $G_z$  axis and 45 G's in the  $G_x$  axis.
8. It is important to note that it is the G applied to the aviators and not the aircraft that determines their ability to survive. The two are closely related but not always the same.
9. The tables on the following page list the human G-tolerances for whole body and regional body impacts.



## Whole body Impacts:

<i>Position</i>		<i>Limit</i>	<i>Duration</i>
Eyeballs out	(-G <sub>x</sub> )	45 G	0.1 sec
		25 G	0.2 sec
Eyeballs in	(+G <sub>x</sub> )	83 G	0.04 sec
Eyeballs down	(+G <sub>z</sub> )	20 G	0.1 sec
Eyeballs up	(-G <sub>z</sub> )	15 G	0.1 sec
Eyeball left/right	(+/-G <sub>y</sub> )	9 G	0.1 sec

- Note - Fully restrained subjects exposed to whole-body impacts at up to 250 G/sec onset rates. Injuries are known to occur if limits are exceeded. For lap belt restraint only, -G<sub>x</sub> tolerance may be reduced to 1/3.

## Regional Body Impacts:

<i>Body Area</i>	<i>Limit</i>	<i>Duration</i>
Head (Frontal Bone, 2" diameter)	180 G	0.002 sec
	57 G	0.02 sec
Nose	30 G	*
Maxilla	50 G	*
Teeth	100 G	*
Mandible	40 G	*
Brain (Concussion)	100 G	0.005 sec
	180 G	0.002 sec

\* Duration figures not available.

- Human tolerance to abrupt acceleration depends on the direction, magnitude, duration and rate of onset of the acceleration force. The manner in which the occupant's body is supported during the acceleration is critical. **(Calculate Crash Forces)**
- If the calculated crash forces on the airframe exceed the human tolerance limits by a factor of 2 or more, survivability is unlikely. If the limits are exceeded by a factor of 1.5, survivability is doubtful. If the limits are exceeded by a factor of 1.25 or less, survivability can be dependent on specific CREEP factors. If the limits are not exceeded, survivability is expected, although individual variations and CREEP factors remain.

## Carbon Monoxide Level Interpretation

1. The carbon monoxide (CO) level in the blood or spleen can give valuable information about the cause of death. It must be remembered, however, that cigarette smoking can raise the carbon monoxide level in the blood significantly. The two-pack-a-day smoker will have an 8% to 9% carboxyhemoglobin. Carboxyhemoglobin levels in nonsmokers (in a minimally polluted area) range from 0.5% to 0.8%.
2. CO levels in the blood (assuming normal atmospheric composition and sea level pressure) are considered normal for the purpose of aviation pathology if < 3% for non-smokers and < 10% for smokers. Levels above these values indicate that the individual was exposed to the products of combustion while alive, either before or after the mishap event. Whole blood is the best specimen but any tissue that contains a considerable amount of blood (such as spleen) can be used.

<b>Findings</b>	<b>Most Likely Explanation</b>
CO elevated with instantaneous non-thermal fatal injury present	Crewmember breathed CO inflight
CO not elevated; instantaneous non-thermal fatal injury present	CO not a mishap factor
CO elevated, no instantaneous fatal injury present	Postcrash fire present: crewmember breathed CO either inflight or postcrash.
	No postcrash fire present: crewmember breathed CO inflight
CO not elevated; no instantaneous fatal injury	CO not a mishap factor
This table does not take into account the possibility of “flash fires”, where a death can be due to thermal injury but the blood CO normal. This has been described in conjunction with fuel fires and should be considered if the death appears to be due to burns, but the blood CO is normal.	

## Ethanol Concentration Interpretation

1. The significance of detectable levels of alcohol (ethanol) in the blood or urine of survivors is straightforward. However, with postmortem specimens the question is always the same: is it real or a postmortem artifact (decomposition or fuel contamination)?
2. Alcohol in the AFIP forensic toxicology laboratory is analyzed by gas chromatography, which is the standard for volatile analysis. In aircraft mishaps, victims frequently do not have residual blood or urine due to the fragmentation and multisystem trauma. In this case, other possible specimens include vitreous and tissue homogenate extracts from various organs. Frequently the tissues are contaminated by fuel or are in an advanced stage of decomposition. In both circumstances, volatiles including ethanol are likely to be present.
3. The presence and quantity of ethanol in putrefactive tissues depends on many factors and always complicates the interpretation of results. Assessment of reported values relies heavily on:
  - a. The condition of the tissues.
  - b. The entire chromatogram may contain several volatiles (frequently tissue samples are limited).
  - c. The distribution of the volatiles in several tissues (often tissue distribution studies are also limited).
  - d. The 72-hour history and witness statements.
  - e. The Flight Surgeon's direct input.
4. Alcohol concentrations due to bacteria have been reported as high as 200 mg/dl or 0.2%. However, rarely are levels over 60 mg/l clearly attributable simply to decomposition. If ethanol is present, the concomitant presence of other substances such as acetaldehyde, acetone, and n-propanol can indicate that the ethanol is due to bacterial production/decomposition. However, acetaldehyde is a normal byproduct of ethanol metabolism and acetaldehyde can be found in diabetes or malnutrition. Therefore, the presence of these substances can occur independent of decomposition.

5. If alcohol is found in urine or vitreous obtained postmortem, the ingestion of alcohol before death is strongly suggested.
6. Drowning and burning per se usually do not effect the concentration of alcohol in tissues.

# REPORTING

Following analysis of all evidence gathered from a mishap, the AMB prepares a complete report called the Safety Investigation Report (SIR). The Flight Surgeon is instrumental in assisting with the preparation of the SIR. The Flight Surgeon submits an Aeromedical Analysis (AA) to the AMB, which becomes privileged evidence. All findings identified in the AA must be addressed by the AMB in the SIR. The AMB does not have to agree with the findings of the AA but must address and accept or reject the findings.

In both reports, all findings must be evidence based and a copy of the evidence must become an enclosure to each report. Evidence includes witness statements, engineering investigations, laboratory studies, AMB analysis of wreckage and photographs that reveal information thought causal to the mishap.

## Safety Investigation Reports

1. Safety Investigation Reports (SIRs) shall be submitted for all naval aircraft mishaps. The reporting custodian of a naval aircraft mishap is responsible for investigating and reporting the mishap. No other investigation relieves the requirement for a mishap investigation. All naval aircraft mishap investigations are conducted solely for safety purposes. Aviation related incidents that do not meet the criteria for an aviation mishap should be investigated and reported using a HAZREP.
2. An SIR should not be confused with a mishap data report (MDR) (also called a mishap message report), which is the official format for reporting the occurrence of a mishap and the basic facts surrounding the event. Among the differences, an MDR contains no privileged information. (SAMPLE MDR)
3. The purpose of SIRs is to report hazards that were causes of the given mishap or were causes of damage or injury occurring in the course of the given mishap and to provide a means for submitting recommendations to eliminate those hazards. Cause factors of a mishap and cause factors of injury and damage occurring in the course of a mishap can be two different matters. Both are the subjects of aircraft mishap investigations.
4. There is not necessarily a correlation between the severity of a mishap and the potential for damage and injury inherent in the hazards detected during investigation of that mishap. The

investigative effort should therefore not be tailored to the severity of the mishap; rather it should be tailored to identify the hazards associated with the mishap. AMBs must assign risk assessment codes to each hazard they wish to eliminate. The RACs must correspond to the causal factors listed in paragraph 12 of the SIR. The SIR reflects the most significant hazard reported therein. (Appendix M contains information on RACs).

5. **OPNAV 3750.6** directs that the SIR be composed of 13 "paragraphs".
  - a. **Paragraph 1.A.** contains a hazard severity statement followed by a brief description of the mishap
  - b. **Paragraph 1.B** contains a privileged mishap narrative that provides a detailed summary of events leading to the mishap, sequence of events during the mishap, causes of the mishap and why the mishap occurred. The paragraph will be developed from only the accepted causal factors found in paragraph 11.
  - c. **Paragraphs 2 through 9** describe the background facts of a mishap repeated from the initial MDR. New non-privileged information not included in previous MDRs will be introduced here.
6. The format of the SIR, in itself, provides a guide for the deliberations of the board. The outline of the SIR reflects a pattern of deductive reasoning:
  - a. What the AMB knows (paragraph 10, Evidence).
  - b. Reasoning of the AMB (paragraph 11, Analysis).
  - c. Deductions of the AMB (paragraph 12, Conclusions).
  - d. Solutions of the AMB (paragraph 13, Recommendations).
7. **Paragraph 10 "SUMMARY OF EVIDENCE"** contains a systematic presentation of everything relevant about the event under investigation.
  - a. Subparagraph A contains a list of enclosures indicating those that are non-privileged as enclosure "1A, 2A" etc. The privileged enclosure list follows and starts with enclosure "1B".

- b. Subparagraph B contains the summary of evidence. Examples of evidence that may be found in paragraph 10 are:
    - i. Chronological order of events.
    - ii. Medical report information.
    - iii. Witness statements.
    - iv. Aircrew level of training.
    - v. Radar tape summaries.
    - vi. Data of a personal nature that must be presented will only be discussed in general terms in this paragraph. Details of this personal data shall be included in the Aeromedical Analysis.
  - c. Subparagraph B contains both privileged and non-privileged (so-called "real") evidence. Privileged evidence will be prefaced with a "(P)".
  - d. Opinions, conclusions and recommendations of the AMB are not permitted in paragraph 10.
8. **Paragraph 11 "ANALYSIS"** is the section that presents the reasoning of the board. There should be no new evidence (not already present in paragraph 10) brought up in paragraph 11. This paragraph should layout all the avenues that the board took as it analyzed the evidence (causal factors of the mishap and causal factors of the damage and injury occurring in the course of the mishap) presented in paragraph 10. For example, a jet engine ingests a bird with resulting disintegration of the engine. The analysis should go beyond simply chalking-up the mishap to poultry and focus on issues such as whether the pilot's training was adequate (as indicated by his performance before, during and after the bird strike) and whether the aircraft's protection and escape systems functioned property. Examples of possible causal factors are material failure, engine malfunction, training deficiencies, supervisory error, lack of proper aircrew coordination, and so on. All cause factors identified in the Aeromedical Analysis must be addressed in this section. The board must logically determine which of the possible causal factors are supported by the evidence and therefore accepted and which must be rejected for lack of supporting evidence. The

following format shall be followed: List (1) possible cause factor, (2) a brief hazard statement including WHO and WHAT or MODE and COMPONENT, (3) whether the board accepted or rejected the possible cause factor, and (4) a discussion of the board's reasoning based on the evidence in paragraph 10 (5) a WHO / WHAT /WHY or COMPONENT / MODE / AGENT summary.

- a. Causal Factors: The following are categories of causal factors that will precede each paragraph presented in the analysis section of the SIR.
    - i. Aircrew.
    - ii. Supervisory.
    - iii. Facilities Personnel.
    - iv. Maintenance.
    - v. Material Factor.
  - b. The hazard statement must be brief and terse specifying acts of omission or commission.
  - c. "WHO" / "WHAT" / "WHY" or "COMPONENT" / "MODE" / "AGENT" format. For each causal factor there is only one WHO and WHAT, but there can be more than one Why. The AMB will select the "who, what and why" that most closely describes this cause factor from Appendix L of OPNAVINST 3750.6.
9. **Paragraph 12 "CONCLUSIONS"** has three subparagraphs (A) the cause factors of the mishap (B) the cause factors of any damage or injury occurring in the course of the mishap and (C) operational risk management assessment of hazards associated with the mishap. It is essentially a listing of all the accepted possible cause factors from paragraph 11. Conclusions under consideration may be evaluated by the question: "If the identified hazard had been eliminated prior to the mishap, would the mishap (or damage and injury) have been prevented?"
- a. The five causal factor conclusions are classified:
    - i. Determined.



- ii. Most probable.
  - iii. Undetermined with the following possible causal factors.
  - iv. Undetermined.
  - v. No fault assigned.
- b. Risk assessment codes (see [Appendix M](#)) shall be assigned to each hazard identified. Conclusions will be written by first identifying the involved area (i.e., aircrew, supervisory, facilities personnel, maintenance, material factor) then a statement of the specific hazard.
- c. An example conclusion:
- i. Aircrew error - MP initiated practice low altitude power loss below NATOPS minimum. RAC: 1  
ASSOCIATED RECOMMENDATIONS 13.A.(1)(a)
- d. The Operational Risk Management Assessment section is intended to list the most significant hazards associated with the mishap and identify risk control measures to mitigate the hazard. An example follows:
- i. HAZARD - Aircrew Fatigue  
(A) CONTROL - Comply with OPNAVINST 3710.7 Rest and sleep requirements.  
(B) CONTROL - Comply with CO, VF-XX memo of June XX of notification of operations department if issues of fatigue arise.
- e. Every accepted conclusion and HAZARD identified in paragraph 12 should lead to at least one recommendation in paragraph 13.
10. **Paragraph 13 "RECOMMENDATIONS"** lists the AMB's recommendations that, if incorporated, would prevent the mishap from recurring. Recommendations that do not serve to eliminate the hazards identified in paragraph 12 shall not be included. Recommendations should be self-explanatory, practical, uninhibited, and pithy. Each causal factor (HAZARD) in paragraph 12 should have at least one corresponding recommendation in paragraph 13. Recommendations under consideration may be evaluated by the question: "If the

recommended action had been taken prior to this mishap, would the hazard(s) have been eliminated and the mishap (or damage and injury) prevented?"

- a. The board should do its best to make specific and definitive recommendations and, whenever possible, include drafts of proposed changes in the recommendation so all concerned may know exactly what is intended.
- b. Examples of ineffective recommendations:
  - i. All squadrons review SOP.
  - ii. All squadrons adhere to NATOPS procedures.
- c. Generally bad "buzz" words: review, comply, insure, reemphasize. These words don't lead to measurable change. Also useless are terms such as all pilots, all aircraft and all squadrons. In addressing everyone, you reach no one.
- d. Good recommendations:
  - i. NAVAIRSYSCOM, fund research into the development of crashworthy crew seats in the UH-1N in the next fiscal year.
  - ii. CO HMLA-969, submit the following proposed NATOPS change within 10 calendar days: (draft of NATOPS change).
- e. Determining which agency is responsible for a particular function in naval aviation is not always a simple matter, and may require some diligent research. Should an AMB err, the first knowledgeable endorser will correct the recommendation.
- f. The AMB should also resist being too specific. For example, a "Jones-built" part may be the needed replacement for the broken "Smith-built" part. However, the board should not presume to recommend the "Jones-built" part. The AMB should only recommend installation of a part with suitable characteristics to solve the problem and possibly refer to the "Jones-built" part as an example.
- g. Finally, the AMB should not let presumptions about the

budget or bureaucracy prevent it from making a recommendation.

11. An SIR folder consists of 2 parts: Part A and Part B:
  - a. Part A consists of the list of nonprivileged information extracted from paragraph 10 of the SIR, the final MR message and nonprivileged enclosures. These will be attached to the left side of the SIR folder. The material in Part A may eventually be disclosed by the Naval Safety Center to the general public.
  - b. Part B is privileged and consists of the complete SIR message, privileged enclosures (including the AA) and all endorsements. These will be attached to the right side of the SIR folder. The material in Part B will be used only for safety purposes. Distribution of Part B of SIRs to anyone not specified in **OPNAV 3750.6** or not authorized by the CNO is strictly prohibited. (See Appendix P for Distribution of SIR and AA)
  - c. The Commander, Naval Safety Center is the only releasing authority for material in either Part A or Part B.
12. Internal command distribution of SIRs is limited to those who require knowledge of the report for safety purposes.
13. To avoid any association with disciplinary action, reports of JAG Manual investigations, Naval Aviator/Naval Flight Officer Evaluation Board reports (for USN), and Field Flight Performance Board reports (for USMC) shall not be appended to nor made a part of any SIR. Nor may an SIR, or any part of one, be made a part of a JAG Manual investigation report, etc.
14. The exercise of command influence to edit, modify or in any way censor the content of SIRs is contrary to the spirit of the Naval Aviation Safety Program and is prohibited. Seniors may comment in an endorsement to the report.
15. SIRs shall be "submitted within 30 calendar days following the mishap. In the case of missing aircraft, the SIR shall be submitted within 30 calendar days after completion of the organized search. The appointing authority may request an extension from the controlling custodian.

16. Frequently the Naval Safety Center will send a specialty trained mishap investigator to assist the AMB. There will be complete cooperation and unrestricted exchange of information between the AMB and the investigator. The investigator will control all real evidence.
  - a. Types of mishaps that normally require the aid of a Naval Safety Center investigator are:
    - i. Class A mishaps where wreckage is available.
    - ii. Inflight structural failure.
    - iii. Inflight fire from unknown source.
    - iv. Midair collision.
    - v. Mishaps where nothing is known of the causes and there are no surviving crew members ("smoking hole").
    - vi. Deep-water recovery attempts.
    - vii. Recurring hazard reports.
  - b. When a Naval Safety Center /AFIP medical investigator is on the scene, he may control medical evidence, including remains.
17. For the investigation of interagency, intercomponent, NATO or any multiple aircraft mishap, refer to **OPNAVINST 3750.6** and **NATO STANAG 3318**.
18. Regardless of the degree of a member's active participation in an investigation, each AMB member should review the completed report prior to its release. However, the AMB is not a democracy and the SIR need not be voted on or cosigned. In the final analysis, it is the work and the responsibility of the senior member.
19. The completed SIR message is routed through the endorsing chain (which is generally coincident with the operational chain of command from the reporting custodian to the controlling custodian). Enclosures, including the AA, are forwarded as requested by the endorser. Endorsements to SIRs are privileged. Any endorser to the SIR has the power to direct the AMB to reconvene to further investigate a specific possible cause factor

that the endorser does not feel was adequately addressed in the SIR.

20. Until concurred with by all cognizant command levels and then subsequently "closed" as action having been implemented, the Naval Safety Center monitors recommendations emanating from mishap investigations and hazard reports through the Mishap and Hazard Recommendation Tracking (MISTRAC) program.

## Safety Investigation Report Enclosure Forms

In Appendix N of **OPNAVINST 3750.6** are found the enclosure forms to the SIR. They serve as a ready source of information for input into the Naval Safety Center data banks. They are important for research and trend analyses. They also provide details and background data to support the SIR and aeromedical analysis (AA). Certain SIR enclosure forms must be submitted on each individual involved in the mishap. These SIR enclosure forms are the responsibility of the entire AMB. Some of these forms are clearly aeromedical in nature, requiring the Flight Surgeon to lead the work on them. Others will require assistance from the operations department, physiologists, PRs, AMEs and other knowledgeable personnel within and outside the squadron. Ensure that forms labeled NP contain only Non-privileged information.

The SIR enclosure forms:

1. General Information Data - NP Word .doc Version
2. Individual Background Data - NP Word .doc Version
3. Medical Information - NP Word .doc Version
4. Aviation Training Data - NP Word .doc Version
5. Aviation Life Support Systems Data - NP Word .doc Version
6. Escape, Egress Data - NP Word .doc Version
7. Ejection or Bail Out Data - NP Word .doc Version
8. Survival and Rescue Data - NP Word .doc Version
9. Aircrew Data - NP Word .doc Version
10. Aircraft Data - NP Word .doc Version
11. Impact Data - NP Word .doc Version
12. Night Vision Device Data - NP Word .doc Version
13. Meteorological Data - NP Word .doc Version
14. Aeromedical Analysis (AA) - P Word .doc Version
15. Chronological Account of Activities of Previous 72 Hours - P Word .doc Version
16. Bird / Animal Strike Hazard Report - NP Word .doc Version

**NP- Non-privileged** Information Only. Submit on **Side A** of SIR

**P** - Contains **Privileged** Information. Submit on **Side B** of SIR

## Aeromedical Analysis (Sample AA in Word .doc)

1. Submission Criteria. If contributing human factors are suspected, where there are personnel injuries, or pertinent medical findings, or attempts to eject, bail out, or otherwise emergency egress, submit an AA. It is a rare aircraft mishap that does not have a human factor component. Human factors do not stop at the level of the pilot, they extends to the maintainers, Air Traffic Controllers, Squadron chain of command through the Airwing to the TYCOM and above. The role of an investigating Flight Surgeon is not only limited to an in-depth analysis of the individuals directly involved in the mishap but to also expose the macroscopic picture that reveals all the events in the mishap chain.

The AA is the **privileged report** by the AMB Flight Surgeon that addresses mishap causes, conclusions and recommendations. The AA documents the aeromedical conditions the Flight Surgeon has determined to be pertinent to the mishap. These conditions include all human factors contributing to the mishap, injury, or other damage. It shall include all aircrew, maintenance, facilities, and supervisory factors. Any aeromedical causal factor discovered during the investigation must be brought to the attention of the AMB and addressed in the SIR message. However, there is no guarantee they will accept it as a causal factor. There may be aeromedical conditions present, which did not contribute to the mishap. List these in the designated subsection of the AA's conclusions. The AA and other portions of the SIR are complementary and expected to overlap. The format for the AA should follow the outline below with double underlined material repeated verbatim:

- a. Review of Events. This section of the AA is a chronological review of the mishap beginning with any preexisting aeromedical conditions and closing with the survivors coming under appropriate medical care. It should stand on its own merit. The reader should be able to understand the discussion section without referring to the SIR message or other documents. This section should include a brief medical and psychological profile of everyone involved. The Flight Surgeon will review sensitive, personal or speculative topics as pertinent in this section and comment on these additional areas for each person involved in the mishap:

- i. 72-hour history / 14 day history (if applicable).
- ii. Physiology training.
- iii. Flight physical.
- iv. Physical qualification waivers.
- v. Life stressors.
- vi. Relationships with co-workers, family and friends.
- vii. Acute medical problems.
- viii. Chronic medical problems.
- ix. Current medication and supplement use.
- x. Post-mishap biological samples/results.
- xi. Autopsy and post-mortem lab studies.
- xii. Escape or egress/survival episodes.
- xiii. SAR effort.
- xiv. Treatment and transport of those injured.
- xv.

**Attach** documents that support the information presented in this section to the end of the AA.

- b. **Discussion and Conclusions (DoD HFACS Analysis)**. In this section Flight Surgeons shall list and justify all the aeromedical conditions that were causal to the mishap using the DoD Human Factors Analysis and Classification System (DoD HFACS). List all of the aeromedical conditions that were causal factors in the mishap in subsection 2a. List all aeromedical conditions that were causal factors of additional damage or injury in subsection 2b. In subsection 2c, list all of the aeromedical conditions that were present but did not contribute to either the mishap or additional damage or injury. (See appendix W). (Appendix V) contains an DoD HFACS primer. Note: The official causal factors of the mishap are defined by the detailed cause factors (who/what/why's) found in the SIR. The DoD HFACS analysis is a tool that facilitates the organization of an in-depth human factors analysis. The more general categories of causal factors found in the DoD HFACS analysis help the AMB determine the detailed causal factors. The DoD HFACS analysis should therefore be consistent with the detailed causal factors in the SIR.
- c. **Aeromedical Recommendations**. This section is similar to paragraph 13 of the SIR. Based on aeromedical conclusions, make your recommendations here to prevent accepted causal factors from recurring and to prevent or limit the severity of additional damage or injury. Key each recommendation to the appropriate conclusion, and address them to the most



appropriate action agency for change. Like SIR recommendations, aeromedical recommendations should be based on a factor causal to the mishap or factors causal to additional injury and should be specific and definitive. (See [Sample AA Appendix W](#)) ([Sample AA in Word .doc](#))

2. Enclosures to the AA. Hold supporting documents to a minimum, but include the following enclosures if pertinent:
  - a. You must include chronological account of activities for the past 72 hours on everyone involved and 14 day history if applicable.
  - b. Post-mishap history and physical examination along with copies of past 2 physical examinations and BUPERS waiver letters.
  - c. Any medical record extracts you need to clarify or support the AA.
  - d. The AFIP aircraft mishap reconstruction by evaluation of injury patterns report. (Blue Report)
  - e. Relevant photographs that depict aeromedical or physiologic evidence that support findings in the AA.
  - f. Sensitive photographs, such as autopsy photographs or other photographs of the deceased. In a separate envelope, seal and mark these photographs: "PASS DIRECTLY TO THE AEROMEDICAL DIVISION, NAVAL SAFETY CENTER. Send them to the Naval Safety Center and nowhere else.
  - g. Reports detailing personal or sensitive material, such as psychiatric or psychological consult reports. In a separate envelope, seal and mark these reports: "PASS DIRECTLY TO THE AEROMEDICAL DIVISION, NAVAL SAFETY CENTER. Send them to the Naval Safety Center and nowhere else.
  - h. Include any other documents that meet the criteria for privilege ([See 3750.6R paragraph 708](#)), that will clarify or support the AA. (i.e. witness statements)
  - i. Submit one Electronic Copy of the AA on disc to the Aeromedical Division, Naval Safety Center CODE14

NOTE: Keep any nonprivileged supporting documentation (such as radiology slips and lab results) on the side A of the SIR. Keep duplication of AA enclosures held in the main body of the report to a minimum and include only those documents that significantly clarify or support the AA.

3. No AA Required. When the nature of the mishap does not meet submission criteria described above for an AA, include a statement to that effect, along with an explanation for your conclusion in paragraph 6 of the initial MDR message. (See **OPNAVINST 3750.6R paragraph 514**.) If the AMB feels that they have the rare mishap that has absolutely no human factor at any level, the Flight Surgeon should call the Aeromedical Division of the Naval Safety Center and discuss the mishap.
4. After proofreading the AA, submit it to the AMB senior member for inclusion as an SIR enclosure. **All aeromedical conclusions must be addressed by the AMB in the SIR**. The conclusions do not have to be accepted by the AMB, but a thorough discussion of reasons for rejection should be documented in the SIR.
5. The Aeromedical Analysis is a privileged enclosure of the SIR and is placed on side B of the final SIR package.

**NOTE: Insert the following header on each page of the AA.**

**AEROMEDICAL ANALYSIS**

**Page ? of ?**

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**THIS IS PART OF A LIMITED USE NAVAL AIRCRAFT SAFETY INVESTIGATION REPORT THIS FORM CONTAINS PRIVILEGED INFORMATION AND SHALL BE PLACED IN PART B OF THE SAFETY INVESTIGATION REPORT.**

**DO NOT ATTACH THIS FORM TO A JAG INVESTIGATION**

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6. Proper handling and distribution of the AA is covered in **Appendix P**. Thorough review of the AA by Aeromedical professionals in the endorsing chain (identified in **Appendix P**) is essential to ensure that all human factors identified in the AA are considered during analysis of the SIR.

# APPENDICES

## Appendix A: Naval Safety Center Telephone Numbers

<b>DSN 564-3520</b> <b>Commercial (757) 444-3520</b>	<b>EXT</b>
Aircraft Mishap Investigation Division	7234 / 6 / 7
Aircraft Maintenance and Material Division	7265
Aircraft Operations and Facilities Division Head	7203
Facilities Analyst	7281
Multi-Eng./Training Analyst	7210
Rotary Wing Analyst	7214
Survey Requests	7276
Fixed Wing Analyst	7272
Aviation Safety Programs Director	7225
Aeromedical Division	7228 / 9 / 7268
Data Retrieval and Analysis Division	7285
Duty Officer	7017
Legal	7047
<b><i>Mishap Telephone Report Submission***</i></b>	<b>DSN 564-2929</b>
OPNAVINST 3750.6 Inquiries	7226
Media, Communications, and Marketing	7310
Shore Safety Programs	7167

## Appendix B: Important Telephone Numbers

<b>Armed Forces Institute of Pathology</b>	Com	(301) 319-0000
Armed Forces Medical Examiner	DSN	285-0000
AFME FAX	Com	(301) 319-0635
Toxicology	DSN	285-0100
<b>Naval Air Warfare Center</b>	DSN	437-6132
Mishap Investigation Support Team	Com	(760) 939-6132
<b>Hammer Ace *Air Force Communications Assistance Team</b>	DSN	575-5785/5691
	COM	(757) 225-5785/5691
<b>Naval Aerospace Medical Institute</b>	Com	Prefix (850) 452-
	DSN	Prefix 922-XXXX
Officer in Charge (OIC)		2741 / 8051
OIC FAX		8320
Academics		2458 / 57
Academics Telecopier / FAX		2357
Aviation Selection		2516
ENT		2257 x1042
Hyperbaric Medicine		3297 / 3409 / 2369
Internal Medicine / Neurology		2257 x1022
Operational Physiology		2257 x1079
Ophthalmology		2257 x1044
Physical Examinations		2257 x1026
Physical Qualls Division		2257 x1074
Psychiatry		2257 x1081
RAM Director		8125
<b>Naval Aerospace Medical Research Lab</b>	DSN	922-XXXX
	Com	(850) 452-XXXX
Commanding Officer		5782
Administration		5782
Front Desk		3486
<b>Bureau of Medicine &amp; Surgery</b>	DSN	762-3453
BUMED M341 Aerospace Medicine	Com	(202) 762-3453
FAX	DSN	762-3464
<b>NAVAVSCOLSCOM</b>	DSN	922-3181
ASO School, Pensacola, Fl	Com	(850) 452-3181
<b>Naval Air Warfare Center WD</b>	DSN	437- 6132
Crew Systems Department	Com	(760) 939-6132
Fleet Support & Survival systems Branch		
<b>Naval Experimental Diving Unit</b>	DSN	436-XXXX
NEDU, Panama City, FL	Com	(850) 230-XXXX
Administration		3100 / 4351
Biomedical Department		3212
<b>Navy Decedent Affairs Office</b>		
<b>BUPERS</b>		(800) 368-3202

<b>Air Force Safety Center</b>	Com	(505) 846-XXXX
Air Force Safety Center AFSA Life Science Branch	DSN	246-0830
<b>Air Force Research Labs at Brooks AFB</b>	Com	(512) 536-XXXX
	DSN	240-XXXX
Information		1110
Human Effectiveness Directorate		3116
<b>Hyperbaric Hotline (Brooks AFB)</b>	DSN	240-3281
	Com	(512) 536-3281
<b>Army Combat Readiness Center (Safety Center)</b>	DSN	558-XXXX
USASC Aeromedical Division	Comm	(334) 255-XXXX
Aviation Branch Safety Director		2763
		2301
<b>Coast Guard Aviation Safety</b>	Com	(202) 267-2971
<b>Federal Aviation Administration</b>		
Federal Air Surgeon	Com	(202) 267-3535
Aeromedical Standards Branch	Com	(202) 493-4075
<b>Civil Aeromedical Institute (CAMI)</b>	Com	(405) 954-1000
Information	DSN	940-1000
Director	Com	1000
Aeromedical Certification Division	Com	4821
Aeromedical Education Division	Com	6205
<b>National Transportation Safety Board</b>	Com	(202) 314-6000
Aviation Accident Investigation Division		6270
Aviation Medicine		6270
Human Performance Division		6270
Radar Analysis		6270
Transportation Data Recorders		6270
<b>Survivability / Vulnerability Info. Analysis Center - Wright Paterson AFB</b>	DSN	785-4840
(SURVIAC)	Com	(937) 255-4840

## Appendix C: Aeromedical Safety Officer Telephone Numbers

<b>Billet</b>	<b>DSN</b>
AMSO 1st MAW Okinawa	645-3888
AMSO 1st MAW KANEOHE BAY	257-5709
AMSO 2nd MAW CHERRY POINT	582-5010
AMSO 3RD MAW Miramar	267-1628
AMSO 4th MAW NEW ORLEANS	678-1926
AMSO AEWINGPAC (Pt Mugu)	351-0301
AMSO AIRLANT	564-0403
AMSO COMFITWINGLANT	433-9273
AMSO HMX 1 QUANTICO	278-3303
AMSO HQMC	224-2423
AMSO HSWINGPAC SAN Diego	577-1633
AMSO MAG 11 (Miramar)	267-1628
AMSO MAG 12 IWAKUNI	253-3968
AMSO MAG 13 YUMA	951-3568
AMSO MAG 14 CHERRY POINT	582-3520
AMSO MAG 16 (Miramar)	267-7815
AMSO MAG 26 Jacksonville NC	752-7183
AMSO MAG 29 NEW RIVER	752-7559
AMSO MAG 31 BEAUFORT	335-7145
AMSO MAG 36 (Japan)	315-636-3319
AMSO MAG 39 PENDLETON	365-4956
AMSO MARFORLANT	564-5306
AMSO MAWTS 1 YUMA	269-3652
AMSO NAVSTRKWARCEN Fallon	890-3093
AMSO SEACONWING Cecil Field	942-8615
AMSO STRKFIGHTWINGPAC	949-1028
AMSO TRAWING 5 Whiting	868-7138
AMSO TRAWING 6 PENSACOLA	922-3997
AMSO TW2	876-6496
AMSO VAQWINPAC	820-3083
AMSO HELSEACOMWINGLANT	565-2166
AMSO CNATRA	861-2377
AMSO MAG24KBAGHI	315-457-5707

**Appendix D: Important Local Telephone Numbers**

<b>Position, Name</b>	<b>Phone Number</b>
CO	
XO	
Squadron Duty Officer	
Senior Member AMB	
Safety Member AMB	
Maintenance Member AMB	
Operations Member AMB	
Other Member AMB	
Safety Center Rep	
AMSO	
APTU	
ATC/TOWER	
Tech Rep	
Tech Rep	
Photo lab	
Civilian Coroner	
Military Pathologist	
Clinic	
Hospital	
Emergency Room	
SAR	
Medevac	
Ambulance	
Paraloft	
Public Works/Seabees	
Security	

## Appendix E: Acronyms and Abbreviations

AA	Aeromedical Analysis or Aeronautically Adaptable
A/C	Aircraft
ACC	Aircraft Controlling Custodian or Aircrew Coordination
ACFT	Aircraft
ACLS	Advanced Cardiac Life Support
ACM	Air Combat Maneuvering
ACT	Aircrew Coordination Training
ADB	Aircraft Discrepancy Book
ADF	Automatic Direction Finder
ADMAT	Administrative-Material [Inspection]
AEPS	Aircrew Escape Propulsion System
AEROMED	Aeromedical or Aeromedicine
AFCS	Adaptive (or Automatic) Flight-Control System
AFFF	Aircraft Fire Fighting Foam
AFIP	Armed Forces Institute of Pathology
AFME	Armed Forces Medical Examiner
AFR	Aircraft Flight Record
AFU	All Fouled-Up
AGARD	Advisory Group for Aerospace Research and Development (NATO)
AGL	Above Ground Level
AGM	Aircraft Ground Mishap or Air-to-Ground Missile
AIMD	Aircraft Intermediate Maintenance Department
AL	All
ALF	Auxiliary Landing Field
ALSS	Aviation Life Support Equipment (ALSS)
ALSS	Aviation Life Support Systems (ALSS)
ALT	Altimeter or Attitude
AM	Amplitude Modification or Amendment
AMAL	Authorized Medical Allowance list
AMB	Aircraft Mishap Board
AME	Aviation Medical Examiner
AMF	Adios My Friend
AMO	Aviation Medical Officer or Aircraft Maintenance Officer
AMSO	Aeromedical Safety Officer
ANSI	American National Standards Institute
AO	Air Observer
AOA	Angle of Attack
AOC (S)	Aviation Officer Candidate (School)
AOM	All Officers Meeting
ANVIS	Aviator's Night Vision Imaging System
APP	Auxiliary Power Plant
APTU	Aviation Physiology Training Unit
APU	Auxiliary Power Unit
ASAP	As Soon As Possible
ASO	Aviation Safety Officer or Aviation Supply Office(r)
ASW	Anti-Submarine Warfare
ATC	Air Traffic Controller
ATK	Attack
ATLS	Advanced Trauma Life Support
AUTOVON	Automatic Voice Network (AV)
AV	Automatic Voice Network (AUTOVON)
AWOL	Absent Without Leave



BAL	Blood Alcohol Level
BN	Bombardier Navigator
BUMED	Bureau of Medicine and Surgery
BUNO	Bureau Number
CATSEYE	Tactical Air Night Vision Goggle System
CAD	Collective Address Designator or Cartridge Actuated Device
CAG	Carrier Air Group
CAMI	Civil Aeromedical Institute
CAT	Catapult or Computed Axial Tomography
CB	Construction Battalion (Sea Bee)
CBC	Complete Blood Count
CBR	Chemical-Biological- (or Bacteriological-) Radiological
CC	Chief Complaint
CDO	Command Duty Officer
CE	Close Encounter or Common Era
CFA	Cognizant Field Activity
CG	Commanding General or Coast Guard or Center of Gravity
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CINC	Commander-in-Chief
CMC	Commandant of the Marine Corps
CNATRA	Chief of Naval Air Training
CNET	Chief of Naval Education and Training
CNO	Chief of Naval Operations
CO	Commanding Officer or Carbon Monoxide
COD	Carrier-On-Board-Delivery
COHGB	Carboxyhemoglobin
COM	Command (er)
COMM	Communication or Commercial
CONUS	Continental United States
CQ	Carrier Qualification
CREEP	Container, Restraints, Environment, Energy Absorption, Post Crash Factors
CRM	Crew Resource Management
CRT	Cathode-Ray Tube
CT	Computed Tomography
CV	Aircraft Carrier
CVW	Carrier Air Wing
CXR	Chest X-Ray
CY	Calendar Year
DC	Dental Corps
DDX	Differential Diagnosis
DET	Detachment
DIACA	Duty Involving Actual Control of Aircraft
DIF	Duty Involving Flying
DIFDEN	Duty in a Flying Status not Involving Flying
DIFOPS	Duty in a Flying Status Involving Operational or Training Flights
DMO	Diving Medical Officer
DO	Duty Officer or Doctor of Osteopathy
DOA	Date Of Admission or Dead On Arrival
DOB	Date Of Birth
DSS	Department of Safety and Standardization
DV (A)	Distance Vision (Acuity)
DWEST	Deep-Water Environmental Survival Training

DX	Diagnosis
EAF	Expeditionary Airfield
EAPS	Engine Air Particle Separator
EBL	Estimated Blood Loss
ECG	Electrocardiogram (EKG)
ECP	Engineering Change Proposal
EDTA	Edentate Disodium (a preservative)
EKG	Electrocardiogram (ECG)
(E) ENT	(Eye), Ear, Nose and Throat
EI	Engineering Investigation
EMS	Emergency Medical System (Service)
EOD	Explosive Ordnance Disposal
EOM (I)	Extraocular Movements (Intact)
EPT	Existed Prior To Enlistment
ETA	Estimated Time of Arrival
ETOH	Ethanol or Ethyl Alcohol or Alcohol
FAA	Federal Aviation Administration
FAILSAFE	Fleet Air Introduction Liaison Survival Aircrew Flight Equipment
FAIR	Fleet Air
FAR	Flight Aptitude Rating or Federal Aviation Regulation
FASO	Field Aviation Supply Office
FAX	Facsimile
FBG	Fasting Blood Glucose (FBS)
FBS	Fasting Blood Sugar (FBG)
FBW	Fly-by-Wire
FCF	Functional Check Flight
FFPB	Field Flight Performance Board (USMC)
FH	Flight Hour
FIGMO	Forget It, I Got Mine
FIT	Fighter
FL (I) R	Forward-Looking (Infrared) Radar
FLT	Flight or Fleet
FM	Flight Mishap or Frequency Modulation
FMC	Full Mission Capable
FMF	Fleet Marine Force
FNAEB	Field Naval Aviator Evaluation Board
FNFOEB	Field Naval Flight Officer Evaluation Board
FNG	Funny New Guy
FOD	Foreign Object Damage
FOUO	For Official Use Only
FPC	Flight Purpose Code
FPO	Fleet Post Office
FRAMP	Fleet Readiness (or Replacement) Aviation Maintenance Personnel
FREDS	Flight Readiness Evaluation Data System
FRM	Flight Related Mishap
FRS	Fleet Readiness Squadron
FS	Flight Surgeon
FSR	Flight Surgeon's Report
FUBAR	Fouled-Up Beyond All Recognition
FUBB	Fouled-Up Beyond Belief
FY	Fiscal Year
FYI	For Your Information
G	Gravity (unit) or Newtonian constant of Gravitation or Gram

	or Grain
GIGO	Garbage In, Garbage Out
G-LOC	G-Induced loss of Consciousness
GMO	General Medical Officer
GM (A) T	Greenwich Mean (or Meridian) (Astronomical) Time
GQ	General Quarters
GRU	Group
GSE	Ground Support Equipment
H	Helicopter or Rotary Wing
HALO	High-Altitude, Low-Opening (parachuting technique)
HAT	Heavy Attack
HAZMAT	Hazardous Material (HM)
HAZREP	Hazard Report (HR)
HC	Helicopter Combat Support Squadron
HCT	Hematocrit
HEED	Helicopter Emergency Egress (escape) Device
HEELS	Helicopter Emergency Egress (escape) Lighting System
HEL (O)	Helicopter
HFACS	Human Factors Analysis and Classification System
HGB	Hemoglobin
HIGE	Hover In Ground Effect
HM	Hazardous Material (HAZMAT) or Helicopter Mine Countermeasures Squadron
HMH	Marine Heavy Helicopter Squadron
HMLA	Marine Light Attack Helicopter Squadron
HMM	Marine Medium Helicopter Squadron
HOGE	Hover Out of Ground Effect
H&P	History and Physical
HQ	Headquarters
HR	Hazard Report (HAZREP)
HS	Helicopter Anti-Submarine Squadron
HSETC	Health Sciences Education and Training Command
HSL	Helicopter Anti-Submarine Squadron, Light
HUD	Heads-Up Display
HX	History
IAW	In Accordance With
ICD	International Classification of Diseases
IFR	Instrument Flight Rules (or Requirement) or In-Flight Refueling
IG	Inspector General
IMC	Instrument Meteorological Conditions
IMA	Intermediate Maintenance Activity
INVS	Integrated Night Vision System
IR	Infrared
IRAC	Interim Rapid Action Change
IROK	Inflate, Release, Oxygen, Koch fittings
JAG	Judge Advocate General
JAMS	Jacksonville (NC) Aerospace Medical Society
JO	Junior Officer
JOPA	Junior Officer Protection (Protective) Association
KIAS	Knots Indicated Airspeed
KISS	Keep It Simple Stupid
LAMPS	Light Airborne Multi-Purpose System (Helicopter)
LANT	Atlantic Fleet or Atlantic
LASER	Light Amplification by Stimulated Emission of Radiation
LBFS	Local Board of Flight Surgeons

LDO	Limited Duty Officer
LIM	Limited
LOC	Loss of Consciousness or Level of Consciousness
LOX	Liquid Oxygen
LPA	Lieutenant Protection (Protective) Association/Life Preserver Assembly
LPU	Life Preserver Unit
LZ	Landing Zone
MAF	Maintenance Action Form or Marine Amphibious Force
MAG	Marine Aircraft Group
MAL	Malfunction
MAN	Manual
MAR	Marine
MASH	Mobile Army Surgical Hospital
MAT	Medium Attack
MAU	Marine Amphibious Unit
MAW	Marine Aircraft Wing
MC	Mission Capable or Medical Corps or Marine Corps
MCAF	Marine Corps Air Facility
MCAS	Marine Corps Air Station
MCCRES	Marine Corps Combat Crew Readiness Evaluation System
MD	Doctor of Medicine (Medical Doctor) or Medical Department
MEDEVAC	Medical Evacuation
MH	Manhours
MHRS	Manhours
MI (M)	Maintenance Instruction (Manual)
SIR	Safety Investigation Report
MISREC	Mishap Report Recommendation
MISTRAC	Mishap and Hazard Recommendation Tracking Program
MMART	Mobile Medical Augmentation Readiness Team
MMTF	Military Medical Treatment Facility
MO	Maintenance Officer or Medical Officer or Modus Operandi
MDR	Mishap Data Report
MR	Material Report
MRE	Meals, Ready to Eat
MRI	Magnetic Resonance Imaging
MSC	Medical Service Corps
MSL	Mean Sea Level
NA	Naval Aviator or Naval Air or North American or Not Applicable or Not Authorized
NAA	Not Aeronautically Adaptable
NACES	Naval Aircrew Ejection Seat
NADEP	Naval Aviation Depot
NADC	Naval Air Development Center
NAEC	Naval Air Engineering Center
NAESU	Naval Aviation Engineering Support Unit
NAF	Naval Air Facility
NAMI	Naval Aerospace and Operational Medical Institute
NAMP	Naval Aviation Maintenance Program
NAMRL	Naval Aerospace Medical Research Laboratory
NAPTP	Naval Aviation Physiology Training Program
NARF	Naval Air Rework Facility
NAS	Naval Air Station
NATC	Naval Air Test Center
NATOPS	Naval Aviation Training & Operations Procedures Standardization

NAV	Navy
NAVAIREWORKFAC	Naval Air Rework Facility (NARF, NADEP)
NAVAIRSYSCOM	Naval Air Systems Command
NAVGRAM	Naval Mailgram
NAVMIIPERSCOM	Naval Military Personnel Command
NAVOSH	Navy Occupational Safety and Health
NAVPRO	Naval Plant Representative Office
NAVSAFECEN	Naval Safety Center
NAWSTP	Naval Aviation Water Survival Training Program
NBC	Nuclear, Biological and Chemical
NCO (IC)	Non-Commissioned Officer (-In-Charge)
NIOSH	National Institute for Occupational Safety and Health
NIS	Naval Investigative Service or Not in Stock (or Store)
NK (D) A	No Known (Drug) Allergies
NPGS	Naval Post Graduate School [Monterey, CA]
NMAC	Near Midair Collision
NMC	Not Mission Capable
NOK	Next Of Kin
NORVA	Norfolk, Virginia
NOTAL	Not To All
NPQ	Not Physically Qualified
NS	Naval Station
NSIH	No Significant Interval History
NSN	National Stock Number
NTSB	National Transportation Safety Board
OAT	Outside Air Temperature
OBE	Overcome By Events
OBOGS	On Board Oxygen Generation System
OFC	OPS Flying Club
OIC	Officer-in-Charge
OOD	Officer of the Day (or Deck)
OPNAV	Office of the Chief of Naval Operations
OPREP	Operation (al) Report
OPS	Operations
OPTAR	Operational Targeting (funding)
OSHA	Occupational Safety and Health
PAA	Polyacrylic Acid
PAC	Pacific Fleet or Pacific
PAD	Propellant Actuated Device
PAO	Public Affairs Office
PAT	Patrol
PAX	Passenger(s) or Patuxent
PCL	Pocket Checklist
PE	Physical Examination
PERRLA	Pupils Equal, Round, Reactive to Light and Accommodation
PID	Personnel Injury/Death (report)
PLAT	Pilot Landing Aid Television
PLT	Pilot
PMC	Partial Mission Capable
PMO	Provost Marshal's Office
POC	Point of Contact or Privately-Owned Conveyance
POD	Plan Of the Day
PQ	Physically Qualified
PR	Parachute Rigger or Pocket Reference
PRN	As Needed (Pro Re Nata)

PY	Pack-Year (cigarettes)
QA	Quality Assurance
RAC	Risk Assessment Code
RAD	Release from Active Duty or Radar or Radical
RADALT	Radar Altimeter
RAG	Replacement Air Group (FRS)
RAMEC	Rapid-Action Minor Engineering Change
RAT	Ram Air Turbine
RBC	Red Blood Cell
REC	Recommendation
RF	Radio Frequency
RIA	Radio-Immuno Assay
RIO	Radar Intercept Officer
RON	Squadron or Remain Over Night
ROS	Review Of Systems
RSSK	Rigid Seat Survival Kit
RX	Treatment or Prescription
SAR	Search and Rescue or Sea-Air Rescue
SAT	Satisfactory or Satellite
SBFS	Special Board of Flight Surgeons
SDO	Squadron (or Staff) Duty Officer
SEAWARS	Sea Water Activated Release System
SERE	Survival, Evasion, Resistance and Escape
SERGRAD	Selectively Retained Graduate
SF	Standard Form
SFS	Senior Flight Surgeon
SG	Specific Gravity or Service Group or Surgeon General
SHAIMS	Safety and Hazard Abatement Information Management System
SITREP	Situation Report
SMA(C)	Sequential Multiple Analyzer (with Computer)
SMO	Senior Medical Officer
SNA	Student Naval Aviator
SNAFU	Situation Normal, All Fouled Up
SNFS	Student Naval Flight Surgeon
SOAP	Subjective, Objective, Assessment and Plan
SOF (A)	Status of Forces (Agreement)
SOP	Standard Operating Procedure
SOS	Save Our Ship (Souls) or Same Old Stuff
SPRINT	Special Psychiatric Rapid Intervention (Team)
SQDN	Squadron
SUSNFS	Society of US Naval Flight Surgeons
SX	Signs or Symptoms
SWMO	Surface Warfare Medical Officer
TAC	Tactical
TACAN	Tactical Air Navigation
TAD	Temporary Additional Duty
TDY	Temporary Duty
TFOA	Things Falling Off Aircraft
TNTC	Too Numerous To Count
T/O	Take-off
TOA	Time Of Arrival
TRA	Training
TYCOM	Type Commander
UA	Unauthorized Absentee (or Absence) or Urinalysis

UCMJ	Uniformed Code of Military Justice
UIC	Unit Identification Code
UV	Ultraviolet
V	Fixed Wing
VA	Fixed Wing Attack (Strike) Squadron
VAK	Aerial Refueling Squadron
VAQ	Fixed Wing Electronic Warfare Squadron
VAW	Carrier Airborne Early Warning Squadron
VERTREP	Vertical Replenishment
VF	Fixed Wing Fighter Squadron
VFA	Fixed Wing Fighter Attack (Strike) Squadron
VIDS	Visual Information Display System
VMA	Marine Attack Squadron
VMAQ	Marine Tactical Electronic Warfare Squadron
VMAT	Marine Attack Training Squadron
VMC	Visual Meteorological Conditions
VMFA	Marine Fighter Attack Squadron
VMFP	Marine Tactical Reconnaissance Squadron
VP	Fixed Wing Patrol Squadron
VQ	Fixed Wing Reconnaissance Squadron
VR	Fixed Wing Logistics Support Squadron
VRC	Air Transport Squadron
VS	Fixed Wing Anti-Submarine Squadron
VX	Test and Evaluation Squadron
VXN	Oceanographic Development Squadron
VTOL	Vertical Take-Off and Landing
WATS	Wide Area Telephone Service
WBC	White Blood Cell
WBGT	Wet-Bulb Globe Temperature
XO	Executive Officer
YOYO	You're-On-Your-Own

## Appendix F: Report Time Limits

Reports	Reference	Time Limit	FS Input
OPREP-3 phone	OPNAV 3100.6	5 Min	-
NAVSAFECEN phone (Class A)	OPNAV 3750.6	60 Min	+/-
OPREP-3 (Message Report)	OPNAV 3100.6	20 Min (ASAP after phone)	-
MDR (Initial Message Mishap Data Report for class A or B)	OPNAV 3750.6	4 Hrs	+/-
Amended MDR (first amended for A or B and Initial MDR for class C)	OPNAV 3750.6	24 Hrs	+/-
Safety Report Message	OPNAV 4790.2 NAVAIR 4730.5	24 Hrs	-
Amended MDRs	OPNAV 3750.6	As required	+/-
Rescue Report	OPNAV 3750.6	7 Cal Days	+/-
SIR & AA	OPNAV 3750.6	30 Cal Days	+
Endorsements	OPNAV 3750.6	7/14 Days	-
HAZREP (Recommended)	OPNAV 3750.6	30 Cal Days	+/-
HAZREP (RAC severe)	OPNAV 3750.6	24 Hrs	+/-
Casualty Report	MILPERSMAN 4210100	ASAP after NOK notified	+/-
JAG	JAG Manual	30 Cal Days	-



**Appendix G: Federal Stock # for Path Specimens**

Federal Stock Items for the Shipment of Pathological Specimens

Bag, Polyethylene, Flat Heat Seal Closure	
8105 - 00 - 579 - 9286	3X5"
8105 - 00 - 680 - 0503	4X6"
8105 - 00 - 702 - 7177	5X12 "
8105 - 00 - 579 - 9285	6X7"
8105 - 00 - 702 - 7178	18X48"
8105 - 00 - 299 - 8532	20X40"
8105 - 00 - 200 - 0195	24X24"
Box, Pathological, Shipping, Insulated	
8115 - 00 - 226 - 1199	2 cu ft
8115 - 00 - 965 - 2300	5 cu ft
Box, Plastic, Insulated, Meat, Dairy Products and Laboratory	
8115 - 00 - 682 - 6525	
Corrugated Mailing Carton for above (8115 - 00 - 682 - 6525)	
8115 - 00 - 183 - 9490	

## Appendix H: Time Table for Frozen Specimens

This table provides guidance in preparing fresh tissue specimens being shipped for use in toxicological studies. This table is, however, just a guideline; it is not meant to be absolute. The shipper is responsible for packing the specimens in such a manner so as to maintain their frozen state until arrival at AFIP.

Outside Temperature	No. Hours in Transit	Weight of Specimen	Amount of Dry Ice
Below 50° F	72	2 lbs	5 lbs
	48	3 lbs	4 lbs
	24	4 lbs	3 lbs
50 - 80° F	72	2 lbs	5 lbs
	48	3 lbs	4 lbs
	24	3 lbs	4 lbs
80 - 100° F	72	1 lb	6 lbs
	48	2 lbs	5 lbs
	24	3 lbs	4 lbs
Over 100° F	(Not recommended for shipments requiring more than 48 hours)		
	48	1 lb	6 lbs
	24	2 lbs	5 lbs

**NOTE:** The frozen specimens and dry ice should not be packed in containers, which seal to the extent that gas is not permitted to escape; gas pressure within a sealed container presents a potential hazard and could cause the container to burst. ***Dry ice must not be placed in a thermos bottle. The thermos will explode!***

## Appendix I: Guide for Witnesses Statements

1. Ask witness to review and sign Advise to Witness Statement  
OPNAVINST 3760.6R Appendix 6A or 6B (See Interviewing).
2. Instructions to Witness:
  - a. Please dictate a statement of the sequence of events, including all details you recall.
  - b. Try to keep the statements in chronological order, but feel free to add any significant information you may recall even if out of sequence.
  - c. Include your best estimate of all times and time intervals.
  - d. Think over your statement before beginning, and then dictate in your normal conversational tone.
  - e. Please make special effort to describe exact details of observations of such important signs as:
    - i. Please state name, rank, title, occupation, address, flight experience, phone number, email.
    - ii. Witness location and activity when mishap was observed.
    - iii. Time of day and weather conditions.
    - iv. Smoke and fire: source or location, color.
    - v. Inflight signs of aircraft damage
    - vi. Unusual or abnormal flight characteristics
    - vii. Normal or abnormal engine noises.
    - viii. All details of any observed ejection or bailout attempts.
    - ix. Attitude of aircraft on descent.

## Appendix J: Guide for Aircrew Survivors Statements

1. Ask individual to review and sign Advise to Witness Statement **OPNAVINST 3760.6R Appendix 6A** (See **Interviewing**).
2. Have survivor provide a detailed chronological account of the mishap from flight planning to rescue. Record the interview on audio or video tape if able.
3. Utilize the following outline for the interview.
  - ◆ Please dictate a statement of the sequence of events, your actions and reactions up to the time following rescue.
  - ◆ Include all times or time intervals and other numerical data (airspeed, attitude, etc.) that you can recall, and give your best estimate for those that you cannot recall specifically.
  - ◆ Take your time and try to keep the statement in chronological order, but if you recall something significant after you have gone past a particular phase, go ahead and dictate it.
  - ◆ While dictating, try to review mentally each phase of the flight before dictating that sequence of events.
  - ◆ Read entire outline first, then begin dictating, and remember to dictate time or time intervals in each phase.
    - a. State your name, rank, title, date, squadron, ship and mishap aircraft and contact phone number.
    - b. Pre-Flight:
      - i. Flight planning, brief, weather and mission.
      - ii. Weight and balance.
      - iii. Filing of flight plan.
      - iv. NVD preflight?
      - v. Dry suit requirements?
      - vi. Aircraft discrepancy book review/signing for aircraft.
    - c. Pre-Taxi, Taxi, Takeoff:
      - i. Man-up, number of occupants, their location and duties.
      - ii. Engine startup, control checks.
      - iii. Taxi and takeoff:
        - Cockpit environment (hot/cold).
        - How long were you in the cockpit prior to launch?
    - d. Inflight:
      - i. What was your location in the aircraft and duties?
      - ii. Significant events during flight.
    - e. The Mishap:
      - i. What was (were) the first sign(s) of trouble (i.e., noise, vibration, smoke, fire, gauges, switches, caution panel, loss of control, etc)?
      - ii. At start of mishap what were your altitude (AGL, MSL,

- within the cabin) and how long at that attitude; airspeed, heading, attitude; were NVDs worn; cloud conditions, weather, horizon?
- iii. If in formation: lead, wing or other (explain), model of other aircraft (if involved).
  - iv. Who was at controls? Sequence of actions and their effects.
- f. Descent/Landing:
    - i. What were your rate of descent, airspeed, attitude, heading?
  - g. Impact/Ejection:
    - i. What were your actions while preparing for impact/ejection?
  - h. Egress: Escape/Bail Out/Ejection:
    - i. Communications prior to egress: describe.
    - ii. Escape phase:
      - Ground / water egress
      - Were there delays? Why?
      - Were there difficulties, obstructions, or injuries?
      - Which exit was used?
      - What was the order of escape?
  - i. Ejection/bail out phase:
    - i. Were there delays? Why? How long?
    - ii. Describe aircraft parameters at escape - (airspeed, altitude, descent rate, AOA, attitude, pitch, yaw, roll, heading, etc.).
    - iii. For bailout: was the parachute actuated manually, automatically or other?
    - iv. How was ejection initiated how and by whom?
      - Describe your body position at ejection.
      - Ejection injuries.
      - Seat-man separation.
      - Opening shock, parachute canopy condition.
      - Helmet, mask.
      - Sequence of IROK procedures.
  - j. Parachute Descent/Landing:
    - i. While descending and before landing indicate what you did and in what order.
    - ii. Landing - HEED, HEELS, LPU or other equipment used direction facing upon landing.
      - What was the terrain/sea state?
      - Landing injuries
      - Parachute drag? For how long and how far?
      - SEAWARS, FLU-8, canopy deflation pockets.

- After landing indicate what you did and in what order.
- k. List any prior ejection/bailout/parachute experience.
- l. Terrain and weather conditions of crash/landing site.
- m. Cockpit/cabin conditions after impact.
- n. Survival/Rescue:
  - i. Survival phase, ALSS equipment used:
    - Difficulties?
    - How long in the water? In the raft?
    - Weather.
    - Terrain at survival/rescue site.
  - ii. Rescue phase - means of location:
    - Retrieval problems.
    - Did you assist in your own rescue?
    - Means of transport to medical.
  - iii. Did physiology, egress and survival training (or lack of training) contribute to any injury, rescue or survival problem?
- o. Describe what you think caused the mishap and any factors that aggravated the conditions present in this mishap. What could be done to prevent the mishap from happening again?

## Appendix K: Post-Mishap Aeromedical Questionnaire

Background:	
Name:	DOB:
Rank:	Today's date:
Age:	Dominant hand:
Mishap date and time:	BUNO:
Mishap location:	Crew function:
Squadron:	Total flight hours:
Aircraft model:	Hours in type:

1. Describe any recent or long standing medical problems:
  - a. Do you have a medical waiver? What for?
  - b. Have you taken any medications, vitamins or health supplements recently?
  - c. What, when, and why?
2. Do you use tobacco products?
  - a. What kind, how much and for how long?
3. When was your last leave?
  - a. How many days?
  - b. What type of leave was it?
  - c. How was it spent?
4. Were you wearing dog tags?
  - a. Where?
5. When was your last flight before this one?
6. Have you ever been involved in a mishap before?
  - a. Give the date and describe the incident(s):
7. Total years of formal education and degree:

## Appendix L: Fire Temperature Estimations

Often, on-scene estimation of fire temperatures can assist in locating fire source and mishap cause. Lab analysis will give accurate temperature ranges but the heat intensity can be approximated by referring to the following chart.

Flash Point and Autoignition Temperatures of Aircraft Fluid		
Fluid	Flash Point (°F)	Autoignition Temperature (°F)
AvGas (Any grade)	-45	830
JP-4, Jet B	-10	430
JP-5	145	460
JP-7	150	460
Jet A, Jet AI	120	460
JP-8	110	460
Lubricating Oil		
Mil-L-7808	435	730
Hydraulic Fluids		
Mil-H-5606B	195	435
Mil-H-83282	400	625
Skydrol 1500 B4	320	945
Hydrazine	126	518

NOTE: Temperatures are approximate and depend on test method and conditions.

500°F	Neoprene rubber blisters
500°F	Cadmium plating starts to discolor
700°F	Silicone rubber blisters
1100°F	Titanium metal has a high affinity for gases when heated and a scale will begin to form. This scale increases thickness with time at temperature.
1200°F	Glass cloth fuses and fiberglass melts.
1400-1600°F	Glass softens.
<b>Typical aircraft zinc chromate paints</b>	
400°F	Softens
450°F	Starts to tan
500°F	Turns brown
600°F	Dark brown
700°F	Blackens
800-850°F	Blisters
900-950°F	Burns off



<b>Melting points of metals</b>	
428°F	Selenium
449°F	Tin
609°F	Cadmium
621°F	Lead
935-1165°F	Aluminum
1175-1250°F	Aluminum Alloys
1202-1250°F	Magnesium Alloys
1600-2000°F	Brass
1760°F	Silver
1981-2000°F	Copper
2273°F	Manganese
2605°F	Silicon
2651°F	Nickel
2802°F	Iron
2550-2740°F	Stainless Steel
2820-3000°F	Titanium Alloys
3000-3100°F	Titanium
3430°F	Chromium
4760°F	Molybdenum
6170°F	Tungsten
Ground Fires	1600-2000°F
Inflight Fires	3000°F

Stainless steel discolors from tan, to light blue, to dark blue, to gray with increasing temperature.

Aircraft aluminum often develops a "broomstraw" appearance if exposed to an in-flight fire.

## Appendix M: Risk Assessment Codes (RAC)

Risk assessment is the process of determining the level of risk associated with hazards that have been identified. A Risk Assessment Matrix is used to obtain a measure of the level of risk in terms of severity and probability, expressed as a Risk Assessment Code (RAC). A RAC is an estimation of overall risk severity potential of an identified hazard. Five matrix-derived codes are used to quantify the risk of aircraft and property damage or personnel injury should that hazard strike again.

### 1. Hazard Severity Category:

- I. The hazard may cause death or loss of a facility/asset (i.e., Class A level damage).
- II. May cause severe injury, severe occupational illness, significant property damage, or severe degradation to the efficient use of assets (i.e., Class B level damage).
- III. May cause minor injury, minor occupational illness, minor property damage, or minor degradation to the efficient use of assets (i.e., Class C level damage)
- IV. Would not significantly affect personnel safety or health, property, or efficient use of assets, but is nevertheless in violation of an established regulation or standard.

### 2. Mishap Probability Subcategory:

- A. Likely to occur immediately or within a short period of time (one or more times within the next year).
- B. Likely to occur in time (within the next 3 years).
- C. Subcategory C - likely to occur several times during the life of the aircraft.
- D. Unlikely to occur, but is feasible within the lifetime of the aircraft.

Risk Assessment Code - The RAC is an expression of overall risk, combining the elements of hazard severity and mishap probability. As defined in the matrix below, the RAC is expressed as a single Arabic number that can be used to help determine hazard abatement priorities. This is the matrix used in several OPNAV instructions addressing risk management.

Hazard Severity	Mishap Probability			
	A	B	C	D
I	1	1	2	3
II	1	2	3	4
III	2	3	4	5
IV	3	4	5	5

3. RAC Definitions:

- 1. **Critical Risk.**
- 2. **Serious Risk.**
- 3. **Moderate Risk.**
- 4. **Minor Risk.**
- 5. **Negligible Risk.**

4. A further breakdown of RACs is necessary for the Naval Aviation Safety Program. A **RAC of 1 or 2** is considered a **severe hazard** while a RAC of 3, 4, or 5 is considered routine. Severe hazards receive priority by COMNAVAIRSYSCOM when allocating resources for corrective actions, and COMNAVSAFECEN tracks all severe hazards until the corrective actions are complete. Severe hazards also require endorsements up to the action agency.

## Appendix N: ALSS Cognizant Field Activities

An engineering investigation (EI) will be conducted on Aviation Life Support Systems (ALSS) Equipment utilized in a mishap or recovered in an investigation.

Item	Address
Ejection seats	Aircraft CFA's
Cartridge Actuated Devices (CADS)	NSWC-IH
Propellant Actuated Devices (PADS)	Indian Head, MD
All Parachute Systems and related hardware	NAWC-WD
Ejection seat drogue parachute assemblies	China Lake, CA
PCU Series integrated parachute restraint harnesses	
Sea Water Activated Releases Systems	
Anti-G garments	NAWC-AD
Flight clothing	Patuxent River, MD
Helmets	
Oxygen equipment	
Inflatable survival equipment	
Restraints (fixed seats)	
Rigid seat survival kits	
Survival and rescue equipment	
Night vision devices (NVDS)	
Survival Avionics	NAWC-AD Indianapolis, IN
Pyrotechnic devices (flares)	NSWC, Crane IN

## Appendix O: Ejection Definitions and Terminology

1. **Ejection System:** A mechanical device designed to forcefully separate the crewmember from the aircraft (i.e., ejection seat, extraction system, crew module) and return him to the earth's surface.
2. **Ejection Episode:** A sequence of events beginning with the ejection attempt and ending after landing. The episode normally consists of three phases:
  - a. Ejection phase: begins with initiation and ends with seat separation and/or parachute deployment.
  - b. Descent phase: from parachute deployment until contact with the earth's surface.
  - c. Landing phase: from initial contact with the earth's surface until free of parachute and stabilized in a survival situation.
3. **Ejection:** Completion of action by the aircrew member to initiate the ejection system (raising handle and/or squeezing trigger, putting face curtain) regardless of outcome, such as sequence being interrupted by ground impact or system malfunction. A successful ejection will result in the seat/man/module clearing the aircraft. If the sequence is interrupted before the seat/man/module clears the airframe (such as impact of the aircraft with the ground or a subsystem component failure) the event will be termed an unsuccessful ejection.
4. **Inadvertent Ejection:** Inadvertent initiation (mechanical or human) of the ejection system during normal operations associated with flight by any stimulus other than impact or thermal forces.
  - a. Inadvertent ejections will include initiation through human error, foreign objects or malfunctions. For example, if a foreign object involvement result in an ejection on the ground, and the crewmember is fatally injured due to the lack of time required for completion of the sequence, it will be considered a fatal ejection. Inadvertent initiation of an ejection system by a ground crewman during maintenance operations will not be considered an ejection.
  - b. If the determination can be made that the ejection system

was initiated by abnormal means, such as violent impact with the ground or another vehicle in flight that renders the system ineffective as a lifesaving device, it will not be considered an ejection. This also includes initiation of the system by fire.

5. **Survived:** Any ejection wherein no fatality occurred from any phase of the ejection episode (ejection, seat separation, parachute deployment, and parachute landing).
  - a. The terms "successful / unsuccessful" shall be disassociated from ejection survivability to avoid possible confusion or misunderstanding concerning system performance. The term "survived / did not survive [fatal]" will be used.
6. **Not Survived:** Any ejection wherein subject received injuries during the ejection episode that resulted in a fatality within a thirty-day period.
7. Termination of the ejection episode after stabilization of the escapee on the earth's surface implies that all actions necessary to begin the survival phase have been accomplished. For example, if the escapee lands in the water and cannot free himself from his parachute and subsequently drowns, it will be considered an ejection fatality. If, on the other hand, he clears the parachute only to encounter a situation after boarding the life raft that results in his demise, then it will not be considered an ejection fatality, but will be considered to have occurred during the survival phase. Inability to collapse the parachute in a high-wind landing, regardless of the circumstances, resulting in the individual's being dragged to death will be considered an ejection fatality.
8. Examples of other conditions that would not be categorized as ejection fatalities include: cold/heat exposure and injuries incurred during the survival phase that subsequently prove fatal.

## Appendix P: SIR and AA Distribution

The Safety representative of the AMB is usually responsible for distribution of the Safety Investigation Report Package. The Flight Surgeon shall work with the Safety representative to ensure that the AA is distributed appropriately.

1. Make only two complete copies of the SIR with all supporting enclosures. The AMB appointing authority keeps one and mails the other via registered mail, return receipt requested, to:

**Commander, Naval Safety Center**

Code 15  
375 A Street  
Norfolk, VA 23511-4399

2. Submit three or four additional partial packages for all mishaps when an Aeromedical Analysis (AA) is prepared. Mail one copy of the SIR message, one copy of the AA and AA enclosures, and one copy of each Appendix N enclosure form to:

**Commander, Naval Safety Center**

Code 14  
375 A Street  
Norfolk, VA 23511-4399  
(See 3 and 4 below)  
*(Enclose electronic copy of AA on disc)*

**Aircraft Controlling Custodian** *(List of Controlling Custodians)*

Attention: Command Surgeon

**OIC, Naval Aerospace Medical Institute**

220 Hovey Road  
Pensacola, FL 32508-1047

**When a fatality is involved:**

**Office of the Armed Forces Medical Examiner**

Armed Forces Institute of Pathology  
1413 Research BLVD  
Building 102  
Rockville, MD 20850  
(See 5 below)

3. Autopsy photos, other photos of the deceased or otherwise sensitive or privileged photos shall be properly marked and

sealed in a separate envelope. In addition to data identifying the mishap (date, squadron, aircraft model, submitting Flight Surgeon's name), the envelope shall be plainly marked: **"PASS DIRECTLY TO THE AEROMEDICAL DIVISION, NAVAL SAFETY CENTER"**. Please send only the relevant photographs that depict aeromedical or physiologic evidence that support findings in the AA.

4. Reports detailing personal or sensitive material, such as psychiatric or psychological consult reports. In a separate envelope, seal and mark these reports: **"PASS DIRECTLY TO THE AEROMEDICAL DIVISION, NAVAL SAFETY CENTER"**. Send them to the Naval Safety Center and nowhere else.
5. If AFIP does not have a set of these photographs (perhaps they did not visit the crash site and attend the autopsy) ensure that they receive a copy along with radiographs, radiology reports, lab reports and the coroner's report.
6. The Aeromedical Analysis and Safety Investigation Report contain privileged and sensitive information and shall not be sent via email over Non-Secure Internet connections.



## Appendix Q: 72-Hour and 14-Day History

1. The Flight Surgeon shall submit a 72-hour history form (**FORM SIR 3750/15 Appendix N Pages N45 & N-46**) as an enclosure to the aeromedical analysis for each aircrew member and for other persons who may have contributed to the mishap. These Forms are privileged and are attached to the AA on Side B of SIR.
2. This history should begin 72 hours prior to the time of the mishap and proceed in a chronological order. Among important items to consider are: (1) exact content of meals (a known), (2) alcohol consumption, (3) sleep periods, (4) stressful situations of any nature, (5) significant events, and (6) medications/drugs. Items listed should be accompanied by time of occurrence (if known). Provide comments concerning any deviation from normal habit patterns. An example is provided:

<b>Sunday, 14 OCT 2000 (wake-up one day before mishap day)</b>	
<b>0500</b>	Woke up, ran 8 1/2 miles.
<b>0900</b>	Showered, breakfast with family, 1 Bloody Mary, 3 cups of coffee, 2 waffles with butter and syrup.
<b>0930</b>	Read Sunday paper.
<b>1030</b>	Dressed for church.
<b>1100</b>	Left to go to church with family.
<b>1330</b>	Lunch at hamburger joint, 1 quarter-pound cheeseburger, fries, and large diet coke.
<b>1400</b>	Took kids to zoo. Fell of elephant ride and bruised left ribs
<b>1600</b>	Returned home, watched football on TV, had 4 beers.
<b>1900</b>	Supper at home, spaghetti and meat sauce, 1 glass of Chianti, salad, 2 slices garlic bread.
<b>2000</b>	Call from mother, father had heart attack, in hospital, condition - stable.
<b>2100</b>	Took 800 mg Motrin for bruised rib
<b>2200</b>	1 glass of sherry, went to bed.
<b>2400</b>	Awakened by baby crying, helped wife with child.
<b>0130</b>	To sleep.

(See OPNAV 3750.6R Appendix N SIR Form 15) (Word .doc)

3. 14-Day History: The 14-day history is useful in determining habit patterns and addressing longer-term fatigue issues. This is not as detailed as the 72-hour history. This history is required for all mishaps involving Air Force personnel.

- a. Circadian Rhythm. Where had the pilot traveled within the past 14 days? What had their duty schedule been like? Their sleep/wake cycle?
- b. Estimate the number of hours slept in the 7 days leading up to the mishap.
- c. Describe the crewmember's alcohol consumption pattern over the 7 days leading to the mishap.
- d. Any significant health, social, emotional, financial, duty or vacation events in the past 14 days?

## Appendix R: Cognizant Field Activities For Naval Aircraft

<b>Aircraft</b>	<b>CFA</b>	<b>ADDRESS</b>
A-4	NADEP	Naval Aviation Depot
EA-6	Jacksonville	Naval Air Station
E-6A		Jacksonville, FL 32212
F-14		
P-3		
T-2		
T-45		
C-2	NADEP	Naval Aviation Depot
E-2	North Island	Naval Air Station North Island
F-4 Drone		San Diego, CA 92135
F-5		
F/A-18		
S-3		
AV-8	NADEP	Naval Aviation Depot
C-130	Cherry Point	Marine Corps Air Station
H-1		Cherry Point, NC 28533
H-46		
H-53		
H-60		
V-22		
C-9	NAVAIR	NAVAIRSYSCOM
C-12	Pax River	PMA 207
C-20		Naval Air Station
C-26		Patuxent River, MD 20670
C-40		
H-2		
H-3		
H-57		
T-34		
T-39		
T-44		
UC-35		

## Appendix S: Search and Recovery of Remains

1. Search and recovery of Human remains can expose team members to potential biological hazards. Team members must be pre-briefed on biohazards and consider reviewing the FAA Video "Aircraft Accidents and Bloodborne Pathogens: A Hazardous Combination" [Part 1](#) and [Part 2](#) Available online at: <http://www.cami.jccbi.gov/National-Resource/CAMI21st.html>.
2. Teams must wear appropriate PPE (see [Bloodborne Pathogens section](#).) and be in compliance with [BUMEDINST 6230](#) for immunizations.
3. Search and recovery team safety is paramount. It cannot be emphasized strongly enough that crash scenes present a multitude of hazards to investigative and recovery personnel. In addition to hazardous materials and biohazards, unexploded ordnance and survival equipment (pencil flares and day/night flares) can present significant dangers. The presence of HAZMAT and EOD (Explosive Ordnance Disposal) specialists can prove invaluable and the Flight Surgeon should not hesitate to request their assistance.
4. Search Phase:
  - a. The Flight Surgeon should brief team members on what to look for.
  - b. A rough sketch should be annotated, as remains are located.
  - c. The search for remains should be extended well beyond the perimeters of aircraft wreckage.
  - d. Use a parallel or contour search pattern.
  - e. One team member can systematically search a 2-linear foot area to the left and right (4-linear feet). A team of 26 members moving abreast can cover about 100-linear feet.
  - f. Team movement is under the command of the team leader, who is positioned in the center (2 flankers may assist).
  - g. When remains are encountered the team leader is alerted, the team is halted, and a stake, with streamers attached, is set. Remains are not be disturbed at this time.
  - h. When the search line completes its first leg, the team uses a pivoting movement to reposition for a second leg etc. When completed, a similar search will be made 90 degrees to the first.
  - i. Remains may be hidden beneath wreckage. Things to consider:

- i. Use instructions in the form of handouts for the team members.
  - ii. Use search dogs to find spread out or hidden remains.
5. Recovery Phase:
  - a. The recovery team usually consists of eight members, a photographer, and a team leader.
  - b. Diagrams are time-consuming, but essential. As the staked remains are located, the following actions should be taken:
    - i. Each fragment or body must be tagged, staked, photographed, and plotted on the remains location sketch. The position within the wreckage of each portion of remains should be diagrammed. This can be done by hand drawing or by having the surveyors document the position of each fragment using GPS, if available.
    - ii. The tag and stake numbers must match and the numbered tag should show in the photographs.
    - iii. The most common designation system used is the “X” system, where each body and fragment is given a unique “X” number, starting with X-1, X-2, etc.
    - iv. Three tags will be required for each remains: one for the specimen, one for its pouch, and one for the stake. For large fragments or for bodies, it is helpful to attach a tag to both the body and to the outside of the body bag or other container.
    - v. Unassociated remains and personal belongings should not be commingled.
    - vi. Be sure to examine the soil beneath bodies for teeth, personal effects, etc. The soil beneath badly fragmented bodies can be sifted through wire mesh to recover small fragments or personal effects.
6. Storage of remains:
  - a. Local medical facilities should be able to provide refrigerated storage of remains.
  - b. In instances of large numbers of fatalities, potentially exceeding the capacity of the local hospital, consider renting a refrigerated semi-trailer. Ensure the trailer has a metal floor to facilitate cleaning at the mishap's conclusion.
7. Hidden remains:
  - a. Inevitable in mishaps resulting in fragmentation of individuals. Remains will be found as wreckage is moved, after the medical team has left the site.

- b. If the possibility of hidden remains exists, make arrangements for a medical representative to be on site with the wreckage reclamation team as wreckage is moved.
- c. Have the representative contact you for disposition.

**Appendix T: List of Witnesses**

**1. Name:**

Phone numbers: Home:

Work:

Address:

Remarks:

**2. Name:**

Phone numbers: Home:

Work:

Address:

Remarks:

**3. Name:**

Phone numbers: Home:

Work:

Address:

Remarks:

**4. Name:**

Phone numbers: Home:

Work:

Address:

Remarks:

## Appendix U: Solving Crash Force Problems

### 1. RECONSTRUCT THE CRASH SEQUENCE

- a. Identify the Initial, Principal, and Secondary Impacts.
- b. Determine the Stopping Distance – look for:
  - i. Structural Collapse.
  - ii. Gouge Marks.

### 2. A METHOD OF SOLVING CRASH FORCE PROBLEMS

- a. Sketch known quantities (draw the picture). These are often estimates obtained from eyewitnesses, radar tapes, and aviator statements.
- b. Determine the airspeed along the flight path, with consideration for altitude and winds. You are trying to determine the ground speed at impact. This will be the hypotenuse for your calculations. Again, this is often an estimate.
- c. Convert Known Quantities to Standard Units.
  - iii. Distances to Feet.
  - iv. Velocities to Feet Per Second (fps).
    - $\text{MPH} \times 1.46 = \text{fps}$ .
    - $\text{KTS} \times 1.69 = \text{fps}$ .
    - $\text{FPM} \div 60.0 = \text{fps}$ .
- d. Determine the magnitude of the velocity components.
  - i. Parallel to the impact surface =  $V_h$ .
  - ii. Perpendicular to impact surface =  $V_v$ .
- e. Determine stopping distances from direct measurements:
  - i. Parallel to the impact surface =  $S_h$  (Skid marks + Longitudinal crush of aircraft).
  - ii. Perpendicular to impact surface =  $S_v$  (Crater depth + aircraft vertical crush).



- f. Determine Acceleration Components - choose "best guess" deceleration pulse shape.

- i. Example - Rectangular Pulse:

Parallel to the surface	$G_h =$	$\frac{\text{Horizontal } V^2}{64.4 \times S_h}$
Perpendicular to the surface	$G_v =$	$\frac{\text{Vertical } V^2}{64.4 \times S_v}$

- ii. Example - Triangular Pulse:

Parallel to the surface	$G_h =$	$\frac{\text{Horizontal } V^2}{32.2 \times S_h}$
Perpendicular to the surface	$G_v =$	$\frac{\text{Vertical } V^2}{32.2 \times S_v}$

- g. Determine resultant acceleration magnitude and direction with respect to the impact surface (the Crash Force Resultant) using a vector analysis of  $G_h$  and  $G_v$ .
- h. Determine direction of resultant acceleration with respect to aircraft axes using the Crash Force Angle:
- Crash Force Angle = Resultant Angle + Pitch Angle - Terrain Angle
  - And determine the resultant forces experienced by the occupants dependent on the orientation of the occupants in the aircraft. [Link to CRASH FORCE ANALYSIS](#)

# DoD HFACS

## Department of Defense Human Factors Analysis and Classification System A mishap investigation and data analysis tool

### Executive Summary

This Department of Defense Human Factors (DoD HF) Guide explains procedures for investigating and reporting all DoD mishaps. It supports DoDI 6055.7, *Accident Investigation, Reporting, and Record Keeping*. The DODI directs DOD components to “Establish procedures to provide for the cross-feed of human error data using a common human error categorization system that involves human factors taxonomy accepted among the DoD Components and U.S. Coast Guard.” It is intended for use by all persons who investigate, report and analyze DoD mishaps, and is particularly tailored to the needs of persons assigned to Interim Safety Boards and formal Safety Investigation Boards following all Classes of mishaps. There are myriad potential human factors, all of which need to be assessed for relevancy during a mishap investigation. No investigator, flight surgeon, physiologist, human factors analyst or aviation psychologist can be expected to be fully familiar with all potential human factors

When using this human factors model, the investigator should consider applying the model to three distinct areas of consideration: environmental, individual and the event or mishap. The mishap crew, operator, or team reacts to the environment to which they are exposed. The environmental factors cover not only the physical environment to which the individual members are exposed, but also the organizational and supervisory environments and specific physical and technological preconditions. The individual factors cover acts, preconditions and supervision factors. The mishap factors can cross all four tiers of the model. The investigator can apply this model by entering at any tier that is specifically related to environmental, individual or mishap factors discovered during the analysis. This model can be used as either a primary or secondary tool to investigate both active and latent failures. Our model is designed to present a systematic, multidimensional approach to error analysis. This human factors model covers human error from three perspectives:

- Cognitive Viewpoint and Human System Interaction and Integration
- Human-to-Human Interaction
- Sociocultural and Organization

When using our DoD HF Taxonomy for either primary investigation or secondary analysis, we must assume error can mean several things:

- Error as the failure itself. For example: The operator’s decision was an error (decision, perceptual, or skill-based errors).
- Error as the cause of failure. For example: This event was due to human error (failure to provide guidance).
- Error as a process or, more specifically, as a departure from some kind of standard (exceptional, routine, intentional or unintentional).

A reasonable synthesis of these assumptions, as suggested by Senders and Moray (1991), is the following: Human error occurs when human action is performed that was either (1) not intended by the actor, (2) not desired according to some specified set of rules or by some external observer, or (3) contributed to the task or system “going outside its acceptable limits.”

This DoD Guide starts with a brief history of the development of the DoD HFACS, followed by an introduction and description of the human factor and human performance application of this model. The Guide concludes with a high-level structural overview of the taxonomy and definitions.

### History

The Secretary of Defense published a memorandum 19 May 2003 stating, “World-class organizations do not tolerate preventable accidents. Our accident rates have increased recently, and we need to turn this situation around. I

challenge all of you to reduce the number of mishaps and accident rates by at least 50% in the next two years.” These goals are achievable, and will directly increase our operational readiness. We owe no less to the men and women who defend our Nation.” This memorandum resulted in the creation of the DOD Safety Oversight Committee to provide guidance to the DOD and individual services on best practices and methods to accomplish this mandate. The Secretary of Defense established the Defense Safety Oversight Council to:

- Review accident and incident trends, ongoing safety initiatives, private sector and other governmental agency best practices, and to make recommendations to the Secretary of Defense for safety improvement policies, programs, and investments
- Assess, review and advise on improving all aspects of the coordination, relevance, efficiency, efficacy, timeliness and viability of existing DoD-wide safety and injury prevention information management systems
- Promote the development and implementation of safety initiatives, including Systems Safety for Acquisitions and operations, to improve mission success as well as preserve human and physical resources throughout DoD
- Coordinate with other federal agencies and industry leaders, to facilitate communication, coordination, and integration of best practices into DoD planning, development and implementation of initiatives and programs that support research to improve human performance, safety education standards/procedures, and equipment

The Aviation Safety Improvement Task Force (ASI-TF) was established to meet these DOD requirements. The ASI-TF subsequently established the Human Factors Working Group (HFWG) with a charter to identify data-driven, benefit-focused, human-factor and human-performance safety strategies designed to identify hazards, mitigate risk and reduce aviation mishaps inherent in aircraft operations throughout DoD. The ASI-TF chair directed the HFWG to accomplish the following tasks:

- Promote common Human Factors taxonomy, investigation, and Analysis system for DoD-wide implementation
- Recommend standardization of human factor and human performance terminology
- Provide human factors subject matter experts to all ASI-TF working groups, and hazard identification and intervention analysis teams
- Identify and analyze top human factor and human performance mishap focus areas
- Identify, catalog and recommend approaches to improve organizational/cultural assessments

This guide is produced to meet the first two tasks of the Human Factors Working Group. The guide was initially developed to investigate aviation mishaps, and therefore uses an aviation-centric language. During production the authors have attempted to modify definitions to ensure the tool can be used in the investigation of multiple types of events. This guide was developed based on the evolution of the works produced by Jens Rasmussen, James Reason as well as Douglas Wiegmann and Scott Shappell. As this dynamic document evolves, we plan to ensure that it can be seamlessly applied across all services, and will be used to investigate aviation, ground, weapons, afloat, space and off-duty mishaps and events.

## **Introduction**

Mishap or event investigation can be extremely difficult, time-consuming and stressful, but it can also be rewarding when we recognize that the contributions we make will improve safety. A thorough mishap investigation is absolutely necessary to determine the cascading events causal to a mishap, and to recommend corrective actions to prevent recurrence. This guide provides the accident investigator with a proven template that aids in organizing the investigation while providing a detailed analysis of human factors for on-scene investigation and post-hoc mishap data analysis, revealing previously unidentified human-error trends and hazards.

Human error continues to plague both military and civilian mishaps. Analysis indicates that human error is identified as a causal factor in 80 to 90 percent of mishaps, and "operator error" is present in 50 to 60 percent of all mishaps, and is therefore the single greatest mishap hazard. Yet, simply writing off mishaps to "operator error" is a simplistic, if not naïve, approach to mishap causation and hazard identification. Further, it is well established that mishaps are rarely attributed to a single cause, or in most instances, even a single individual. Rather, mishaps are the end result of myriad latent failures or conditions that precede active failures (Shappell in *“The Naval Flight Surgeon’s Pocket Reference to Aircraft Mishap Investigation”*). The goal of a mishap or event

investigation is to identify these failures and conditions in order to understand why the mishap occurred and how it might be prevented from happening again.

This reference is an adjunct to formal instructions that govern mishap investigation and is not meant to supplant the other references that address service-specific guidance for mishap investigation. Use this guide as a ready reference in the field to ensure that your data retrieval is complete and that you preserve perishable evidence. This guide is also designed to ensure uniformity of inter-service human factors definitions and data driven analysis.

## Description

This guide is designed for use as a comprehensive event/mishap, human error investigation, data identification, analysis and classification tool. It is designed for use by all members of an investigation board in order to accurately capture and recreate the complex layers of human error in context with the individual, environment, team and mishap or event.

In the past, investigators have thrown human factors analysis to the medical investigator and have asked him or her to do this work on their own. This practice has sometimes produced human error analyses that differed considerably from the boards' investigation and findings of fact. Integrating human factors analysis into all aspects of the investigation will result in a much more coherent final product.

As described by Reason (1990), *active failures* are the actions or inactions of operators that are believed to cause the mishap. Traditionally referred to as "error", they are the last "acts" committed by individuals, often with immediate and tragic consequences. For example, an aviator forgetting to lower the landing gear before touch down or showing off by flying low through a box canyon will yield relatively immediate, and potentially grave, consequences. In contrast, *latent failures* or *conditions* are errors that exist within the organization or elsewhere in the supervisory chain of command that effect the tragic sequence of events characteristic of a mishap. For example, it is not difficult to understand how tasking crews or teams at the expense of quality crew rest can lead to fatigue and ultimately errors (active failures) in the cockpit. Viewed from this perspective then, the actions of individuals are the end result of a chain of factors originating in other parts (often the upper echelons) of the organization. The problem is that these latent failures or conditions may lie dormant or undetected for some period of time prior to their manifestation as a mishap.

The question for mishap investigators and analysts alike is how to identify and mitigate these active and latent failures or conditions. One approach is the "Domino Theory" which promotes the idea that, like dominoes stacked in sequence, mishaps are the end result of a series of errors made throughout the chain of command.

A "modernized" version of the domino theory is Reason's "Swiss Cheese" model that describes the levels at which active failures and latent failures/conditions may occur within complex operations (see Figure 1).

Working backward from the mishap, the first level of Reason's model depicts those *Unsafe Acts of Operators* (operator, maintainers, facility personnel, etc.) that ultimately lead to a mishap. Traditionally, this is where most mishap investigations have focused their examination of human error, and consequently where most causal factors are uncovered. After all, it is typically the actions or inactions of individuals that can be directly linked to the mishap. Still, to stop the investigation here only uncovers part of the story.

What makes Reason's model particularly useful in mishap investigation is that it forces investigators to address latent failures and conditions within the causal sequence of events. For instance, latent failures or conditions such as fatigue, complacency, illness, and the physical/technological environment all effect individual performance but can be overlooked by investigators with even the best of intentions. These particular latent failures and conditions are described within the context of Reason's model as *Preconditions for Unsafe Acts*. Likewise, *Supervision* can promote unsafe conditions of operators and ultimately unsafe acts will occur. For example, if an Operations Officer were to pair a below average team leader with a very junior/inexperienced crew, the result is increased risk of mission failure. Regardless, whenever a mishap does occur, the crew naturally bears a part of the responsibility and accountability. However, often the latent failures or conditions at the supervisory level are equally responsible for poor hazard analysis and subsequent increased mission risk, and may ultimately cause the mishap. In this particular example, the crew was set up for the opportunity for failure.

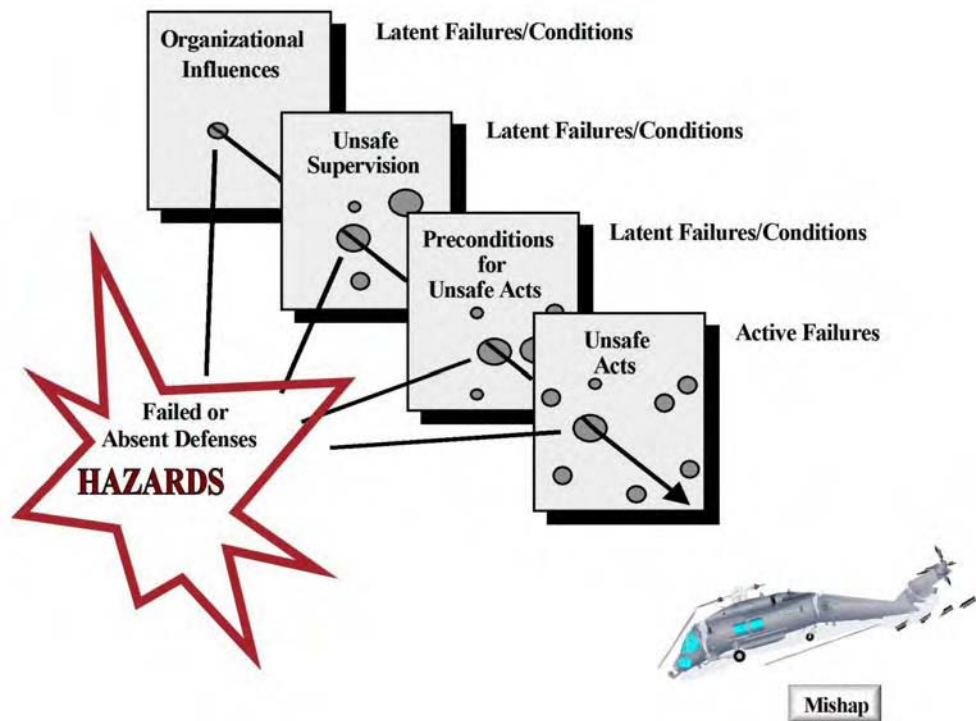


Figure 1. The "Swiss Cheese" Model (adapted from Reason, 1990)

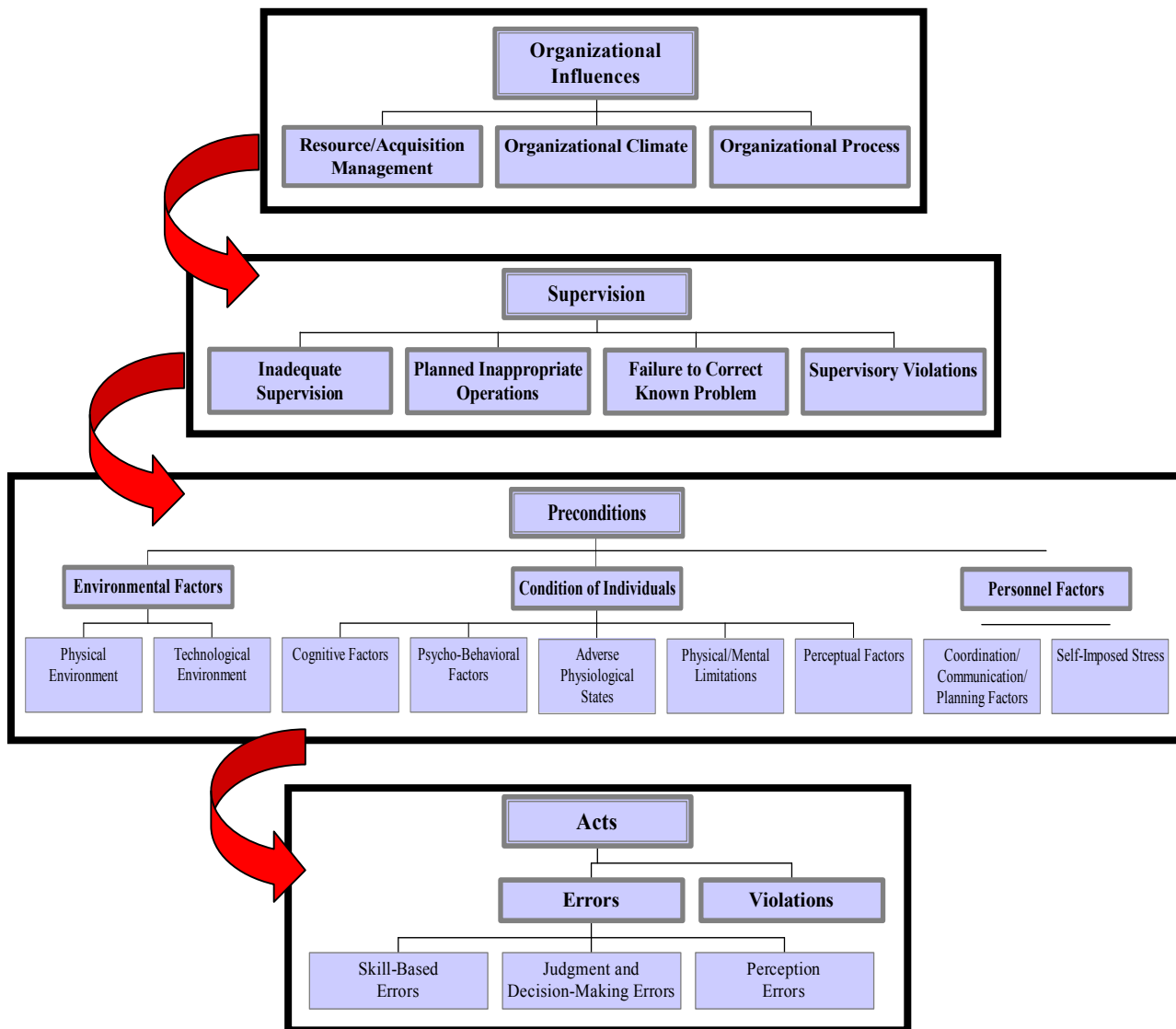
Reason's model does not stop at supervision; it also considers *Organizational Influences* that can impact performance at all levels. For instance, in times of fiscal constraints, funding may be short and may lead to limited training opportunities. Supervisors are sometimes pressed to task "non-proficient" crews with complex missions. Not surprisingly, unintended and unrecognized errors may appear, and mission performance will consequently suffer. As such, hazards and risks at all levels must be addressed if any mishap investigation process is going to be effective.

The investigation process then endeavors to detect and identify the "holes (*hazards*) in the cheese" (see Figure 1). So how do we identify these hazards? *Aren't they really too numerous to define? After all, every mishap is unique, so the hazards will always be different for each mishap ... right?* Well, it turns out that each mishap is not unique from its predecessors. In fact, most mishaps have very similar causes. They are due to the same holes in the cheese, so to speak. The hazards identified in each new mishap are not unique to that mishap. Therefore, if you know what these system failures/hazards or "holes" are, you can better identify their roles in mishaps -- or better yet, detect their presence and develop a risk mitigation strategy correcting them **before** a mishap occurs.

## Department of Defense (DoD) Human Factors Analysis and Classification System

Drawing upon Reason's (1990) and Wiegmann and Shappell's (2003) concept of active failures and latent failures/conditions, a new DoD taxonomy was developed to identify hazards and risks called the DoD Human Factors Analysis and Classification System. DOD-HFACS describes four main tiers of failures/conditions: 1) Acts, 2) Preconditions, 3) Supervision, and 4) Organizational Influences (Figure 2). A brief description of the major tiers with associated categories and sub-categories follows, beginning with the tier most closely tied to the mishap.

Attachment 1 is the in-depth reference document, and contains all the currently accepted definitions for the sub-codes that fall within the 4 major tiers of human error. This document is subject to review and update every 6 months by the Human Factors Working Group of the Joint Services Safety Chiefs. For comments please contact the Command Flight Surgeon of the Naval Safety Center.



**Figure 2. DOD HFACS Model**

*Note In the electronic version of this document each of the HFACS Model boxes are hyper-linked to more in-depth descriptions*

## 1. Acts

Acts are those factors that are most closely tied to the mishap, and can be described as active failures or actions committed by the operator that result in human error or unsafe situation. We have identified these active failures or actions as *Errors and Violations* (see Figure 3).

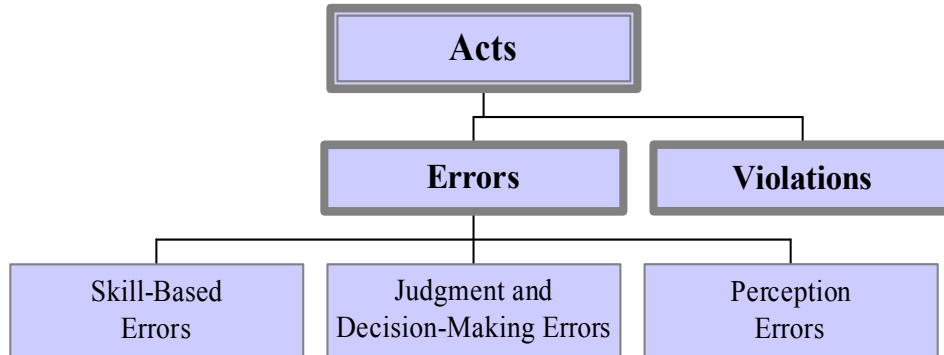


Figure 3. Categories of Acts of Operators

**Errors:** Errors are factors in a mishap when mental or physical activities of the operator fail to achieve their intended outcome as a result of skill-based, perceptual, or judgment and decision making errors, leading to an unsafe situation. Errors are unintended. We classified Errors into three types: *Skill-Based*, *Judgment and Decision Making*, and *Perception Errors*. Using this error analysis process, the investigator must first determine if an individual or team committed an active failure. If so, the investigator must then decide if an error or violation occurred. Once this is done, the investigator can further define the error.

**Skill-based Errors:** skill based errors are factors in a mishap when errors occur in the operator's execution of a routine, highly practiced task relating to procedure, training or proficiency and result in an unsafe situation. Skill-based Errors are unintended behaviors. (Table 1)

**Judgment and Decision Making Errors:** Judgment and Decision making errors are factors in a mishap when behavior or actions of the individual proceed as intended yet the chosen plan proves inadequate to achieve the desired end-state and results in an unsafe situation (Table 1).

**Perception Errors:** Perception errors are factors in a mishap when misperception of an object, threat or situation (such as visual, auditory, proprioceptive, or vestibular illusions, cognitive or attention failures) results in human error (Table 1).

**Violations:** Violations are factors in a mishap when the actions of the operator represent willful disregard for rules and instructions and lead to an unsafe situation. Unlike errors, violations are deliberate. (Table 1)

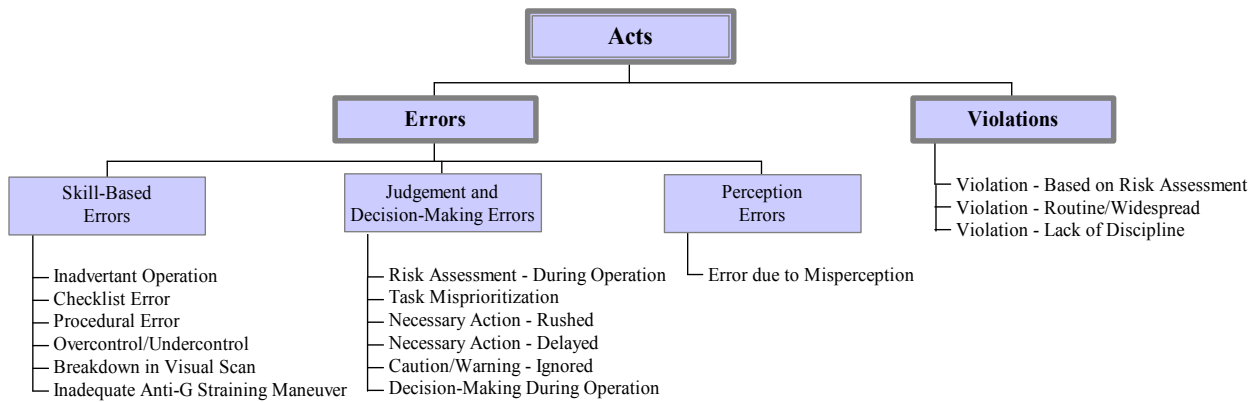


Table 1 Acts

## 2. Preconditions

Preconditions are factors in a mishap if active and/or latent preconditions such as conditions of the operators, environmental or personnel factors affect practices, conditions or actions of individuals and result in human error or an unsafe situation (Figure 4). In this error analysis model preconditions include *Environmental Factors*, *Condition of the Individuals* and *Personnel Factors*.

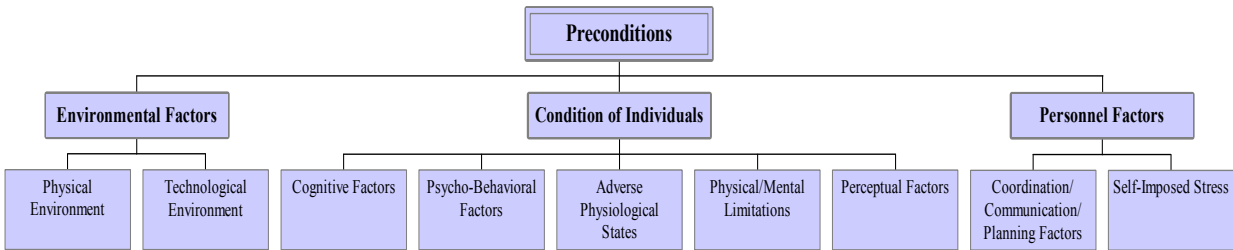


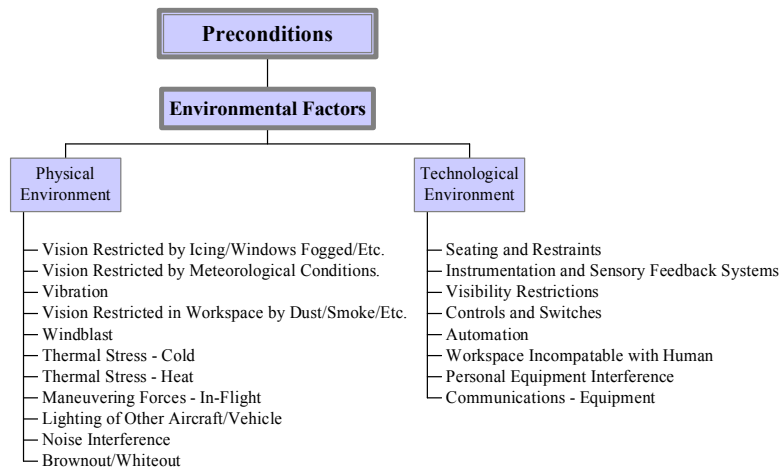
Figure 4. Categories of Preconditions for Unsafe Acts

**Environmental Factors:** Environmental factors are factors in a mishap if *physical* or *technological* factors affect practices, conditions and actions of individual and result in human error or an unsafe situation. Environmental factors include:

**Physical Environment:** Physical environment are factors in a mishap if environmental phenomena such as weather, climate, white-out or dust-out conditions affect the actions of individuals and result in human error or an unsafe situation. (Table 2)

**Technological Environment:** Technological environment are factors in a mishap when cockpit/vehicle/workspace design factors or automation affect the actions of individuals and result in human error or an unsafe situation. (Table 2)



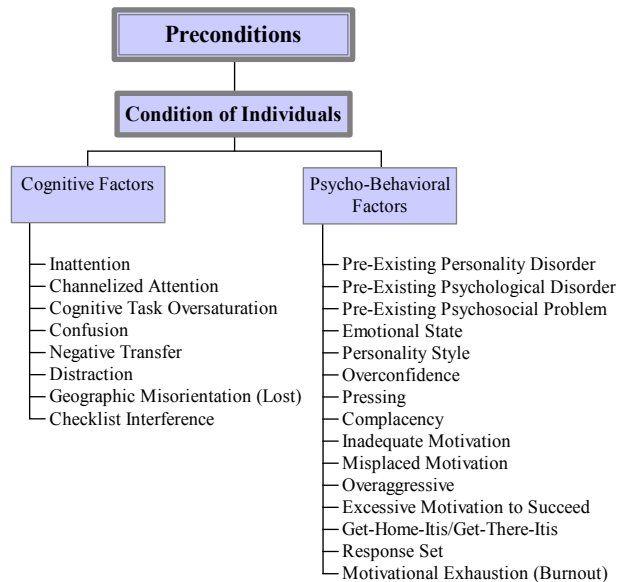


**Table 2. Environmental Factors**

**Condition of the Individual:** Condition of the individual are factors in a mishap if cognitive, psycho-behavioral, adverse physical state, or physical/mental limitations affect practices, conditions or actions of individuals and result in human error or an unsafe situation. Condition of the Individuals include:

**Cognitive Factors:** Cognitive factors are factors in a mishap if cognitive or attention management conditions affect the perception or performance of individuals and result in human error or an unsafe situation. (Table 3)

**Psycho-Behavioral Factors:** Psycho-Behavioral factors are factors when an individual’s personality traits, psychosocial problems, psychological disorders or inappropriate motivation creates an unsafe situation. (Table 3)

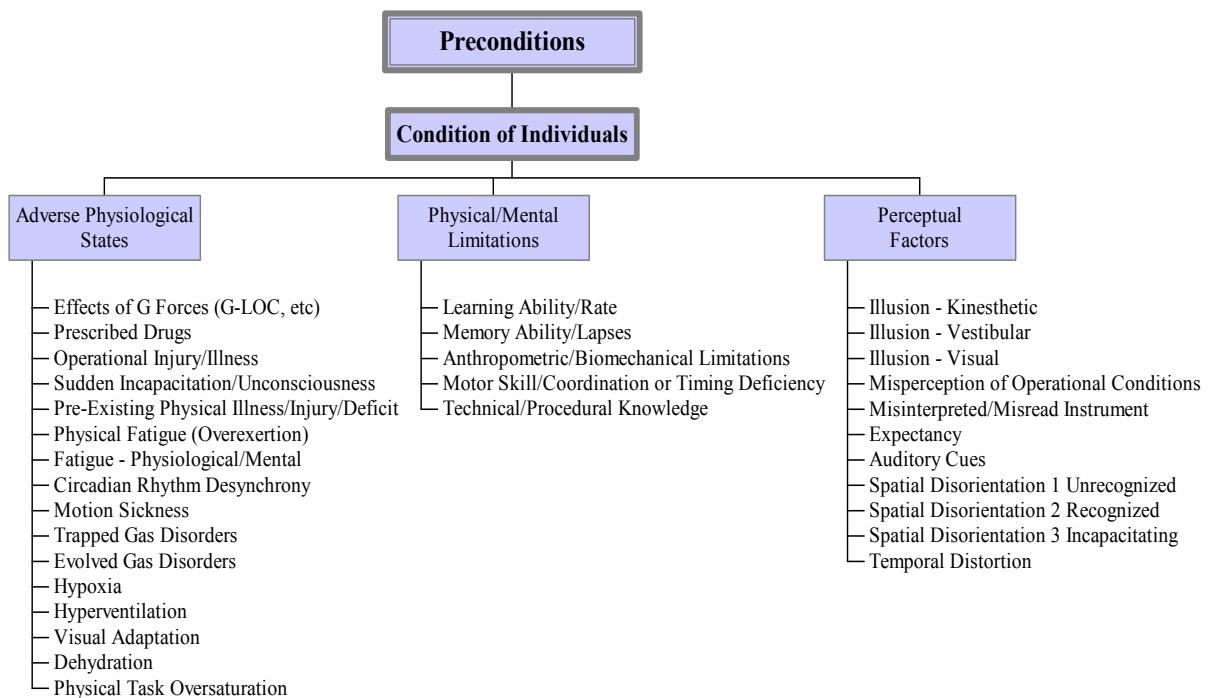


**Table 3. Conditions of the individual (part 1)**

**Adverse Physiological States:** Adverse physiological states are factors when an individual experiences a physiologic event that compromises human performance and this decreases performance resulting in an unsafe situation. (Table 4)

**Physical/Mental Limitations:** Physical/mental limitations are factors in a mishap when an individual lacks the physical or mental capabilities to cope with a situation, and this insufficiency causes an unsafe situation. This often, *but not always*, indicates an individual who does not possess the physical or mental capabilities expected in order to perform the required duties safely. (Table 4)

**Perceptual Factors:** Perceptual factors are factors in a mishap when misperception of an object, threat or situation (visual, auditory, proprioceptive, or vestibular conditions) creates an unsafe situation. If investigators identify spatial disorientation (SD) in a mishap the preceding causal illusion should also be identified. Vice versa, if an illusion is identified as a factor in a mishap then the investigator should identify the resultant type of SD. (Table 4)



**Table 4. Conditions of the individual (part 2)**

**Personnel Factors:** Personnel factors are factors in a mishap if self-imposed stressors or crew resource management affects practices, conditions or actions of individuals, and result in human error or an unsafe situation. Personnel factors include:

**Coordination / Communication / Planning:** Coordination / communication / planning are factors in a mishap where interactions among individuals, crews, and teams involved with the preparation and execution of a mission that resulted in human error or an unsafe situation

**Self-Imposed Stress:** Self-imposed stress are factors in a mishap if the operator demonstrates disregard for rules and instructions that govern the individuals readiness to perform, or exhibits poor judgment when it comes to readiness and results in human error or an unsafe situation. These are often violations of established rules that are in place to protect people from themselves and a subsequent unsafe condition. One example of self-imposed stress is drinking alcohol prior to operating a motor vehicle.

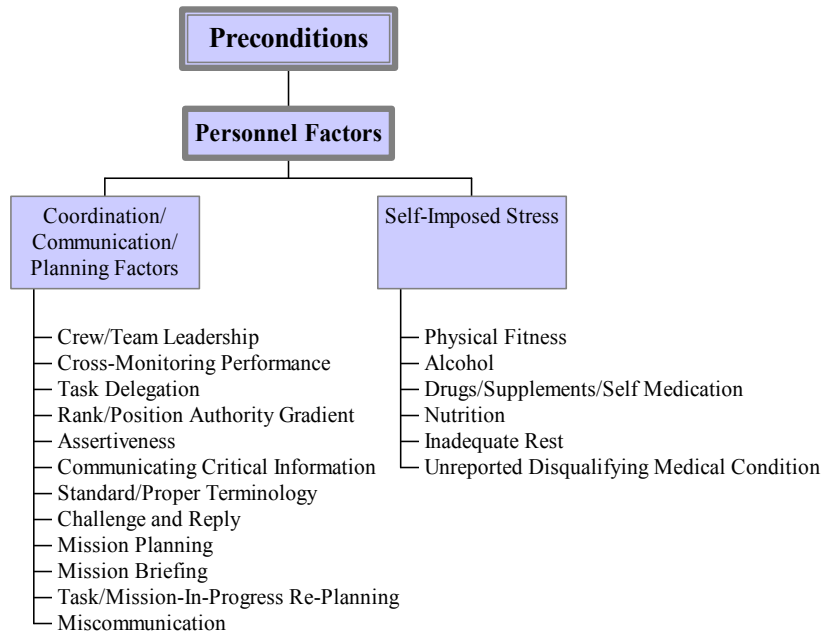


Table 5. Personnel Factors

### 3. Supervision

The Human Factors Working Group has determined that a mishap event can often be traced back to the supervisory chain of command. As such, there are four major categories of Unsafe Supervision: *Inadequate Supervision*, *Planned Inappropriate Operations*, *Failed to Correct a Known Problem*, and *Supervisory Violations* (see Figure 5).

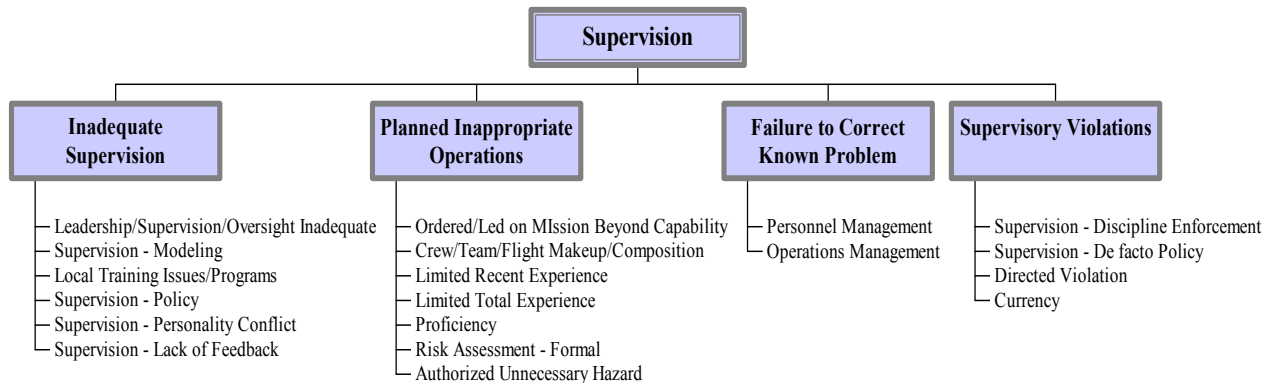


Figure 5 / Table 6. Categories of Unsafe Supervision

**Inadequate Supervision:** The role of supervisors is to provide their personnel with the opportunity to succeed. To do this, supervisors must provide guidance, training opportunities, leadership, motivation, and the proper role model, regardless of their supervisory level. Unfortunately, this is not always the case. It is easy to imagine a situation where adequate CRM training was not provided to an operator or team member. Conceivably, the operator's coordination skills would be compromised, and if put into a non-routine situation (e.g., emergency), would be at risk for errors that might lead to a mishap. Therefore, the category Inadequate Supervision accounts for those times when supervision proves inappropriate, improper, or may not occur at all (see Table 6). Inadequate Supervision is a factor in a mishap when supervision proves inappropriate or improper and fails to identify a hazard, recognize and control risk, provide guidance, training and/or oversight and results in human error or an unsafe situation.

**Planned Inappropriate Operations:** Occasionally, the operational tempo or schedule is planned such that individuals are put at unacceptable risk, crew rest is jeopardized, and ultimately performance is adversely affected. Such Planned Inappropriate Operations, though arguably unavoidable during emergency situations, are not acceptable during normal operations. Included in this category are issues of crew pairing and improper manning. For example, it is not surprising to anyone that problems can arise when two individuals with marginal skills are paired together. During a period of downsizing and/or increased levels of operational commitment, it is often more difficult to manage crews. However, pairing weak or inexperienced operators together on the most difficult missions may not be prudent (see Table 6). Planned Inappropriate Operations is a factor in a mishap when supervision fails to adequately assess the hazards associated with an operation and allows for unnecessary risk. It is also a factor when supervision allows non-proficient or inexperienced personnel to attempt missions beyond their capability or when crew or flight makeup is inappropriate for the task or mission.

**Failure to Correct a Known Problem:** Failed to Correct a Known Problem refers to those instances when deficiencies among individuals, equipment, training or other related safety areas are "known" to the supervisor, yet are allowed to continue uncorrected. For example, the failure to consistently correct or discipline inappropriate behavior certainly fosters an unsafe atmosphere and poor command climate (see Table 6). Failure to Correct Known Problem is a factor in a mishap when supervision fails to correct known deficiencies in documents, processes or procedures, or fails to correct inappropriate or unsafe actions of individuals, and this lack of supervisory action creates an unsafe situation.

**Supervisory Violations:** Supervisory Violations, on the other hand, are reserved for those instances when supervisors willfully disregard existing rules and regulations. For instance, permitting an individual to operate an aircraft without current qualifications is a flagrant violation that invariably sets the stage for the tragic sequence of events that predictably follow (see Table 6). Supervisory Violations is a factor in a mishap when supervision, while managing organizational assets, willfully disregards instructions, guidance, rules, or operating instructions and this lack of supervisory responsibility creates an unsafe situation.

#### 4. Organizational Influences

Fallible decisions of upper-level management directly effect supervisory practices, as well as the conditions and actions of operators. These latent conditions generally involve issues related to *Resource/Acquisition Management*, *Organizational Climate*, and *Organizational Processes* (see Figure 6). Organizational Influences are factors in a mishap if the communications, actions, omissions or policies of upper-level management directly or indirectly affect supervisory practices, conditions or actions of the operator(s) and result in system failure, human error or an unsafe situation.

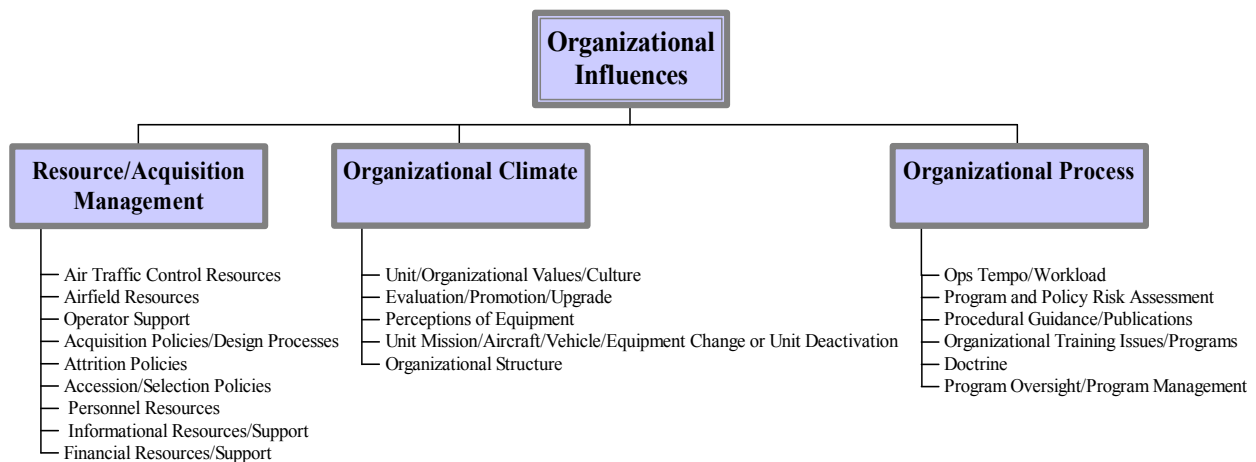


Figure 6 / Table 7. Categories of Organizational Influences

**Resource / Acquisition Management:** This category refers to the management, allocation, and maintenance of organizational resources--human, monetary, and equipment/facilities. The term “human” refers to the management of operators, staff, and maintenance personnel. Issues that directly influence safety include selection (including background checks), training, and staffing/manning. “Monetary” issues refer to the management of nonhuman resources, primarily monetary resources. For example, excessive cost cutting and lack of funding for proper equipment have adverse effects on operator performance and safety. Finally, “equipment/facilities” refers to issues related to equipment design, including the purchasing of unsuitable equipment, inadequate design of workspaces, and failures to correct known design flaws. Management should ensure that human-factors engineering principles are known and utilized and that existing specifications for equipment and workspace design are identified and met (see Table 7). Resource / Acquisition Management is a factor in a mishap if resource management and/or acquisition processes or policies, directly or indirectly, influence system safety and results in poor error management or creates an unsafe situation.

**Organizational Climate:** Organizational Climate refers to a broad class of organizational variables that influence worker performance. It can be defined as the situational consistencies in the organization's treatment of individuals. In general, Organizational Climate is the prevailing atmosphere or environment within the organization. Within the present classification system, climate is broken down into three categories--structure, policies, and culture. The term “structure” refers to the formal component of the organization. The “form and shape” of an organization are reflected in the chain-of-command, delegation of authority and responsibility, communication channels, and formal accountability for actions. Organizations with maladaptive structures (i.e., those that do not optimally match to their operational environment or are unwilling to change) will be more prone to mishaps. “Policies” refer to a course or method of action that guides present and future decisions. Policies may refer to hiring and firing, promotion, retention, raises, sick leave, drugs and alcohol, overtime, accident investigations, use of safety equipment, etc. When these policies are ill-defined, adversarial, or conflicting, safety may be reduced. Finally, “culture” refers to the unspoken or unofficial rules, values, attitudes, beliefs, and customs of an organization (“The way things really get done around here.”). Other issues related to culture include organizational justice, psychological contracts, organizational citizenship behavior, *esprit de corps*, and union/management relations. All these issues affect attitudes about safety and the value of a safe working environment (see Table 7). Organizational Climate is a factor in a mishap if organizational variables including environment, structure, policies, and culture influence individual actions and results in human error or an unsafe situation.

**Organizational Processes:** This category refers to the formal process by which “things get done” in the organization. It is subdivided into three broad categories--operations, procedures, and oversight. The term “operations” refers to the characteristics or conditions of work that have been established by management. These characteristics include operational tempo, time pressures, production quotas, incentive systems, and schedules. When set up inappropriately, these working conditions can be detrimental to safety. “Procedures” are the official or formal procedures as to how the job is to be done. Examples include performance standards, objectives, documentation, and instructions about procedures. All of these, if inadequate, can negatively impact employee supervision, performance, and safety. Finally, “oversight” refers to monitoring and checking of resources, climate, and processes to ensure a safe and productive work environment. Issues here relate to organizational self-study, risk management, and the establishment and use of safety programs (see Table 7). Organizational Processes is a factor in a mishap if organizational processes such as operations, procedures, operational risk management and oversight negatively influence individual, supervisory, and/or organizational performance and results in unrecognized hazards and/or uncontrolled risk and leads to human error or an unsafe situation.

## **DOD HFACS**

### **Quick user instruction and in-depth Nanocodes (definitions)**

#### **HFACS Quick Users Guide**

After any event investigators must gather human factors evidence. One method to do this is to start with the event outcome and create a time line documenting each step that leads up to the event. As you probe backwards determine whether a material (a part failed) event occurred or an individual committed or failed to commit an act the resulted in the outcome event.

At each step the investigator must document who committed the act then utilize the taxonomy to further classify the act. Once the investigator has identified the nanocode that reflects the act he/she must dig deeper.

The next step is to look evaluate the preconditions that resulted in the unsafe act. A method that may help evaluating preconditions is to review each of the categories and sub categories in this tier of HFACS and rule in or eliminate the various preconditions that lead to the act. Once the investigator has fully devolved into the preconditions and has recorded all preconditions for the act the focus must move on to supervisory and subsequent organizational issues that contributed to the precondition.

I recommend that for each nanocode chosen the investigator write a short narrative discussing the nanocode

Conduct an evaluation of each item in the time line. This should give the investigator a thorough human factors picture of all the events that lead up to the mishap.

# DoD HFACS Nanocodes

## Acts

Are those factors that are most closely tied to the mishap, and can be described as active failures or actions committed by the operator that result in human error or unsafe situation.

## Errors (AE<sub>xxx</sub>)

Are factors in a mishap when mental or physical activities of the operator fail to achieve their intended outcome as a result of skill-based, perceptual, or judgment and decision making errors leading to an unsafe situation. Errors are unintended.

### Skill-Based Errors (AE<sub>1xx</sub>)

Are factors in a mishap when errors occur in the operator's execution of a routine, highly practiced task relating to procedure, training or proficiency and result in an unsafe a situation.

#### **AE101 Inadvertent Operation**

Inadvertent Operation is a factor when individual's movements inadvertently activate or deactivate equipment, controls or switches when there is no intent to operate the control or device. This action may be noticed or unnoticed by the individual.

#### **AE102 Checklist Error**

Checklist Error is a factor when the individual, either through an act of commission or omission makes a checklist error or fails to run an appropriate checklist and this failure results in an unsafe situation.

#### **AE103 Procedural Error**

Procedural Error is a factor when a procedure is accomplished in the wrong sequence or using the wrong technique or when the wrong control or switch is used. This also captures errors in navigation, calculation or operation of automated systems.

#### **AE104 Overcontrol/ Undercontrol**

Overcontrol/Undercontrol is a factor when an individual responds inappropriately to conditions by either overcontrolling or undercontrolling the aircraft/vehicle/system. The error may be a result of preconditions or a temporary failure of coordination.

#### **AE105 Breakdown in Visual Scan**

Breakdown in Visual Scan is a factor when the individual fails to effectively execute learned / practiced internal or external visual scan patterns leading to unsafe situation.

#### **AE106 Inadequate Anti-G Straining Maneuver**

Inadequate Anti-G Straining Maneuver is a factor when the individuals AGSM is improper, inadequate, poorly timed or non-existent and this leads to adverse neuro-circulatory effects.

## **Judgment and Decision-Making Errors (AE2xx)**

Are factors in a mishap when behavior or actions of the individual proceed as intended yet the chosen plan proves inadequate to achieve the desired end-state and results in an unsafe situation.

### **AE201 Risk Assessment – During Operation**

Risk Assessment – During Operation is a factor when the individual fails to adequately evaluate the risks associated with a particular course of action and this faulty evaluation leads to inappropriate decision and subsequent unsafe situation. This failure occurs in real-time when formal risk-assessment procedures are not possible.

### **AE202 Task Misprioritization**

Task Misprioritization is a factor when the individual does not organize, based on accepted prioritization techniques, the tasks needed to manage the immediate situation.

### **AE203 Necessary Action – Rushed**

Necessary Action – Rushed is a factor when the individual takes the necessary action as dictated by the situation but performs these actions too quickly and the rush in taking action leads to an unsafe situation.

### **AE204 Necessary Action – Delayed**

Necessary Action – Delayed is a factor when the individual selects a course of action but elects to delay execution of the actions and the delay leads to an unsafe situation.

### **AE205 Caution/Warning – Ignored**

Caution/Warning – Ignored is a factor when a caution or warning is perceived and understood by the individual but is ignored by the individual leading to an unsafe situation.

### **AE206 Decision-Making During Operation**

Decision-Making During Operation is a factor when the individual through faulty logic selects the wrong course of action in a time-constrained environment.

## **Perception Errors (AE3xx)**

Are factors in a mishap when misperception of an object, threat or situation, (such as visual, auditory, proprioceptive, or vestibular illusions, cognitive or attention failures, etc), results in human error.

### **AE301 Error due to Misperception**

Error due to Misperception is a factor when an individual acts or fails to act based on an illusion; misperception or disorientation state and this act or failure to act creates an unsafe situation.



## **Violations (AVxxx)**

**Are factors in a mishap when the actions of the operator represent willful disregard for rules and instructions and lead to an unsafe situation. Violations are deliberate.**

### **AV001 Violation - Based on Risk Assessment**

Violation- Based on Risk Assessment is a factor when the consequences/risk of violating published procedures was recognized, consciously assessed and honestly determined by the individual, crew or team to be the best course of action. Routine “work-arounds” and unofficial procedures that are accepted by the community as necessary for operations are also captured under this code.

### **AV002 Violation - Routine/Widespread**

Violation - Routine/Widespread is a factor when a procedure or policy violation is systemic in a unit/setting and not based on a risk assessment for a specific situation. It needlessly commits the individual, team, or crew to an unsafe course-of-action. These violations may have leadership sanction and may not routinely result in disciplinary/administrative action. Habitual violations of a single individual or small group of individuals within a unit can constitute a routine/widespread violation if the violation was not routinely disciplined or was condoned by supervisors. These violations may also be referred to as “Routine Violations.”

### **AV003 Violation - Lack of Discipline**

Violation - Lack of Discipline is a factor when an individual, crew or team intentionally violates procedures or policies without cause or need. These violations are unusual or isolated to specific individuals rather than larger groups. There is no evidence of these violations being condoned by leadership. These violations may also be referred to as “exceptional violations.” (NOTE: These violations may also carry UCMJ consequences. Boards should consult the Judge Advocate of the convening authority.)

## **Preconditions**

**Are factors in a mishap if active and/or latent preconditions such as conditions of the operators, environmental or personnel factors affect practices, conditions or actions of individuals and result in human error or an unsafe situation.**

## **Environmental Factors (PExxx)**

**Are factors in a mishap if *physical* or *technological* factors affect practices, conditions and actions of individual and result in human error or an unsafe situation.**

### **Physical Environment (PE1xx)**

Are factors in a mishap if environmental phenomena such as weather, climate, white out or brown out conditions affect the actions of individuals and result in human error or an unsafe situation.

#### **PE101 Vision Restricted by Icing/Windows Fogged/Etc**

Vision Restricted by Icing/Windows Fogged/Etc is a factor when it is determined by the investigator that icing or fogging of the windshield/windscreen or canopy restricted the vision of the individual to a point where normal duties were affected.

#### **PE102 Vision Restricted by Meteorological Conditions**

Vision Restricted by Meteorological Conditions is a factor when weather, haze, or darkness restricted the vision of the individual to a point where normal duties were affected.

#### **PE103 Vibration**

Vibration is a factor when the intensity or duration of the vibration is sufficient to cause impairment of vision or adversely effect the perception of orientation.

#### **PE104 Vision Restricted in Workspace by Dust/Smoke/Etc.**

Vision restricted in workspace by dust/smoke/etc. is a factor when dust, smoke, etc. inside the cockpit, vehicle or workstation restricted the vision of the individual to a point where normal duties were affected.

#### **PE105 Windblast**

Windblast is a factor when the individual's ability to perform required duties is degraded during or after exposure to a windblast situation.

#### **PE106 Thermal Stress – Cold**

Thermal Stress – Cold is a factor when the individual is exposed to cold resulting in compromised function.

**PE107 Thermal Stress – Heat**

Thermal Stress – Heat is a factor when the individual is exposed to heat resulting in compromised function.

**PE108 Maneuvering Forces – In-Flight**

Maneuvering Forces – In-Flight is a factor when acceleration forces of longer than one second cause injury, prevent or interfere with the performance of normal duties. Do not use this code to capture G-induced loss of consciousness

**PE109 Lighting of Other Aircraft/Vehicle**

Lighting of Other Aircraft/Vehicle is a factor when the absence, pattern, intensity or location of the lighting of other aircraft/vehicle prevents or interferes with safe task accomplishment.

**PE110 Noise Interference**

Noise Interference is a factor when any sound not directly related to information needed for task accomplishment interferes with the individual's ability to perform that task.

**PE111 Brownout/Whiteout**

Brownout/Whiteout is a factor when dust, snow, water, ash or other particulates in the environment are disturbed by the aircraft, vehicle or person and cause a restriction of vision to a point where normal duties are affected

**Technological Environment (PE2xx)**

Are factors in a mishap when cockpit / vehicle / control station / workspace design factors or automation affect the actions of individuals and result in human error or an unsafe situation.

**PE201 Seating and Restraints**

Seating and Restraints is a factor when the design of the seat or restraint system, the ejection system, seat comfort or poor impact-protection qualities of the seat create an unsafe situation.

**PE202 Instrumentation and Sensory Feedback Systems**

Instrumentation and Sensory Feedback Systems is a factor when instrument factors such as design, reliability, lighting, location, symbology or size are inadequate and create an unsafe situation. This includes NVDs, HUD, off-bore-site and helmet-mounted display systems and inadequacies in auditory or tactile situational awareness or warning systems such as aural voice warnings or stick shakers.

**PE203 Visibility Restrictions**

Visibility Restrictions is a factor when the lighting system, windshield / windscreen / canopy design, or other obstructions prevent necessary visibility and create an unsafe situation. This includes glare or reflections on the canopy / windscreen / windshield. Visibility restrictions due to weather or environmental conditions are captured under PE101 or PE102.

**PE204 Controls and Switches**

Controls and Switches is a factor when the location, shape, size, design, reliability, lighting or other aspect of a control or switch is inadequate and this leads to an unsafe situation.

**PE205 Automation**

Automation is a factor when the design, function, reliability, use guidance, symbology, logic or other aspect of automated systems creates an unsafe situation.

**PE206 Workspace Incompatible with Human**

Workspace Incompatible with Human is a factor when the workspace is incompatible with the mission requirements and mission safety for this individual.

**PE207 Personal Equipment Interference**

Personal Equipment Interference is a factor when the individual's personal equipment interferes with normal duties or safety.

**PE208 Communications – Equipment**

Communications - Equipment is a factor when comm. equipment is inadequate or unavailable to support mission demands. (i.e. aircraft/vehicle with no intercom) This includes electronically or physically blocked transmissions. Communications can be voice, data or multi-sensory.

**Condition of Individuals (PCxxx)**

**Are factors in a mishap if cognitive, psycho-behavioral, adverse physical state, or physical/mental limitations affect practices, conditions or actions of individuals and result in human error or an unsafe situation.**

**Cognitive Factors (PC1xx)**

Are factors in a mishap if cognitive or attention management conditions affect the perception or performance of individuals and result in human error or an unsafe situation.

**PC101 Inattention**

Inattention is a factor when the individual has a state of reduced conscious attention due to a sense of security, self-confidence, boredom or a perceived absence of threat from the environment which degrades crew performance. (This may often be a result of highly repetitive tasks. Lack of a state of alertness or readiness to process immediately available information.)

**PC102 Channelized Attention**

Channelized Attention is a factor when the individual is focusing all conscious attention on a limited number of environmental cues to the exclusion of others of a subjectively equal or higher or more immediate priority, leading to an unsafe situation. May be described as a tight focus of attention that leads to the exclusion of comprehensive situational information.

**PC103 Cognitive Task Oversaturation**

Cognitive Task Oversaturation is a factor when the quantity of information an individual must process exceeds their cognitive or mental resources in the amount of time available to process the information.

**PC104 Confusion**

Confusion is a factor when the individual is unable to maintain a cohesive and orderly awareness of events and required actions and experiences a state characterized by bewilderment, lack of clear thinking, or (sometimes) perceptual disorientation.

**PC105 Negative Transfer**

Negative Transfer is a factor when the individual reverts to a highly learned behavior used in a previous system or situation and that response is inappropriate or degrades mission performance.

**PC106 Distraction**

Distraction is a factor when the individual has an interruption of attention and/or inappropriate redirection of attention by an environmental cue or mental process that degrades performance.

**PC107 Geographic Misorientation (Lost)**

Geographic Misorientation (Lost) is a factor when the individual is at a latitude and/or longitude different from where he believes he is or at a lat/long unknown to the individual and this creates an unsafe situation.

**PC108 Checklist Interference**

Checklist Interference is a factor when an individual is performing a highly automated/learned task and is distracted by another cue/event that results in the interruption and subsequent failure to complete the original task or results in skipping steps in the original task.

**Psycho-Behavioral Factors (PC2xx)**

Are factors when an individual's personality traits, psychosocial problems, psychological disorders or inappropriate motivation creates an unsafe situation.

**PC201 Pre-Existing Personality Disorder**

Pre-existing Personality Disorder is a factor when a qualified professional determines the individual met Diagnostic and Statistical Manual criteria for a personality disorder.

**PC202 Pre-Existing Psychological Disorder**

Pre-existing Psychological Disorder is a factor when a qualified professional determines the individual met Diagnostic and Statistical Manual criteria for a psychological disorder.

**PC203 Pre-Existing Psychosocial Problem**

Pre-existing Psychosocial Problem is a factor when a qualified professional determines the individual met Diagnostic and Statistical Manual criteria for a psychosocial problem.

**PC204 Emotional State**

Emotional State is a factor when the individual is under the influence of a strong positive or negative emotion and that emotion interferes with duties.

**PC205 Personality Style**

Personality style is a factor when the individual's personal interaction with others creates an unsafe situation. Examples are authoritarian, over-conservative, impulsive, invulnerable, submissive or other personality traits that result in degraded crew performance.

**PC206 Overconfidence**

Overconfidence is a factor when the individual overvalues or overestimates personal capability, the capability of others or the capability of aircraft/vehicles or equipment and this creates an unsafe situation.

**PC207 Pressing**

Pressing is a factor when the individual knowingly commits to a course of action that presses them and/or their equipment beyond reasonable limits.

**PC208 Complacency**

Complacency is a factor when the individual's state of reduced conscious attention due to an attitude of overconfidence, undermotivation or the sense that others "have the situation under control" leads to an unsafe situation.

**PC209 Inadequate Motivation**

Motivation – Inadequate is a factor when the individual's motivation to accomplish a task or mission is weak or indecisive.

**PC210 Misplaced Motivation**

Misplaced Motivation is a factor when an individual or unit replaces the primary goal of a mission with a personal goal.

**PC211 Overaggressive**

Overaggressive is a factor when an individual or crew is excessive in the manner in which they conduct a mission.

**PC212 Excessive Motivation to Succeed**

Motivation to Succeed – Excessive is a factor when the individual is preoccupied with success to the exclusion of other mission factors leading to an unsafe situation.

**PC213 Get-Home-Itis/Get-There-Itis**

Get-Home-Itis/Get-There-Itis is a factor when an individual or crew is motivated to complete a mission or reach a destination for personal reasons, thereby short cutting necessary procedures or exercising poor judgment, leading to an unsafe situation.

**PC214 Response Set**

Response set is a factor when the individual has a cognitive or mental framework of expectations that predispose them to a certain *course of action* regardless of other cues.

**PC215 Motivational Exhaustion (Burnout)**

Motivational Exhaustion (Burnout) is a factor when the individual has the type of exhaustion associated with the wearing effects of high operations and personal tempo where their operational requirements impinge on their ability to satisfy their personal requirements and leads to degraded cognitive or operational capability.

**Adverse Physiological States (PC3xx)**

Are factors when an individual experiences a physiologic event that compromises human performance and this decreases performance and results in an unsafe situation.

**PC301 Effects of G Forces (G-LOC, etc)**

Effects of G Forces (G-LOC, etc) is a factor when the individual experiences G-induced loss of consciousness (GLOC), greyout, blackout or other neuro-circulatory affects of sustained acceleration forces.

**PC302 Prescribed Drugs**

Prescribed Drugs is a factor when the individual uses a prescribed drug with measurable effect interfering with performance.

**PC303 Operational Injury/Illness**

Operational Injury/Illness is a factor when an injury is sustained or illness develops from the operational environment or *during* the mission and this injury or illness results in an unsafe situation. This includes toxic exposure. Details of injury, illness or toxic exposure should be captured in the medical investigation. Do not use this code to capture injury or illness that does not cause an unsafe situation or contribute to the mishap sequence.

**PC304 Sudden Incapacitation/Unconsciousness**

Sudden Incapacitation/Unconsciousness is a factor when the individual has an abrupt loss of functional capacity / conscious awareness. (NOT GLOC) Capture medical causes for the incapacitation in the AFSAS medical module.

**PC305 Pre-Existing Physical Illness/Injury/Deficit**

Pre-Existing Physical Illness/Injury/Deficit is a factor when a physical illness, injury or deficit that existed at the time the individual boarded the aircraft or began the mission/task causes an unsafe situation. This includes situations where wavered physical defects contribute to an unsafe situation and situations where vision deficit or loss of prosthetic devices during the mission cause an unsafe situation. An individual must board

the aircraft or begin the mission/task with prior knowledge of illness/injury/deficit otherwise mark and rate PC303. Details of injury, illness or deficit should be captured in the medical investigation. Do not use this code to capture injury or illness that does not cause an unsafe situation or contribute to the mishap sequence. (i.e. medevac patient whose condition deteriorates during flight).

**PC306 Physical Fatigue (Overexertion)**

Physical Fatigue (Overexertion) is a factor when the individual's diminished physical capability is due to overuse (time/relative load) and it degrades task performance. (The effects of prolonged physical activity, or the effects of brief but relatively extreme physical activity, either of which taxes a person's physical endurance or strength beyond the individual's normal limits.)

**PC307 Fatigue - Physiological/Mental**

Fatigue - Physiological/Mental is a factor when the individual's diminished physical or mental capability is due to an inadequate recovery, as a result of restricted or shortened sleep or physical or mental activity during prolonged wakefulness. Fatigue may additionally be described as acute, cumulative or chronic.

**PC308 Circadian Rhythm Desynchrony**

Circadian Rhythm Desynchrony is a factor when the individual's normal, 24-hour rhythmic biological cycle (circadian rhythm) is disturbed and it degrades task performance. This is caused typically by night work or rapid movement (such as one time zone per hour) across several time zones. Referred to as "shift lag" and "jet lag." (Time in the new time zone will lead to adaptation and recovery; the amount of time depends on the number of time zones crossed and the direction of travel. Recovery from shift lag may never occur.)

**PC309 Motion Sickness**

Motion Sickness is a factor when the symptoms of motion sickness impair normal performance. Motion sickness symptoms include nausea, sweating, flushing, vertigo, headache, stomach awareness, malaise, and vomiting.

**PC310 Trapped Gas Disorders**

Trapped Gas Disorders are a factor when gasses in the middle ear, sinuses, teeth, or intestinal tract expand or contract on ascent or descent causing an unsafe situation. Also capture alternobaric vertigo under this code. If the alternobaric vertigo induces spatial disorientation you must mark and rate PC508, PC509 or PC510.

**PC311 Evolved Gas Disorders**

Evolved gas disorders are a factor when inert-gas evolves in the blood causing an unsafe situation. This includes, chokes, CNS, bends or parasthesias or other conditions caused by inert-gas evolution.



**PC312 Hypoxia**

Hypoxia is a factor when the individual has insufficient oxygen supply to the body sufficient to cause an impairment of function.

**PC313 Hyperventilation**

Hyperventilation is a factor when the effect of ventilating above the physiological demands of the body causes the individual's performance capabilities to be degraded.

**PC314 Visual Adaptation**

Visual Adaptation is a factor when the normal human limitation of dark-adaptation rate affects safety, for example, when transitioning between aided and unaided night vision.

**PC315 Dehydration**

Dehydration is a factor when the performance of the operator is degraded due to dehydration as a result of excessive fluid losses due to heat stress or due to insufficient fluid intake.

**PC316 Physical Task Oversaturation**

Physical Task Oversaturation is a factor when the number or complexity of manual tasks in a compressed time period exceeds an individual's capacity to perform.

**Physical/Mental Limitations (PC4xx)**

Are factors in a mishap when an individual, temporarily or permanently lacks the physical or mental capabilities to cope with a situation and this insufficiency causes an unsafe situation.

**PC401 Learning Ability/Rate**

Learning Ability – Rate is a factor when the individual's relative efficiency with which new information is acquired, and relatively permanent adjustments made in behavior or thinking, are not consistent with mission demands.

**PC402 Memory Ability/Lapses**

Memory Ability/Lapses is a factor when the individual is unable or has lapses in the ability to recall past experience needed for safe mission completion. (Experience includes any information a person receives through any means, any cognitive functions he or she performed on that information, and any response he or she made as a result of it.)

**PC403 Anthropometric/Biomechanical Limitations**

Anthropometric/Biomechanical limitations are a factor when the size, strength, dexterity, mobility or other biomechanical limitations of an individual creates an unsafe situation. It must be expected that the average individual qualified for that duty position could accomplish the task in question.

**PC404 Motor Skill/Coordination or Timing Deficiency**

Motor Skill/Coordination or Timing Deficiency is a factor when the individual lacks the required psychomotor skills, coordination or timing skills necessary to accomplish the task attempted.

**PC405 Technical/Procedural Knowledge**

Technical/Procedural Knowledge is a factor when an individual was adequately exposed to the information needed to perform the mission element but did not absorb it. Lack of knowledge implies no deficiency in the training program, but rather the failure of the individual to absorb or retain the information. (Exposure to information at a point in the past does not imply "knowledge" of it.)

**Perceptual Factors (PC5xx)**

Are factors in a mishap when misperception of an object, threat or situation, (visual, auditory, proprioceptive, or vestibular conditions) creates an unsafe situation

**PC501 Illusion – Kinesthetic**

Illusion – Kinesthetic is a factor when somatosensory stimuli of the ligaments, muscles, or joints cause the individual to have an erroneous perception of orientation, motion or acceleration leading to degraded performance. (If this illusion leads to spatial disorientation you must mark and rate PC508, PC509 or PC510.)

**PC502 Illusion – Vestibular**

Illusion – Vestibular is a factor when stimuli acting on the semicircular ducts or otolith organs of the vestibular apparatus cause the individual to have an erroneous perception of orientation, motion or acceleration leading to degraded performance. (If this illusion leads to spatial disorientation you must mark and rate PC508, PC509 or PC510.)

**PC503 Illusion – Visual**

Illusion – Visual is a factor when visual stimuli result in an erroneous perception of orientation, motion or acceleration, leading to degraded performance. (If this illusion leads to spatial disorientation you must mark and rate PC508, PC509 or PC510.)

**PC504 Misperception of Operational Conditions**

Misperception of Operational Conditions is a factor when an individual misperceives or misjudges altitude, separation, speed, closure rate, road/sea conditions, aircraft/vehicle location within the performance envelope or other operational conditions and this leads to an unsafe situation.

**PC505 Misinterpreted/Misread Instrument**

Misinterpreted/Misread Instrument is a factor when the individual is presented with a correct instrument reading but its significance is not recognized, it is misread or is misinterpreted.

**PC506 Expectancy**

Expectancy is a factor when the individual's expects to perceive a certain reality and those expectations are strong enough to create a *false perception* of the expectation.

**PC507 Auditory Cues**

Auditory Cues is a factor when the auditory inputs are correctly interpreted but are misleading or disorienting. Also when the inputs are incorrectly interpreted and cause an impairment of normal performance.

**PC508 Spatial Disorientation (Type 1) Unrecognized**

Spatial Disorientation is a failure to correctly sense a position, motion or attitude of the aircraft or of oneself within the fixed coordinate system provided by the surface of the earth and the gravitational vertical. Spatial Disorientation (Type 1) Unrecognized is a factor when a person's cognitive awareness of one or more of the following varies from reality: attitude; position; velocity; direction of motion or acceleration. Proper control inputs are not made because the need is unknown.

**PC509 Spatial Disorientation (Type 2) Recognized**

Spatial Disorientation is a failure to correctly sense a position, motion or attitude of the aircraft or of oneself within the fixed coordinate system provided by the surface of the earth and the gravitational vertical. Spatial Disorientation (Type 2) is a factor when recognized perceptual confusion is induced through one or more of the following senses: visual; vestibular; auditory; tactile; proprioception or kinesthetic. Proper control inputs are still possible.

**PC510 Spatial Disorientation (Type 3) Incapacitating**

Spatial Disorientation is a failure to correctly sense a position, motion or attitude of the aircraft or of oneself within the fixed coordinate system provided by the surface of the earth and the gravitational vertical. Spatial Disorientation (Type 3) Incapacitating is a factor when an individual is unable to make proper control inputs for safe operation of the aircraft or system due to a conflict (often extreme) between the sensory systems identified in type 2.

**PC511 Temporal Distortion**

Temporal Distortion is a factor when the individual experiences a compression or expansion of time relative to reality leading to an unsafe situation. (Often associated with a "fight or flight" response.)

**Personnel Factors (PPxxx)**

**Are factors in a mishap if self imposed stressors or crew resource management affect practices, conditions or actions of individuals and result in human error or an unsafe situation.**

**Coordination/Communication/Planning Factors(PP1xx)**

Refer to interactions among individuals, crews, and teams involved with the preparation and execution of a mission that resulted in human error or an unsafe situation.

**PP101 Crew/Team Leadership**

Crew/Team Leadership is a factor when the crew/team leadership techniques failed to facilitate a proper crew climate, to include establishing and maintaining an accurate and shared understanding of the evolving mission and plan on the part of all crew or team members.

**PP102 Cross-Monitoring Performance**

Cross-monitoring performance is a factor when crew or team members failed to monitor, assist or back-up each other's actions and decisions.

**PP103 Task Delegation**

Task delegation is a factor when the crew or team members failed to actively manage the distribution of mission tasks to prevent the overloading of any crewmember.

**PP104 Rank/Position Authority Gradient**

Rank/position authority gradient is a factor when the differences in rank of the team, crew or flight caused the mission performance capabilities to be degraded. Also conditions where formal or informal authority gradient is too steep or too flat across a crew, team or flight and this condition degrades collective or individual performance.

**PP105 Assertiveness**

Assertiveness is a factor when individuals failed to state critical information or solutions with appropriate persistence.

**PP106 Communicating Critical Information**

Communicating critical information is a factor when known critical information was not provided to appropriate individuals in an accurate or timely manner.

**PP107 Standard/Proper Terminology**

Standard/proper terminology is a factor when clear and concise terms, phrases and signals, etc per service standards and training were not used.

**PP108 Challenge and Reply**

Challenge and reply is a factor when communications did not include supportive feedback or acknowledgement to ensure that personnel correctly understand announcements or directives.

**PP109 Mission Planning**

Mission planning is a factor when an individual, crew or team failed to complete all preparatory tasks associated with planning the mission, resulting in an unsafe situation. Planning tasks include information collection and analysis, coordinating activities within the crew or team and with appropriate external agencies, contingency planning, and risk assessment.

**PP110 Mission Briefing**

Mission briefing is a factor when information and instructions provided to individuals, crews, or teams were insufficient, or participants failed to discuss contingencies and strategies to cope with contingencies.

**PP111 Task/Mission-In-Progress Re-Planning**

Task/mission-in-progress re-planning is a factor when crew or team members fail to adequately reassess changes in their dynamic environment during mission execution and change their mission plan accordingly to ensure adequate management of risk.

**PP112 Miscommunication**

Miscommunication is a factor when correctly communicated information is misunderstood, misinterpreted, or disregarded.

**Self-Imposed Stress (PP2xx)**

Is a factor in a mishap if the operator demonstrates disregard for rules and instructions that govern the individuals readiness to perform, or exhibits poor judgment when it comes to readiness and results in human error or an unsafe situation.

**PP201 Physical Fitness**

Physical Fitness is a factor when the relative physical state of the individual, in terms of a regular rigorous exercise program or a physically active lifestyle, is not adequate to support mission demands.

**PP202 Alcohol**

Alcohol is a factor when the acute or residual effects of alcohol impaired performance or created an unsafe situation.

**PP203 Drugs/Supplements/Self medication**

Drugs/Supplements/Self-medication is a factor when the individual takes any drug, other than prescribed, that interferes with performance. This includes nicotine or caffeine in sufficient quantities to cause impairment of normal function. This also includes any chemical compound taken for purposes of prevention of disease, treatment of disease, weight management, mood alteration, birth control or sleep management, etc. The effects may be direct or residual. Alcohol is captured under PP206.

**PP204 Nutrition**

Nutrition is a factor when the individual's nutritional state or poor dietary practices are inadequate to fuel the brain and body functions resulting in degraded performance

**PP205 Inadequate Rest**

Inadequate rest is a factor when the opportunity for rest was provided but the individual failed to take the opportunity to rest.

**PP206 Unreported Disqualifying Medical Condition**

Unreported Disqualifying Medical Condition is a factor when the operator intentionally operates/flies with a known disqualifying medical condition that results in an unsafe situation.

# **Supervision**

**Is a factor in a mishap if the methods, decisions or policies of the supervisory chain of command directly affect practices, conditions, or actions of individual and result in human error or an unsafe situation.**

## **Inadequate Supervision (SIxxx)**

**Is a factor in a mishap when supervision proves inappropriate or improper and fails to identify hazard, recognize and control risk, provide guidance, training and/or oversight and results in human error or an unsafe situation.**

### **SI001 Leadership/Supervision/Oversight Inadequate**

Leadership/Supervision/Oversight Inadequate is a factor when the availability, competency, quality or timeliness of leadership, supervision or oversight does not meet task demands and creates an unsafe situation. Inappropriate supervisory pressures are also captured under this code.

### **SI002 Supervision – Modeling**

Supervision – Modeling is a factor when the individual's learning is influenced by the behavior of peers and supervisors and when that learning manifests itself in actions that are either inappropriate to the individual's skill level or violate standard procedures and lead to an unsafe situation.

### **SI003 Local Training Issues/Programs**

Local Training Issues/Programs are a factor when one-time or recurrent training programs, upgrade programs, transition programs or any other local training is inadequate or unavailable (etc) and this creates an unsafe situation. (Note: the failure of an individual to absorb the training material in an adequate training program does not indicate a training program problem. Capture these factors under PC401 "Learning ability/rate" or PC405 "Technical/Procedural Knowledge." The failure of an individual to recall learned information under stress or while fatigued despite attending an adequate training program does not indicate a training program problem. Capture these factors under PC402 "Memory/ Ability lapses" or other cognitive factors such as PC104 "Confusion," PC106 "Distraction," PC105 "Negative Transfer," etc.)

### **SI004 Supervision – Policy**

Supervision – Policy is a factor when policy or guidance or lack of a policy or guidance leads to an unsafe situation.

### **SI005 Supervision – Personality Conflict**

Supervision – Personality Conflict is a factor when a supervisor and individual member experience a "personality conflict" that leads to a dangerous error in judgment / action.

### **SI006 Supervision – Lack of Feedback**

Supervision – Lack of Feedback is a factor when information critical to a potential safety issue had been provided to supervisory or management personnel without feedback to the source (failure to close the loop).

## **Planned Inappropriate Operations (SPxxx)**

**Is a factor in a mishap when supervision fails to adequately assess the hazards associated with an operation and allows for unnecessary risk. It is also a factor when supervision allows non-proficient or inexperienced personnel to attempt missions beyond their capability or when crew or flight makeup is inappropriate for the task or mission.**

### **SP001 Ordered/Led on Mission Beyond Capability**

Ordered/Led on Mission Beyond Capability is a factor when supervisor / management directs personnel to undertake a mission beyond their skill level or beyond the capabilities of their equipment.

### **SP002 Crew/Team/Flight Makeup/Composition**

Crew/Team/Flight Makeup/Composition is a factor when, in the opinion of the investigator, the makeup of the crew or of the flight should have reasonably raised obvious safety concerns in the minds of crewmembers involved in the mission, or in any other individual directly related to the scheduling of this mission.

### **SP003 Limited Recent Experience**

Limited Recent Experience is a factor when the supervisor selects an individual who's experience for either a specific maneuver, event or scenario is not sufficiently current to permit safe mission execution.

### **SP004 Limited Total Experience**

Limited Total Experience is a factor when a supervisor selects an individual who's individual has performed a maneuver, or participated in a specific scenario, infrequently or rarely.

### **SP005 Proficiency**

Proficiency is a factor when and individual is not proficient in a task, mission or event.

### **SP006 Risk Assessment – Formal**

Risk Assessment – Formal is a factor when supervision does not adequately evaluate the risks associated with a mission or when pre-mission risk assessment tools or risk assessment programs are inadequate.

### **SP007 Authorized Unnecessary Hazard**



Authorized Unnecessary Hazard is a factor when supervision authorizes a mission or mission element that is unnecessarily hazardous without sufficient cause or need. Includes intentionally scheduling personnel for mission or operation that they are not qualified to perform.

## **Failure to Correct Known Problem (SFxxx)**

**Is a factor in a mishap when supervision fails to correct known deficiencies in documents, processes or procedures, or fails to correct inappropriate or unsafe actions of individuals, and this lack of supervisory action creates an unsafe situation.**

### **SF001 – Personnel Management**

Personnel management is a factor when a supervisor fails to identify an operator or aviator who exhibits recognizable risky behaviors or unsafe tendencies or fails to institute remedial actions when an individual is identified with risky behaviors or unsafe tendencies.

### **SF002 – Operations Management**

Operations management is a factor when a supervisor fails to correct known hazardous practices, conditions or guidance that allows for hazardous practices within the scope of his/her command

## **Supervisory Violations (SVxxx)**

**Is a factor in a mishap when supervision while managing organizational assets willfully disregards instructions, guidance, rules, or operating instructions and this lack of supervisory responsibility creates an unsafe situation.**

### **SV001 Supervision – Discipline Enforcement (Supervisory act of omission)**

Supervision – Discipline Enforcement is a factor when unit (organizational) and operating rules have not been enforced by the normally constituted authority.

### **SV002 Supervision – Defacto Policy**

Supervision – Defacto Policy is a factor when unwritten or “unofficial” policy perceived and followed by the individual, which has not been formally established by the properly constituted authority, leads to an unsafe situation.

### **SV003 Directed Violation**

Directed Violation is a factor when a supervisor directs a subordinate to violate existing regulations, instructions or technical guidance.

### **SV004 Currency**

Currency is a factor when an individual has not met the general training requirements for his job/weapon system and is considered “non-current” and supervision/leadership inappropriately allows the individual to perform the mission element for which the individual is non-current.

## **Organizational Influences**

**Are factors in a mishap if the communications, actions, omissions or policies of upper-level management directly or indirectly affect supervisory practices, conditions or actions of the operator(s) and result in system failure, human error or an unsafe situation.**

## **Resource/Acquisition Management (ORxxx)**

**Is a factor in a mishap if resource management and/or acquisition processes or policies, directly or indirectly, influence system safety and results in poor error management or creates an unsafe situation.**

### **OR001 Air Traffic Control Resources**

Air Traffic Control Resources is a factor when inadequate monitoring of airspace, enroute nav-aids or language barriers in air traffic controllers cause an unsafe situation. Note: If the unsafe acts of an individual air traffic controller are determined to be a factor in a mishap then the controller must be added and investigated as a mishap person.

### **OR002 Airfield Resources**

Airfield Resources are a factor when runways, taxiways, ramps, terminal ATC resources or nav-aids, lighting systems, SOF/RSU resources or the environment surrounding the airfield are inadequate or unsafe. If the airfield or environment created a visual illusion that contributed to the mishap sequence you must also mark and rate PC503 "Illusion - Visual."

### **OR003 Operator Support**

Operator Support is a factor when support facilities (dining, exercise, quarters, medical care, etc) or opportunity for recreation or rest are not available or adequate and this creates an unsafe situation. This includes situations where leave is not taken for reasons other than the individual's choice.

### **OR004 Acquisition Policies/Design Processes**

Acquisition Policies/Design Processes is a factor when the processes through which aircraft, vehicle, equipment or logistical support are acquired allows inadequacies or when design deficiencies allow inadequacies in the acquisition and the inadequacies create an unsafe situation.

### **OR005 Attrition Policies**

Attrition Policies is a factor when the process through which equipment is removed from service is inadequate and this inadequacy creates an unsafe situation.

### **OR006 Accession/Selection Policies**

Accession/Selection Policies is a factor when the process through which individuals are screened, brought into the service or placed into specialties is inadequate and creates an unsafe situation.

**OR007 Personnel Resources**

Personnel Resources is a factor when the process through which manning, staffing or personnel placement or manning resource allocations are inadequate for mission demands and the inadequacy causes an unsafe situation.

**OR008 Informational Resources/Support**

Informational Resources/Support is a factor when weather, intelligence, operational planning material or other information necessary for safe operations planning are not available.

**OR009 Financial Resources/Support**

Financial Resources/Support is a factor when an organization or operation does not receive the financial resources to complete its assigned mission and this deficiency creates an unsafe situation.

**Organizational Climate (OCxxx)**

**Is a factor in a mishap if organizational variables including environment, structure, policies, and culture influence individual actions and results in human error or an unsafe situation.**

**OC001 Unit/Organizational Values/Culture**

Unit/Organizational Values/Culture is a factor when explicit/implicit actions, statements or attitudes of unit leadership set unit/organizational values (culture) that allow an environment where unsafe mission demands or pressures exist.

**OC002 Evaluation/Promotion/Upgrade**

Evaluation/Promotion/Upgrade is a factor when an individual perceives that their performance on a task will inappropriately impact an evaluation, promotion or opportunity for upgrade and this pressure creates an unsafe situation. Other inappropriate supervisory pressures are captured under SI001 Supervision – Inadequate.

**OC003 Perceptions of Equipment**

Perceptions of Equipment is a factor when over or under confidence in an aircraft, vehicle, device, system or any other equipment creates an unsafe situation.

**OC004 Unit Mission/Aircraft/Vehicle/Equipment Change or Unit Deactivation**

Unit Mission/Aircraft/Vehicle/Equipment Change or Unit Deactivation is a factor when the process of changing missions/aircraft/vehicle/equipment or an impending unit deactivation creates an unsafe situation.

**OC005 Organizational Structure**

Organizational Structure is a factor when the chain of command of an individual or structure of an organization is confusing, non-standard or inadequate and this creates an unsafe situation.

## **Organizational Processes (OPxxx)**

**Is a factor in a mishap if organizational processes such as operations, procedures, operational risk management and oversight negatively influence individual, supervisory, and/or organizational performance and results in unrecognized hazards and/or uncontrolled risk and leads to human error or an unsafe situation.**

### **OP001 Ops Tempo/Workload**

Ops Tempo/Workload is a factor when the pace of deployments, workload, additional duties, off-duty education, PME, or other workload-inducing condition of an individual or unit creates an unsafe situation.

### **OP002 Program and Policy Risk Assessment**

Program and Policy Risk Assessment is a factor when the potential risks of a large program, operation, acquisition or process are not adequately assessed and this inadequacy leads to an unsafe situation.

### **OP003 Procedural Guidance/Publications**

Procedural Guidance/Publications is a factor when written direction, checklists, graphic depictions, tables, charts or other published guidance is inadequate, misleading or inappropriate and this creates an unsafe situation.

### **OP004 Organizational Training Issues/Programs**

Organizational Training Issues/Programs are a factor when one-time or initial training programs, upgrade programs, transition programs or other training that is conducted outside the local unit is inadequate or unavailable (etc) and this creates an unsafe situation. (Note: the failure of an individual to absorb the training material in an adequate training program does not indicate a training program problem. Capture these factors under PC401 "Learning Ability/Rate" or PC405 "Technical/Procedural Knowledge." The failure of an individual to recall learned information under stress or while fatigued despite attending an adequate training program does not indicate a training program problem. Capture these factors under PC402 "Memory/ Ability lapses" or other cognitive factors such as PC104 "Confusion," PC106 "Distraction," PC105 "Negative Transfer" or one of the forms of Fatigue, etc.)

### **OP005 Doctrine**

Doctrine is a factor when the doctrine, philosophy or concept of operations in an organization is flawed or accepts unnecessary risk and this flaw or risk acceptance leads to an unsafe situation or uncontrolled hazard.

### **OP006 Program Oversight/Program Management**

Program Oversight/Program Management is a factor when programs are implemented without sufficient support, oversight or planning and this leads to an unsafe situation.

# **Human Factor Analysis**



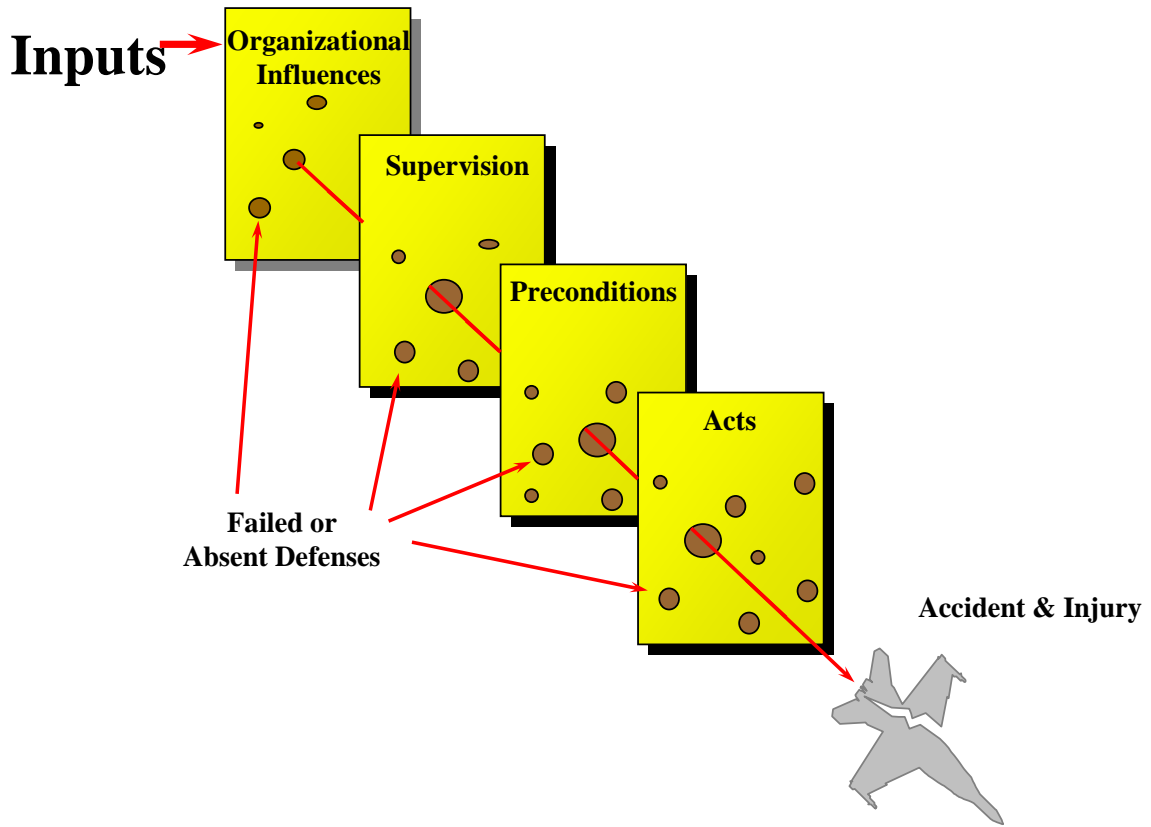
## **Flip Book**

## INTRODUCTION.....

Human error remains the leading cause of Navy and Marine mishaps. Mishaps are rarely attributed to a single cause but are often the end result of a series of errors, sometimes called the “Swiss Cheese Model” (see below). Root cause analysis can be performed in many different ways, but it always comes down to first asking why something occurred. Start with the problem, asking what prompted the problem to happen in the first place. Then keep taking it further and further until you can pinpoint specific processes, policies, or procedures that didn’t work. It all comes down to asking “why?” until you see a pattern in the problem. This HFACS flip book was developed as a tool to guide in root cause analysis, and can also be used to develop interview questions, determine potential ORM hazards, and detect human error trends. The concept of Human Factors Analysis and Classification flip book is to provide a quick reference guide for mishap investigators. This booklet demonstrates a hierarchical approach to link each act to a precondition to supervisory and then organizational role. This tool can help identify the starting point of the investigation.

## BENEFITS OF DOD HFACS.....

- 1 Structured analysis of human error
  - Sophisticated, complete...yet operational
  - Detects error patterns
- 1 Gets to the “why”... not just the “what”
  - More insightful root cause determination
  - Better CO decisions...more effective ORM
- 1 A new, data-driven approach
  - Supports research across the Force
  - Easily applied to large body of existing data
  - Easily applied to new incidents and mishaps
- 1 Can be used for more than Operational purposes
  - Can be a tool for ORM brainstorming
  - Can help develop interview questions
  - Applies to both on-duty and off-duty evolutions

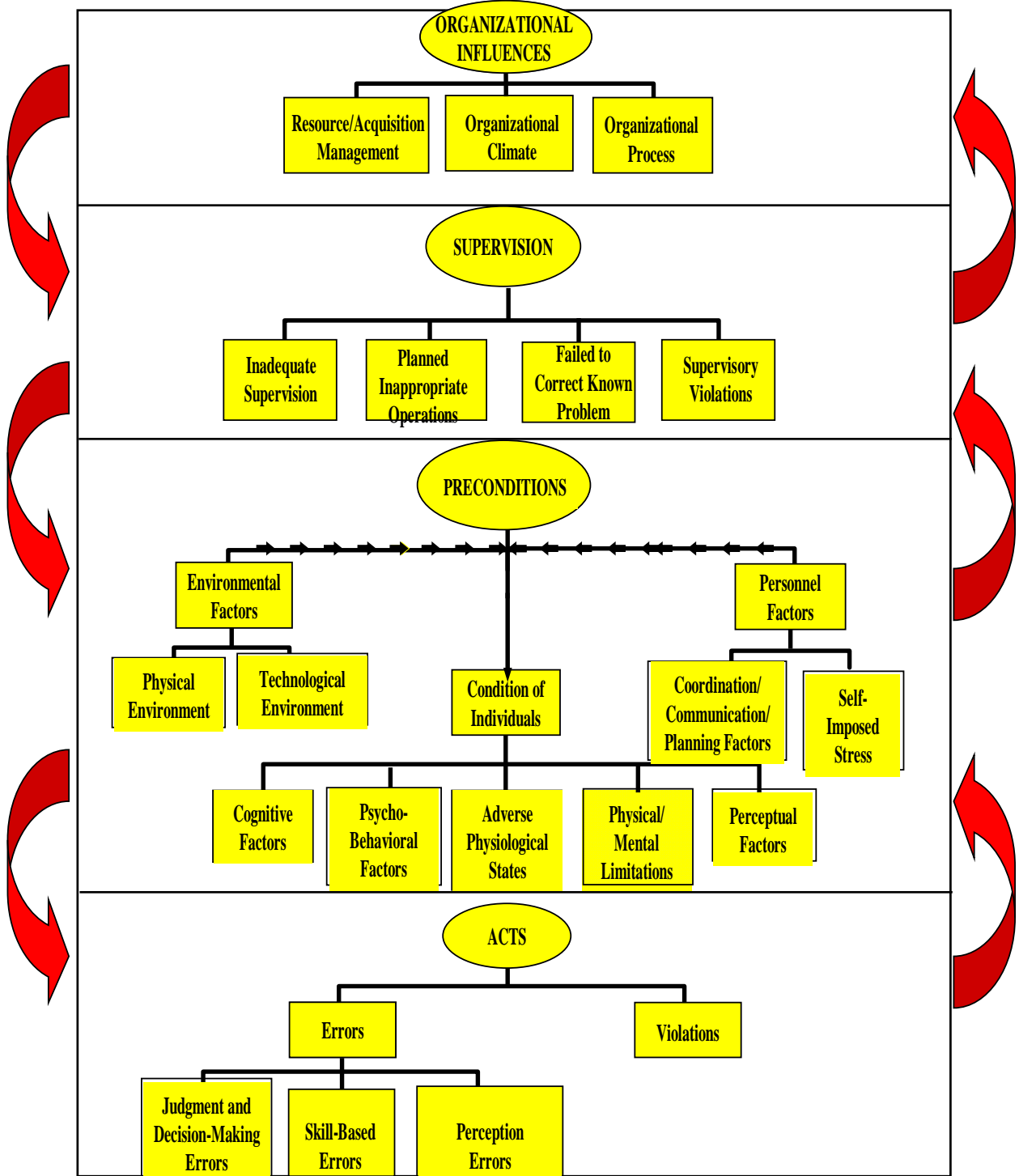


## HOW IT WORKS.....

- 1 Start at the lowest level and ask "What did the person do, or not do, to cause the mishap (e.g., pushed the wrong button, made a bad decision, or violated the regulations)?" This is called the "Acts" level. Using the HFACS model on the next page, look at the boxes under "Acts", along with the most common types of errors, and pick those that apply to your situation.
  
- 1 Next, ask "Why did the person do this unsafe act?" This is what is called the "Precondition" level. Perhaps he was fatigued, going through a divorce, complacent, or was trying to do the procedure in really bad weather. Just like before, look at all the boxes under "Preconditions", along with the most common types, and pick those that apply.
  
- 1 Now that you know the preconditions for the individual, you look at what the command's role was in this event. Many times we find that someone in the command knew about the person's preconditions, but didn't take steps to prevent disaster, or perhaps there were SOPs in place, but they were unclear or not enforced. This level helps the command to know where they can tighten up things.
  
- 1 Finally, you look at the organization as a whole. Perhaps the procedures the guy was given to use were unclear or the training he got was inadequate. Sometimes we even find that because of big-Navy budget issues, items are known to be faulty but don't get fixed.



# DoD HFACS



## “What happened?” (Acts)

SKILL-BASED ERRORS: Errors that occur during an individual’s performance of a routine, highly practiced task that are considered “ingrained” skills.

- ♦ Unintended operation of equipment..... AE101
- ♦ Checklist not followed correctly ..... AE102
- ♦ Procedure not followed correctly ..... AE103
- ♦ Over-controlled/ Under-controlled aircraft/vehicle..... AE104
- ♦ Breakdown in visual scan ..... AE105
- ♦ Inadequate Anti-G straining maneuver ..... AE106

JUDGMENT & DECISION-MAKING ERRORS: Errors that occur when an individual proceeds as he intended, yet the plan proves inadequate or inappropriate for the situation (i.e., “an honest mistake”).

- ♦ Inadequate real-time risk assessment ..... AE 201  
(e.g. failure of Time Critical ORM)
- ♦ Failure to prioritize tasks adequately ..... AE 202
- ♦ Rushed a necessary action ..... AE 203
- ♦ Delayed a necessary action ..... AE 204
- ♦ Ignored a Caution/Warning..... AE 205
- ♦ Wrong choice of action during an operation ..... AE 206  
(e.g. wrong response to an emergency)

PERCEPTION ERRORS: Unique skill-based and decision-based errors that occur as a result of an individual’s inappropriate response to his degraded or “unusual” sensory inputs (such as sight, hearing, or balance illusions).

- ♦ Incorrect response to a misperception ..... AE301  
(e.g. visual illusion or spatial disorientation)

Note: Specific type of skill-based and decision errors will need to be identified with this error.

VIOLATIONS: Are factors in a mishap when the operator intentionally breaks the rules and instructions. Violations are deliberate.

- ♦ Work-around violation..... AV001  
(e.g. breaking the rules is perceived as the best solution)
- ♦ Widespread/routine violation ..... AV002  
(e.g. habitual deviation from the rules that is tolerated by management)
- ♦ Extreme violation (e.g. a violation not condoned by management) ..... AV003

## **“Why did they do it?” (Preconditions)**

**PHYSICAL ENVIRONMENT:** Are factors when the environment such as weather, climate, brownout (dust or sand storm) or whiteout (snow storm) affect the actions of individual.

- ♦ Icing/fog on window restricts vision ..... PE 101
- ♦ Weather conditions restricts vision ..... PE 102
- ♦ Vibration effect vision or balance ..... PE 103
- ♦ Dust/smoke in workspace obstructs vision ..... PE 104
- ♦ Windblast in workspace obstructs vision ..... PE 105
- ♦ Cold stress ..... PE 106
- ♦ Heat stress ..... PE 107
- ♦ Extreme forces limits an individual’s movement ..... PE 108
- ♦ Lights of other vehicle/aircraft interfere with performance ..... PE 109
- ♦ Noise ..... PE 110
- ♦ Brownout (e.g. sand storm)/Whiteout (e.g. snow storm) ..... PE 111

**TECHNOLOGICAL ENVIRONMENT:** Are factors in a mishap when automation or the design of the workspace (e.g., cockpit, inside vehicle, or control station) affects the actions of an individual.

- ♦ Seat and restraint systems problems ..... PE 201
- ♦ Instrumentation and warning system issues ..... PE 202
- ♦ Visibility restrictions (not weather related) ..... PE 203
- ♦ Controls and switches are inadequate ..... PE 204
- ♦ Automated system creates an unsafe situation ..... PE 205
- ♦ Workspace incompatible with operation ..... PE 206
- ♦ Personal equipment interference ..... PE 207
- ♦ Communication equipment inadequate ..... PE 208

**SELF-IMPOSED STRESS:** Operator demonstrates disregard for rules and instructions that govern the individual’s readiness to perform.

- ♦ Physical fitness level (inappropriate for mission demands) ..... PP 201
- ♦ Alcohol ..... PP 202
- ♦ Drugs/over-the-counter medication/supplements (not prescribed) ..... PP 203
- ♦ Nutrition/diet ..... PP 204
- ♦ Inadequate rest (self-imposed) ..... PP 205
- ♦ Operating with known disqualifying medical condition ..... PP 206

## **Preconditions (Continued)**

**COORDINATION/COMMUNICATION/PLANNING FACTORS:** Refer to interactions among individuals, crews, and teams involved with the preparation and execution of a mission that resulted in human error or an unsafe situation.

- ◆ Failure of crew/team leadership..... PP 101
- ◆ Failure to cross-check/ back-up..... PP 102
- ◆ Inadequate task delegation ..... PP 103
- ◆ Rank/position intimidation..... PP 104
- ◆ Lack of assertiveness ..... PP 105
- ◆ Critical information not communicated..... PP 106
- ◆ Standard/proper terminology not used ..... PP 107
- ◆ Failure to ensure communicated intentions/actions were understood and followed ..... PP 108
- ◆ Mission planning inadequate ..... PP 109
- ◆ Mission briefing inadequate ..... PP 110
- ◆ Failure to re-assess risk and adjust to changing circumstances..... PP 111
- ◆ Information is misinterpreted or disregarded ..... PP 112

**AWARENESS (COGNITIVE) FACTORS:** Attention management or awareness failures that affect the perception or performance of individuals.

- ◆ Not paying attention..... PC 101
- ◆ Fixation (“channelized attention”) ..... PC 102
- ◆ Task over-saturation (e.g., too much information to process)..... PC 103
- ◆ Confusion ..... PC 104
- ◆ Negative transfer (e.g., using old procedures for a new system)..... PC 105
- ◆ Distraction ..... PC 106
- ◆ Geographically lost (Confusion about location) ..... PC 107
- ◆ Interference/interruption during task ..... PC 108

**PHYSICAL/MENTAL LIMITATIONS:** Limitations in physical or mental capabilities that decrease the ability to cope with a situation.

- ◆ Learning rate limitations ..... PC 401
- ◆ Memory limitations..... PC 402
- ◆ Body size/movement limitations ..... PC 403
- ◆ Coordination deficiency ..... PC 404
- ◆ Technical or procedural knowledge not retained after training ..... PC 405

## Preconditions (Continued)

PERCEPTUAL FACTORS: Degraded sensory inputs (visual, auditory, or vestibular) create a misperception of an object, threat, or situation.

- ◆ Motion illusion..... PC 501
- ◆ Turning illusion/balance ..... PC 502
- ◆ Visual illusion..... PC 503
- ◆ Misperception of changing environment ..... PC 504
- ◆ Misinterpreted/misread instrument ..... PC 505  
(e.g., misjudge altitude/distance/speed)
- ◆ Inaccurate expectation (e.g., seeing/hearing what is expected instead of what is actually there/heard) ..... PC 506
- ◆ Misinterpretation of auditory cues..... PC 507
- ◆ Spatial disorientation -- not recognized ..... PC 508
- ◆ Spatial disorientation -- recognized ..... PC 509
- ◆ Spatial disorientation -- incapacitating ..... PC 510
- ◆ Time distortion ..... PC 511

PSYCHO-BEHAVIORAL FACTORS: Factors when an individual's personality traits, psychosocial problems, psychological disorders, or inappropriate motivation creates an unsafe situation.

- ◆ Pre-existing personality disorder\* ..... PC 201
- ◆ Pre-existing psychological disorder\* ..... PC 202
- ◆ Pre-existing psychosocial problem\* ..... PC 203
- ◆ Emotional state..... PC 204
- ◆ Personality style ..... PC 205
- ◆ Overconfidence ..... PC 206
- ◆ Pressing (e.g., pushing self or equipment too hard) ..... PC 207
- ◆ Complacency (e.g., absence of worry) ..... PC 208
- ◆ Not enough motivation..... PC 209
- ◆ Misplaced motivation ..... PC 210
- ◆ More aggressive than necessary..... PC 211
- ◆ Excessive motivation to succeed (e.g., "do or die") ..... PC 212
- ◆ "Get-home-it is"/"get-there-it is" ..... PC 213
- ◆ Inappropriate response due to expectation ..... PC 214
- ◆ Motivational exhaustion ("burnout") ..... PC 215

\* As determined by qualified medical personnel.

## **Preconditions (Continued)**

ADVERSE PHYSIOLOGICAL STATES: Medical or physiological conditions that can result in unsafe situations

- ◆ Effects of G forces (e.g., G-LOC) ..... PC 301
- ◆ Effects of prescribed drugs ..... PC 302
- ◆ Operational injury/illness ..... PC 303
- ◆ Sudden incapacitation/unconsciousness (not due to G)..... PC 304
- ◆ Pre-existing physical illness/injury ..... PC 305
- ◆ Physical overexertion ..... PC 306
- ◆ Fatigue (sleep deprivation) ..... PC 307
- ◆ Circadian rhythm de-synchronization (e.g., jet lag or shift work) ..... PC 308
- ◆ Motion sickness ..... PC 309
- ◆ Trapped gas disorders..... PC 310
- ◆ Evolved gas disorders (e.g., decompression sickness/bends) ..... PC 311
- ◆ Reduced oxygen (hypoxia) ..... PC 312
- ◆ Hyperventilation (rapid breathing)..... PC 313
- ◆ Inadequate adaptation to darkness ..... PC 314
- ◆ Dehydration ..... PC 315
- ◆ Physical task over-saturation..... PC 316

**“What errors did the command make?” (Supervision)**

INADEQUATE SUPERVISION: Is a factor in a mishap when department-level or command-level supervision proves inappropriate or improper and/or fails to identify hazards, recognize and control risk, provide guidance, training and/or oversight and results in human error or an unsafe situation.

- ◆ Command oversight inadequate ..... SI 001
- ◆ Failed to ensure proper role-modeling ..... SI 002
- ◆ Failed to provide proper training ..... SI 003
- ◆ Failed to provide appropriate policy/guidance ..... SI 004
- ◆ Personality conflict with supervisor ..... SI 005
- ◆ Lack of supervisory responses to critical information ..... SI 006

FAILURE TO CORRECT KNOWN PROBLEM: This is a factor in a mishap when supervision fails to correct known deficiencies in documents, processes or procedures, or fails to correct inappropriate or unsafe actions of individuals, and this lack of supervisory action creates an unsafe situation.

- ◆ Failed to identify/correct risky behavior ..... SF 001
- ◆ Failed to correct unsafe practices ..... SF 002

PLANNED INAPPROPRIATE OPERATIONS: Are factors in a mishap when supervision fails to adequately plan or assess the hazards associated with an operation and allows for unnecessary risk.

- ◆ Directed mission beyond personnel capabilities ..... SP 001
- ◆ Personnel mismatch ..... SP 002
- ◆ Selected individual with lack of current experience ..... SP 003
- ◆ Selected individual with limited overall experience ..... SP 004
- ◆ Selected individual with lack of proficiency ..... SP 005
- ◆ Performed inadequate risk assessment ..... SP 006
- ◆ Authorized unnecessary hazard ..... SP 007

SUPERVISORY VIOLATIONS: Are factors in a mishap when supervisors willfully disregard instructions or policies, that creating the unsafe situation.

- ◆ Failure to enforce existing rules ..... SV 001
- ◆ Allowing unwritten policies to become standard ..... SV 002
- ◆ Directed individual to violate existing regulations ..... SV 003
- ◆ Authorized unqualified individuals for mission ..... SV 004

**“Did organizational errors influence the outcome?” (Organizational Influence)**

RESOURCE/ACQUISITION MANAGEMENT: Resource management is a factor when processes or policies influence system safety, result in inadequate error management or create an unsafe situation

- ◆ Air traffic control resources are deficient ..... OR 001
- ◆ Airfield resources are deficient ..... OR 002
- ◆ Operational support facilities/equipment are deficient ..... OR 003
- ◆ Purchasing or providing poorly designed or unsuitable equipment..... OR 004
- ◆ Failure to remove inadequate/worn-out equipment in a timely manner .. OR 005
- ◆ Personnel recruiting and selection policies are inadequate ..... OR 006
- ◆ Failure to provide adequate manning/staffing resources ..... OR 007
- ◆ Failure to provide adequate operational informational resources ..... OR 008
- ◆ Failure to provide adequate funding ..... OR 009

ORGANIZATIONAL CLIMATE: Is a factor in a mishap where the working atmosphere within the organization influences individual actions resulting in human error. (e.g., command structure, policies, and working environment)

- ◆ Organizational culture (attitude/actions) allows for unsafe mission demand/pressure..... OC 001
- ◆ Inappropriate perception of promotion or evaluation procedures lead to an unsafe act ..... OC 002
- ◆ Organizational over-confidence or under-confidence in equipment..... OC 003
- ◆ Impending unit deactivation or mission/equipment change leads to unsafe situation ..... OC 004
- ◆ Organizational structure is unclear or inadequate ..... OC 005

ORGANIZATIONAL PROCESSES: Organizational processes are factors in a mishap if these processes negatively influence performance and result in an unsafe situation.

- ◆ Pace of ops-tempo/workload creates unsafe situation ..... OP 001
- ◆ Organizational program/policy risks not adequately assessed, leading to an unsafe situation ..... OP 002
- ◆ Provided inadequate procedural guidance or publications ..... OP 003
- ◆ Organizational (formal) training is inadequate or unavailable ..... OP 004
- ◆ Flawed doctrine/philosophy leads to unnecessary risks ..... OP 005
- ◆ Inadequate program management leads to unsafe situation ..... OP 006



## Sample Case Study

A 21-year-old man was driving his motorcycle home after working the mid-watch. He noticed his LPO's car at a bar along the way, and decided to stop and have a drink with him, even though he was tired. Well, as was usually the case for him, one drink turned into a couple, which turned into several. When he decided to call it a night, he staggered out of the bar into a pouring rain, jumped on his motorcycle, and took off into the night. Feeling invincible, he was speeding and weaving in and out of traffic until he found himself behind a semi-truck whose driver suddenly slammed on the brakes. He didn't see the brake lights in time and lost control of his motorcycle, causing him to swerve into oncoming traffic where he hit a 20-year-old woman's vehicle. The crash killed the woman, but he walked away with only some terrible road rash and other minor injuries.

Before this incident, our motorcyclist had a prior DUI. His command set him up with a meeting with DAPA, but he decided that he didn't need it and didn't go. No one at his command bothered to make sure he followed through with the DAPA. According to his LPO, our motorcyclist was quite the heavy drinker, but no one in his chain of command had counseled him about his drinking habits. Speeding was a repeated offense for him and he had never taken the required motorcycle safety course. He had told his LPO that he had tried to enroll last year, but that there weren't enough classes available.



## Sample Case Study (Cont)

### **Causal Factor 1:**

ACTS: What caused him to lose control?

*Judgment & decision-making errors:*

- ♦ Delayed a necessary action (AE204)

He did not brake in time, causing him to hard-brake and lose control.

PRECONDITIONS: Why did he delay braking?

*Self-imposed stress*

- ♦ Alcohol (PP201)

*Psycho-Behavior Factor*

- ♦ Overconfidence (PC205)

Alcohol increased his reaction time.

He was feeling invincible.

SUPERVISION: Could the command have influenced his braking skills?

- ♦ None noted.

Motorcycle classes could have taught him better driving skills.

ORGANIZATIONAL: Could the Navy have influenced his braking skills?

*Organizational Processes:*

- ♦ Organizational (formal) training is inadequate or unavailable (OP 004)

### **Causal Factor 2:**

ACTS: What caused him to not see the truck's brake lights in time?

*Skilled-Based Error*

- ♦ Breakdown in visual scan (AE105)

PRECONDITIONS: Why did his scan break down?

*Physical Environment*

- ♦ Weather conditions restricted vision (PE102)

*Self-Imposed Stress*

- ♦ Alcohol (PP201)
- ♦ Inadequate rest (self-imposed) (PP205)

*Psycho-Behavior factors*

- ♦ More aggressive than necessary (PC211)

Pouring rain reduced visibility.

Alcohol blurred his vision.

Felt tired from staying up after his duty day.

Weaving in and out of traffic impaired his visibility.

SUPERVISION: Could the command have influenced his scanning skills?

- ♦ None noted.

Motorcycle classes could have taught him better scanning skills.

ORGANIZATIONAL: Could the Navy have influenced his breaking skills?

*Organizational Processes:*

- ♦ Organizational (formal) training is inadequate or unavailable (OP 004)

### **Causal Factor 3:**

**ACTS:** What caused him to drive recklessly (speeding, DUI, weaving in and out of traffic)?

*Violations:*

- ♦ **Extreme Violation (AV003)**

He intentionally violated speeding rules and chose to drive under the influence.

**PRECONDITIONS:** Why did he violate the rules?

*Self-imposed stress*

- ♦ **Alcohol (PP201)**

Alcohol impaired his judgment.

*Psycho-Behavior Factor*

- ♦ **Overconfidence (PC205)**

He was feeling invincible.

- ♦ **Personality style (PC205)**

He felt rules don't apply to him and denied he has a drinking problem.

*Coordination/Communication/Planning*

- ♦ **Failure of crew/team leadership (PP101)**

LPO failed to take action, and prevented intoxicated Sailor from driving.

**SUPERVISION:** Could the command have influenced his extreme behavior?

*Inadequate Supervision*

- ♦ **Command oversight inadequate (SI 001)**

Command did not ensure sailor went to DAPA appointment.

*Failure to Correct Known Problem*

- ♦ **Failure to identify/correct risky behavior (SF001)**

Command knew he was a heavy drinker, but did not council him.

**ORGANIZATIONAL:** Could the Navy have influenced his extreme behavior?

- ♦ **None noted.**

This booklet is a result of a collaborative effort from many contributors. Both a print and electronic version of this booklet is available. The electronic version is available on line at the Naval Safety Center's Home Page:

[http://www.safetycenter.navy.mil/aviation/aeromedical/downloads/human\\_factor\\_analysis\\_flip-book.pdf](http://www.safetycenter.navy.mil/aviation/aeromedical/downloads/human_factor_analysis_flip-book.pdf)

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**THIS IS PART OF A LIMITED USE NAVAL AIRCRAFT SAFETY INVESTIGATION REPORT  
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PART B OF THE SAFETY INVESTIGATION REPORT.  
DO NOT ATTACH THIS FORM TO A JAG INVESTIGATION.**

### Aeromedical Analysis Sample

The structure and content of the Aeromedical Analysis (AA) is presented in the Aeromedical Analysis section of this guide. A sample AA is included here to represent how a good AA should be written. For those Flight Surgeons that are unfamiliar with or need review of the DoD Human Factors Analysis and Classification system (HFACS), an introduction to DoD HFACS can be found in the Aeromedical CD or in the electronic version of The Naval Flight Surgeons' Pocket Reference to Aircraft Mishap Investigation.

Finally, the Naval Safety Center cannot stress enough the inclusion of all the enclosures and the proper completion of all of the forms. This information is placed in a database from which important conclusions are derived about saving lives and aircraft. Flight Surgeons are encouraged to elicit the help of AMSO's, PR's, NATOPS personnel, squadron safety personnel, and the Naval Safety Center, so that the forms may be finished in a timely and complete manner. **NOTE: The AA and 72 hour history contain privileged information and must be labeled accordingly and submitted with all AA enclosures on Side B of SIR.** Along with a hard copy of your AA, make sure an electronic copy of your AA is included in your submission of your package to Code 14, Aeromedical division, Naval Safety Center.

#### SAMPLE AEROMEDICAL ANALYSIS

**FLT SRGN:** Doe, Jane **Rank/Grade:** LT, MC, USN (FS)  
**Mailing Address:** UNIT 009, BOX 636, FPO AE 12345-6789  
**Phone Numbers:** DSN 999-1234, Commercial (123) 321-1234  
**FLT SRGN Email:** doe.jane@navysquad.navy.mil  
**Date AA submitted:** 1/1/2007  
**Hours spent in investigation:** 90  
**AMSO or others who assisted:** LT Hypoxia Jones, MSC, USN  
**AMSO Email:** hjones@astc@navy.mil

#### ENCLOSURES TO AEROMEDICAL ANALYSIS

- 01 72-Hour Histories for Mishap Aircrew (FORM SIR 3750/15)
- 02 AFIP Reports
- 03 Post Mishap Physical Examinations and pertinent medical record extracts
- 04 Copies of past two Physical exams with waivers for all personnel
- 05 **Electronic version of AA to Safety Center (CODE14 only) \*\*REQUIRED\*\***
- 06 Sensitive reports and pertinent photographs (PASS DIRECTLY TO THE AEROMEDICAL DIVISION CODE14 NAVAL SAFETY CENTER)
- 07 Privileged supporting documentation.

#### ABBREVIATIONS USED

AA = Aeromedical Analysis  
AC = Aircraft  
AFIP = Armed Forces Institute of Pathology

Reporting Custodian:	<u>NSC</u>	Mishap Severity:	<u>A</u>
Date of Mishap:	<u>7 Jan 2008</u>	Mishap Category:	<u>FM</u>
Aircraft Model:	<u>X15</u>	BUNO:	<u>123456</u>

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AMB = Aircraft Mishap Board  
 ASO = Aviation Safety Officer  
 AMO = Aviation Maintenance Officer  
 AOM = All Officers Meeting  
 ASO = Aviation Safety Officer  
 AMB = Aviation Mishap Board  
 CDI = Collateral Duty Inspector  
 CO = Commanding Officer  
 CTW = Commander Training Wing  
 FAC(A) = Forward Air Control (Airborne)  
 FNAEB = Field Naval Aviator Evaluation Board  
 FRS = Fleet Replacement Squadron  
 FS = Flight Surgeon  
 IMC = Instrument Meteorological Condition  
 MP = Mishap Pilot  
 LSO = Landing Signal Officer  
 MA = Mishap Aircraft  
 MFL = Mishap Flight Leader  
 MSQD = Mishap Squadron  
 NATOPS = Naval Aviation Training and Operating Procedures Standardization  
 OPSO = Operation Officer  
 ORM = Operation Risk Management  
 SA = Situational Awareness  
 SIR = Safety Investigation report  
 SOP = Standard Operating Procedures  
 VFR = Visual Flight Rules  
 VMC = Visual Meteorological condition  
 WNL = Within Normal Limits  
 XO = Executive Officer

## 1. REVIEW OF EVENTS

### INTRODUCTION:

The MP was a fast-track fighter pilot. His CO, said of him, "...outstanding stick-and-rudder man, ...able to hit all the numbers, the altitude, on speed, on time, on target, he was better than anyone in the squadron, as good as I've ever seen it." The MP was an outgoing, upbeat, and a good athlete. He was a likeable guy; and a community leader where he lived. He had been a top fighter instructor for 2 years. He was groomed by the CO who hand-picked him to come to joint him as the OPSO. Together, they built a squadron of unmatched air-to-air capability within the fighter community. His mother and friends told how he loved being a fighter pilot.

After listening to testimony from squadron members, MP met all the key characteristics for the "Best Pilot" aviator risk category. The XO commented: he was great to fly with on the most aggressive air-to-air missions, tactically he was superb in teaching and in briefing, he gave a "big boy's" brief (glossed though the admin with other senior aviators). The MP prided himself in teaching the young aviators tactical flying, the squadrons nuggets looked up to him; but through experience, the more experienced pilots became wary of the MP; the MP was better than the jet; he was invincible and above the rules. He was also a repeat violator of SOP/NATOPS and showed declining attention

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to detail. The MSQD had two class A mishaps in 24 months; three jets destroyed, two pilots killed; and a common thread. The MP was linked to the previous mishap (a midair collision) after he provided an inadequate brief that failed to take into account a less experienced, very junior wingman. When the new CO took over the squadron he had begun to identify the MP as an at risk aviator and attempted to implement corrective actions, short of grounding him.

In the current mishap, the AMB goes into detail regarding causal factors. These causal factors are centered on the MP's failure to ensure adequate air crew coordination for the administrative portion of the hop, inadequate preflight briefing, and inadequate ORM to know his environment. The AMB recognized MP's dangerous habit patterns and the previous command climate that nurtured those behaviors.

### **REVIEW OF EVENTS:**

**PERSONAL HISTORY:** The MP graduated from the WhatsTheMatterU, class of '63, and earned his Wings of Gold July '65. After 18 months with Fleet Replacement Squadron, he took orders to MSQD, where he worked for and developed a close friendship with the P-CO for four years. His tour included 15 months in Korea and 9 months on WESTPAC to the Philippines. For two years the MP was a "Top" instructor at the Naval Fighter School. He returned from the Philippines to work for the old CO as OPSO when he took command of the MSQD two years prior to the MF.

**CHANGE OF COMMAND TO MIDAIR MISHAP:** The new CO had studied the MSQD in great detail and had extensive changes he wanted to effect when he took the command. It was natural for MP to take this as personal criticism; he felt the new CO didn't care for him or trust him; he felt a bit singled out. With the change of command, the MP moved into the AMO job, in charge of over 90% of the squadron personnel (the most complex department head job in the squadron). He would go all out for this job, and predictably he would make mistakes and the CO would ride him pretty hard on this. The other department heads asserted the MP was not singled out by any means: the new CO was making huge demands on all the department heads. In fact, the new CO was careful not to criticize the MP publicly; in private they would discuss their thoughts and plans; the CO adapted his plans with input from his department heads.

**AFTER THE MIDAIR MISHAP:** 3 months prior to his fatal mishap, the MP was flight lead in a Class A midair; his jet was struck by his wingman's jet during the administrative portion of a tanking hop. His wingman ejected over water and was rescued unharmed. When the MP landed his damaged jet safely at base, he wondered if he would be given an air medal. He felt slighted when the CO failed to congratulate him for his bravery and skill. He was insulted further when the CO mentioned he wanted him to have a FNAEB out of fairness to both pilots. The CO intentionally did not discuss the mishap further until the investigation was done.

The SIR came out the week the MSQD started its TRANSLANT to South Africa and thirty days before the MF. One of the causal factors in the SIR was the MP's inadequate mission brief. The CO was upset with the MP and OPSO when he read the SIR; he explained to our board that his specific instructions to his OPSO were for this first tanker mission for the two new pilots to focus only on tanking. He had approved a sight-seeing hop so the guys could check-off other minor training requirements instead of just burning fuel. The MP however, briefed for the return trip to include air-to-ground simulated low-altitude-low-angle-ordnance-delivery maneuvers carrying three full external fuel tanks (CO saw this as cavalier and an inappropriate hop for new pilots).

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The CO was preparing his SIR endorsement during the TRANSLANT, when the MP came to him to clear up the items sited in the SIR. The MP felt his mission briefs were exemplary and was proud of his ability to train young pilots to fly; the SIR had listed him as a causal factor for an inadequate administrative brief in that mishap. The CO chose this conversation to mention the MP's SOP violation from a few days prior. The MP came into the overhead for the break with a degraded flight control system and a wingman in parade. In this circumstance with possible flight control malfunction, by SOP you make a straight in landing. The MP at first said he had forgotten the SOP but went on to say with a grin "but you and I know nothing would have happened anyway". To get his attention, the CO told him he would have grounded him if he didn't need him to fly the TRANSLANT. Instead of grounding the MP, the CO directed him to discuss his SOP violation at an informal AOM.

After this conversation, the CO began to see the MP differently. Also in the mishap flight, the CO noted the MP flew the damaged jet home, while losing fuel very quickly, and while passing up two adequate runways to land with arresting gear. He landed with 900 lbs of fuel. The CO and other squadron pilots admitted it would have been hard to explain if he had run out of fuel and had to ditch the jet. The CO formally debriefed the MP on his endorsement of the midair SIR.

Next day a human factors council was held with the ASO/OPSO/XO/FS, the MP was not present. They determined from their interactions with the MP that he was dealing with it well, was back to normal, and was part of the team. They couldn't find any reason they shouldn't fly him (CO, XO, FS, ASO). That night as a form of discipline, the MP ran the hotwash, an informal officers' gathering to discuss lessons learned in the TRANSPAC. He spoke to the squadron about his SOP violation as well as other squadron issues. The CO was pleased and felt it had been a worth while exercise for the squadron and for the MP who had been very professional. JOs spoke highly of the MP's hotwash. Of historical interest, two other HFC's were held after the midair mishap and before this night in which the MP was discussed and found fit to fly as well.

**SUMMARY OF THE 72-HOUR HISTORY:** the weekend prior to the mishap, the MP enjoyed the company of his squadron mates. While bike riding with his best friend, he indicated that all was well regarding his squadron job and his flying, and that he felt strong, 100% and "good-to-go". Three days prior to the mishap, the CO's endorsement was officially released, no mood changes were witnessed in the MP. In the 72 hours before the mishap, the MP was observed to be in a good mood, working hard, and joking appropriately with all (including the CO). In conversation he commented on how he was proud of the guys in maintenance and that he was looking forward to an upcoming visit with his family. Everything was business as usual. Also to note, MP had had adequate rest cycles, work-day lengths, and was seen at the gym, was eating regularly, and not drinking excessively.

**THE MISHAP FLIGHT BRIEF:** The mishap flight was an air-to-ground sortie with a junior MFL and the MP as a wingman. Both pilots were current and qualified for the flight. The 50 minute brief focused on the tactical portion of the hop. The flight was to head south from Dambro to the Z354, holding at 15000' in a right hand pattern of 15 NM legs heading (HDG) 095 and 310. AK-3 FAC(A) pilot who was responsible for aircraft deconfliction would then give them coordinates and identification of their targets and the flight would drop their bombs. The terrain in the target area (which included elevations averaging 2100') was covered extensively but the holding area terrain was not briefed at all. The holding area extended over parts of the mountain range with elevations as high as 14,000'. The Air Force exercise rules required flight to remain in visual meteorological conditions (VMC). In route and holding procedures were given minimal attention at the brief. Sun and moon data were not reviewed, but mean nautical twilight would be nearly complete, there would be no moon, and ambient starlight would be the only light source and it would be filtered though an overcast ceiling. Operational Risk Management factors were briefed to

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include lookout for bad weather, target fixation, and increased instrument scan. The MFL remarked the MP was in a good mood and appeared enthusiastic, and professionally satisfied.

**THE MISHAP FLIGHT:** The flight launched on time. After turning the strobes on, they rejoined. During their climb to 15000' enroute to the holding area they encountered a haze layer and requested lower altitude recommendations from the FAC(A) to remain in VMC. "Try 11000" was the reply from the FAC(A). MFL took it (he later states he believed that was a controller altitude assignment). As they descended the MP asked the MFL if he knew the terrain elevation. The MFL replied he couldn't recall but he could see they were well clear. The squadron training officer had prepared an exercise chart for cockpit use, but neither pilot had one during the MF. Had either pilot carried this chart, they could have looked and realized that the FAC(A) recommendation placed them dangerously below the highest terrain in the pattern.

The MFL then asked the MP for his position and the MP admitted he had gone into (an un-briefed) radar trail formation. The MFL turned his strobes and position lights on to assist the MP in keeping sight of him. On reaching the Z354, the MFL called for and initiated a left hand turn (vice the briefed right hand turn) to avoid spilling out of the area, to avoid high terrain to the right as depicted on his moving map, and to avoid weather to the south and west. The MP in a 1.5 NM trail overrode this call with a calm "not to get in you cockpit but aren't we supposed to be making a right hand turn?" and the flight turned back to the right to comply with the briefed holding pattern.

As the MFL continued turning though HDG 156, he momentarily entered IMC and called to keep turning to 060 to avoid the weather. On the flight path analysis when the MFL was HDG 220 alt 10360', the MP was at HDG 120 alt 9728'. It was speculated the MP could have had a spurious radar lock on a mountain-top, this would have been brief; he would not have mistaken it for the MFL for long due to his extensive radar experience. At this point though, it was physically impossible to have a radar lock or sight of the MFL, and the MP was violating SOP by not executing lost sight/drop lock procedures. The MFL was not aware they were flying as two separate flights and could do nothing to help now. The MP continued to descend below the cloud deck to remain in VMC, relying only on his NVG's for terrain clearance. Ambient starlight filtered by the overcast sky, absence of cultural lighting, unfamiliar snow covered mountains and ridgelines, and possible complicating snow fall restricted the usefulness of the MP's NVG's in navigating the high terrain. The MP, a seasoned veteran with over 2000 hrs, had only 25 hours flying goggles, he was making a serious beginner's mistake: he was "hacking it."

As the MFL rolled out to HDG 080, the MP was HDG 290 at 9350'. The MP adjusted to the briefed HDG 210 and continued his descent to 8988' staying under the weather. Two seconds prior to impact the MP commanded full stick aft generating 37 degrees alpha resulting in a climb from 8988' to 9135'. He impacted the mountainside at 9135' about 110' from the top, and was killed on impact. The MFL heard the ELT beacon but his situation awareness was so low that he continued four turns in holding attempting to contact his wingman; he copied target coordinates and when given clearance to the target he called "trouble shooting" to stall for time for the MP rejoin. Finally assuming the MP had returned to base and remembering there was another section coming in behind him, he called to proceed to the target as a flight of one. FAC(A) called the knock-it-off and initiated the SAR effort once the MFL confirmed he heard a beacon.

### AEROMEDICAL FACTORS

FLIGHT PHYSICAL EXAMINATION/ PHYSICAL QUALIFICATIONS/ WAIVERS: MP was physically qualified and aeronautically adapted for Class 1 duties involving actual command of the aircraft. He was issued

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aeromedical clearance after a long form post mishap PE and one week follow-up exam. He did not require or use corrective lenses. He had no waivers.

**MEDICAL HISTORY ACUTE AND CHRONICAL MEDICAL CONDITIONS:** The MP had no chronic medical conditions. He was grounded for one week, post mishap because of neck strain which was completely resolved.

**MEDICATIONS:** none

**LIFE STRESSORS/ RELATIONSHIPS:** These are discussed above in the review of events. The MP had a stable and happy home life. On TRANSLANT he was keeping close contact with his family and girl friend and was looking forward to going home for leave in late October. He was working long hours on his new job as AMO, he was proud of the people working for him, and his job was satisfying (OPSO, AMO, MP).

**POSTMISHAP BIOSAMPLES:** The Report of Toxicological Examination, AFIP for brain, vitreous fluid, gastric contents, liver, epidural blood, and skeletal muscle specimens was as follows: Carbon Monoxide and Cyanide testing could not be performed due to unsuitable specimens. Alcohol and drugs were not detected from brain and liver specimens.

**AUTOPSY RESULTS:** The autopsy performed by AFIP Pathologist indicated the cause of death was multiple blunt forces injuries. The manner of death was accident/Jerry.Larson@med.navy.milaircraft mishap. A positive identification was made with dentition and DNA matching. Injury patterns to the upper extremities were consistent with control-type injuries. Absence of soot in the trachea and larynx were consistent with a postmortem post crash fire.

**ESCAPE AND EGRESS:** Though the parachute canopy was found partially deployed near the MP's remains, there was no evidence of a command ejection attempt. Seat experts determined that the seat/man mass was ejected from the aircraft structure as a result of aircraft impact and subsequent sympathetic detonation of the ejection seat cartridge devices. In support of this, there was no evidence the drogue gun had fired, the canopy had not been jettisoned, and autopsy findings were consistent with control type injuries.

**COMMAND CLIMATE WITH THE PREVIOUS CO: 3 TO 25 MONTHS PRIOR TO THE MISHAP**

“HACK IT OR PACK IT, A-TEAM/ B-TEAM” After reviewing hours of taped and written testimony by the pilots of the MSQD, it became apparent that under the P-CO the wardroom and squadron officers' interactions were governed insidiously by a “hack it or pack it” attitude. Coincidentally, an A-team and B-team emerged; the “have's” and “have not's.” The A-team enjoyed special audience with the P-CO, flight schedule priority, and privilege to bend rules without punishment. B-team players were ignored and impugned. “Hackers” were willing to fly as per schedule and did not raise questions regarding safety (including concerns over flight qualifications, intensity of training, weather, crew rest, etc...). Raising such questions could categorize you as a whiner. You could loose credibility. You could be relegated to the “B-team.”

The XO who served the old CO for 3 months, observed that officers were hesitant to bring safety concerns to the old CO because of his promoted a “hack it or pack it” mentality. Pilots were flying hops they felt were unsafe or that they were uncomfortable with without questioning, “because you supposedly have the experience to do what you are listed for on the schedule”. The squadron was “always pushing to do varsity hops and not practicing the stuff in

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the simulators” “There was never time for a guy to get hours as a section lead, they were always pressing for the next qualification. Seems like we pushed pretty hard”. The removal of the squadron training and scheduling officer a few days before his ACT (I) certification (an exam and three flights) served as a “hack it or pack it” warning. Schedules had expressed concerns with the training schedules’ pace and was now gone. Peers thought he was doing real well and liked working with him. They were never given a debrief or an explanation.

**WILLINGNESS TO BEND THE RULES AND TAKE RISKS:** A casual attitude towards SOP, NATOPS, and safety was in place; if the old CO and the MP were willing to break the rules, you should be too, or you were not a “hacker.” The old CO wanted the briefs shortened so the squadron began to brief admin portions of hops as “that’s SOP”. The XO said the “big boy” attitude in the squadron was why the guys weren’t bothering with SOP, were hesitant to discuss safety, and hid their violations. The XO recalls the brief the old CO gave: he spoke of going into the overhead with bee-bees in the nose. The XO remarked “I thought you needed triple x’s in the HUD (before you could land).” The old CO seemed irritated and replied “no ya don’t.” The XO looked it up and the old CO was wrong. One officer was scheduled to fly at the end of a 48 hour watch duty, he canceled his flight and the MP called him a “non-hacker”. The old CO and three other squadron pilots landed with live ordnance in a foreign country, a violation of that country rules. A squadron pilot had warned them of these rules in the ready room prior to leaving and the reply by MP was “those rules don’t apply to us.”

Scheduling air-to-ground hops was costly and unreliable so most of this training was deferred to the deployments. Consequently, the old CO’s programs focused on the more demanding and rewarding air-to-air training. In preparation for Southern Watch’ 74, the OPSO and ASO were concerned the squadron was rusty and needed to slow tasking air-to-ground hops early in the det to warm up (they were 9 ½ months out from the last air-to-ground training). The ASO presented this to the MP who answered there wasn’t time to “baby-sit” guys in circle-the-wagon bombing hops. At the pre-det AOM, the old CO announced the det would begin with Mission Commander hops, the most complex air-to-ground missions. One week into the det, a group of junior officers met and discussed how they still felt rusty and were not meeting delivery parameters. They were concerned the program was too aggressive and someone could get killed. The AOPSO presented this to the MP, who said things were going as planned and that jumping right into the hardest missions was the best way to prepare for combat. AOPSO died in a CFIT mishap during an air-to-ground mission about one week later. In his interview for that AMB, the MP accused squadron pilots on the board of disloyalty for asking questions.

**ALLIENATION OF THE SAFETY DEPARTMENT BACK-UP:** Our investigation revealed significant undermining of the squadron’s safety program. The old CO didn’t like department head meetings; the AMO and MP dealt directly with him. The XO became administrative supervisor to the enlisted, and was out of the loop in regards to flying and operations, which were handled by the MP. One year prior to the mishap, MP confronted the ASO in front of the old CO and an AOM for presenting a discussion on crew-rest periods, “if you’re gonna complain about crew rest, don’t expect to get put on the flight schedule...” “be a team player.” Later ASO recommendations regarding weather, qualifications, etc., were discredited and the ASO - MP relationship became adversarial. The current ASO became ASO six months prior to the MH; he was of the “B-team” from the start. XO admitted the old CO had dual standards of conduct for “have’s” and “have not’s”. As early as a month before joining the squadron, their FS was categorized as a “B-teamer” after a conversation with the old CO over a beer. The old CO rarely spoke with the FS and excluded her from most squadron issues. The required periodic human factor council seldom met.

**COMMAND CLIMATE, WITH THE NEW CO FROM PRESENT TO THREE MONTHS PRIOR TO THE MISHAP**

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CHANGES EFFECTED BY THE NEW CO: At the first AOM, the CO presented his commander’s intent, in which he gave his assessment and plan for the command. He addressed poor communication by re-instituting department head meetings, and increasing the frequency of AOMs. He actively sought feedback from his department heads. He had noted wide variances in interpretation of “that’s SOP...” which was used to abbreviate briefs. He was having the SOP re-written to address squadron level issues. He made it clear he would not neglect violations of the SOP and held guys accountable to it by having aircrew training and less formal hotwashes and kangaroo courts. He wanted the collective body to learn from the mistakes of others rather than stopping at counseling individuals; everyone including himself would be required to get up and tell of their mistakes. To bring equity and safety to the flight schedule, the OPS department started a tracking sheet showing who was flying, checking currency, watch duties, leave, and other parameters. For safety, he reinstated ORM and Human Factors Council meetings.. He found the air-to-air training excellent but air-to-ground training was neglected and the guys were getting behind in their night qualifications and barely flying their mins on the goggles. He actively sought opportunities to resolve these deficits. The CO re-instituted AOMs and Department Head Meetings his first week after taking command, and empowered the XO to do his job.

**RE-ESTABLISHING A FUNCTIONING SAFETY DEPARTMENT:** With the start up of a department head meeting and AOMs the FS finally became included in the command activity. The FS now had easy access to the CO and for the first time was free to address aeromedical concerns with the CO. The ASO was getting support from the new CO, and safety programs were brought back on line. The command climate was still difficult; people were still trying to figure out the new CO, but now able to bring concerns up without the fear of being blasted publicly. Things were definitely changing.....

**AEROMEDICAL ANALYSIS FINDINGS**

**Causal Factor 1**

**ACTs**

**Violations:**

- ♦ Widespread/routine violation, (AV002) e.g., habitual deviation from the rules that is tolerated by management.

CO and MP were willing to bend the rules and take risks. A casual attitude toward SOP, NATOPS, and safety was in place in the squadron. CO wanted the briefs shortened so the squadron began to brief admin portion of the flight as “that’s SOP”. CO and MP landed with live ordnance at a host country air base, a violation of host country rules. A squadron pilot warned them of these rules, and the reply was “those rules don’t apply to us”.

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## PRECONDITIONS

### Psycho-Behavior Factors:

- ◆ Personality Style, (PC205)

CO's authoritarian style lead to willingness to bend the rules and take risks. With support of MP, CO promoted a "hack it or pack it" mentality. A team or a B team emerged, "haves and have nots" The A team enjoyed special audience with the CO, flight schedule priority, and privilege to bend the rules without punishment. The B team players were ignored and impugned.

## SUPERVISION

### Inadequate Supervision:

- ◆ Leadership/supervision/oversight inadequate (SI001)

### Failure to correct known problem:

- ◆ Failed to identify/correct risky behavior (SF001)
- ◆ Failed to correct unsafe practices (SF002)

CO personally groomed MP and recruited him to serve in his squadron. CO failed to recognize or act on MP's complacency and dangerous behaviors. CO did not like department head meetings and preferred to have individual department heads deal with him directly. All Hands, All Officer and Human Factors Council meetings seldom met. With the "hack it or pack it mentality", pilots were flying hops they felt were unsafe or they were uncomfortable with, without questioning it.

## ORGANIZATIONAL

None noted

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## Causal Factor 2

### ACTs

#### Skill-Based errors

- ◆ Procedure not followed correctly (AE103)

MP and MFL failed to do a proper preflight briefing. The brief focused on the tactical portion of the hop. Although both the target and holding areas contained mountainous terrain, the brief only addressed terrain elevation in the target area.

Although the planning and training officer had prepared charts for the exercise, neither the MP nor the MFL had the charts with them during the mishap flight. If they had taken the charts and used them, they might have realized that the FAC(A)'s recommendation placed them dangerously below the highest terrain in the holding area.

### PRECONDITIONS

#### Coordination/communication/planning factors:

- ◆ Mission briefing inadequate (PP110)

MP and MFL accepted a dangerous low altitude recommendation from the FAC(A) without knowing the terrain elevation. Because MP and MFL failed to brief altitude in their holding area during their mission brief, they were unable to recognize that the FAC(A)'s altitude recommendation put them at risk. The exercise rules indicated the FAC(A) was responsible for the aircraft deconfliction and target identification only. Both pilots continued to navigate on NVGs as a means of terrain clearance in questionable weather condition.

#### Psycho-behavioral factors:

- ◆ Personality style (PC205)

MP falls into the "best pilot" aviator risk category. MP was better than the jet, he was invincible and above the rules. In one of his flights, he ignored an indicator of possible flight control malfunction, and came into the overhead for the break with a wingman in parade. SOP mandated he should have made a straight in landing. MP violated NATOPS and showed declining attention to detail.

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## SUPERVISION

### Inadequate Supervision:

- ◆ Failed to ensure proper role-modeling (SI002)

CO wanted the briefs shortened, admin portions of the hops were less focused and not as emphasized. The admin portion of the flight was briefed as "that's SOP". A casual attitude toward SOP, NATOPS, and safety developed.

### Supervisory violation

- ◆ Allowing unwritten policy to become standard. (SV002)

Command has developed an unwritten policy to keep flight briefs short, and to give less emphasis to the importance of the admin portions of flights. Flight brief needed to be complete and thorough. Abbreviated briefings, particularly for the admin portion of the mission, had become a standard in the squadron. This led to complacency, not following procedure, and side-stepping safety issues.

## ORGANIZATION

None noted

### Causal Factor 3

## ACTS

### Judgement and decision-making errors

- ◆ Wrong choice of action during an operation (AE206)

Squadron training officer had prepared an exercise chart for cockpit use. Neither pilot carried this chart; they could have looked at it and realized that the FAC(A) recommendation placed them dangerously below the highest terrain in the pattern.

## PRECONDITIONS

### Coordination/communication/planning factors:

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- ♦ Mission planning inadequate (PC109)
- ♦ Briefing inadequate (PC110)
- ♦ Complacency (PC208)

MP and MFL failed to provide an adequate brief, and neglected essential information regarding terrain elevation in the holding pattern. If they had given a proper brief, they would have realized the need for the exercise chart map and would have known the elevation of the terrain.

### SUPERVISION

#### Inadequate Supervision:

- ♦ Command oversight inadequate (SI001)

Command culture had deteriorated to the point pilots were flying hops they felt were unsafe or they were uncomfortable with, without questioning them. It is all about the "hack it or pack it mentality that the CO had developed. One of the squadron pilots was removed from his assigned duty after he expressed concern over the training schedule pace. His peers thought he was doing well and liked working with him. They were not provided a debrief or explanation for his unexpected departure.

### ORGANIZATION

None noted

#### Causal Factor 4

#### ACTs

#### Judgment and decision-making errors:

- ♦ Inadequate real time risk assessment (AE201)

MP failed to: adequately consider his environment, to recognize or admit that he was lost, to recognize that he should go off goggles, and to cancel the operation as the situation deteriorated.

### PRECONDITIONS

#### Physical environment:

- ♦ Weather conditions restrict vision (PE102)

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MP had only 20 hours on NVGs, and MFL had even less experience. They were flying in an overcast layer with possible snow flurries. There was no horizon, just clouds up to snow-covered mountains. The conditions were not appropriate for use of NVDs as the primary means of terrain clearance.

**Awareness (cognitive) factors:**

- ◆ Geographically lost (PC107)

MP had lost his lead and failed to communicate with MFL, thus failing two basic wingman responsibilities. If MP had communicated that he was lost, instead of continuing in the racetrack pattern assigned, the MFL might have been able to assist the MP in rejoining the flight safely. The MFL had altered his holding pattern to prevent from going out of bounds, avoid weather, and to avoid high terrain.

**Coordination/communication/planning factors:**

- ◆ Failure to re-assess risk and adjust to changing environments (PP111)

MP and MFL persisted in using NVGs as their only means of terrain clearance in conditions that were not appropriate for NVG use, and accepted an altitude recommendation from FAC(A) without knowing the terrain elevation.

**Psycho-Behavioral factors:**

- ◆ Personality style (PC205)

MP showed all the signs of the “best pilot” aviator-at-risk category who lacks judgment and accurate perception of mission risks, and violates NATOPS/SOP. More experienced pilots in the squadron became more wary of the MP and started to question his judgment.

## SUPERVISION

**Inadequate Supervision:**

- ◆ Failed to ensure proper role-modeling (SI002)

CO developed a “hack it or pack it” squadron climate, resulted in a “A team/B team”. “Hackers” were willing to fly as per schedule and did not raise questions regarding safety including concern regarding flight qualifications, intensity of training or lack of training, weather, and crew rest. Raising such questions could categorize one as a whiner, and would relegate the complainer to the “B team”. MP supported this policy with the CO. This policy discouraged junior pilot like MFL from raising questions about safety and the use of time critical risk assessment. Pilots were flying hops they felt were unsafe, or were uncomfortable with, without questioning.

Reporting Custodian: <u>NSC</u>	Mishap Severity: <u>A</u>	
Date of Mishap: <u>7 Jan 2008</u>	Mishap Category: <u>FM</u>	
Aircraft Model: <u>X15</u>	BUNO: <u>123456</u>	

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### ORGANIZATION

None noted

### MISHAP SEQUENCE OF EVENTS

Causal Factor	DoD HFACS Category
1. CO and MP were willing to bend the rules and take risks.	<u>Widespread/routine violation, (AV002)</u>
2. MP and MFL failed to do a proper preflight briefing.	<u>Procedure not followed correctly (AE103)</u>
3. Neither pilot carried exercise chart, they could have looked at it and realized that the FAC(A) recommendation placed them in dangerously below the highest terrain in the pattern.	<u>Wrong choice of action during an operation (AE206)</u>
4. MP failed to know his environment, to admit when he is lost, to admit it is time to get off his goggles, and to cancel the operation.	<u>Inadequate real time risk assessment (AE201)</u>

### 3. Aeromedical Recommendations

a. For VX 99: Recommend that this mishap is to be used in PCO course as case study for what not to do as a leader or commanding officer. A case study in failure leadership, and misguided motivation.

b. For VX 99: Conduct pilot training on the hazards associated with poorly done preflight briefing, review squadron ORM process, and ensure this process is done properly. Recommend aircrew training that reviews the importance of conducting thorough pre- and post-flight briefs.

c. For VX 99: Recommend training for all aircrew to include

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comprehensive review of aircrew coordination and human factors processes.  
Training should include review of operational risk management principles and  
individual obligations to identify and report hazards.

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Mishap Severity: A  
Mishap Category: FM  
BUNO: 123456

## Appendix X: Human Factors Engineering Investigation

### 1. Introduction.

Whether investigating a civil, commercial, or military aircraft mishap, one critical component of that investigation must be to assess the extent to which Human Factors Engineering (HFE) may have played a role in contributing to the mishap.

Specifically, the investigator should look for any element(s) of aircraft or personal gear design, as well as aircrew/passenger-related indicators that suggest impairment of performance, error in decision-making or operation, or other such human-machine interactive variable. While some of this information will be determined during later off-site briefings and engineering analyses, it is critical that the Aeromedical investigator obtain timely (that is, undisturbed) on-site evidence as soon as possible after the mishap.

- a. The ability to accomplish the HFE analysis will rely on the intact state of the aircraft and condition of the crew/passengers. If the aircraft is severely damaged or destroyed, the HFE analysis will be limited. If the aircraft is partially or slightly damaged, access to certain portions of the vehicle may still be possible and the HFE analysis more extensive. In the event of fatalities, it may be possible to obtain some HFE data from the remains; however in the more severe mishaps where damage to the remains is extensive, this may not always be the case.
- b. By the time the investigator arrives at the mishap site, survivors will usually have already been taken to a local medical facility, and therefore may not immediately be available for interviews. Although survivors may possess information that may implicate human engineering in the cause of the mishap, such critical information will usually be recorded off-site and is therefore out of the scope of this narrative.
- c. For a complete overview of human factors engineering principles associated with aircraft mishaps, the reader is directed to Bellenkes, Yacavone, and Alkov (1991). The following paragraphs address only those procedures to be carried out by the investigator whilst at the mishap site.

There are **four primary steps involved in the HFE** portion of the aeromedical investigation. These are: **Preparation:** All the necessities to have on-hand and ready before you must head out to the mishap site. **Crash Site Overview:** Provides a general overview of the entire mishap site, including the location, orientation, and condition of the aircraft and remains.

- iii. **Cockpit/cabin inspection:** The condition of the cockpit and/or cabin will help you to identify possible human engineering factors that may have contributed to the mishap.
- iv. **Flight Gear Inspection:** an examination of flight suits and ancillary gear can provide important clues to what the aircrew was doing at the time of the mishap. This is especially critical when the design of the flightgear may have contributed to the mishap.

## 2. **Preparation.**

As member of the mishap investigation team, you will already have prepared an Aeromedical investigation kit prior to heading out to the mishap site. There are some items that should be included in the kit that can facilitate your human engineering survey of the crash site, aircraft, and survivors/remains. Some of these are as follows:

- a. *A pocket tape recorder* for notes. This precludes having to do much writing and allows for more spontaneous reflection on the situation at hand.
- b. *Human Factors Engineering Investigation Checklist.* Photocopy this HFE investigation checklist and reduce it to a manageable yet readable size. To prevent damage to these documents, make certain to seal all checklist plates in a clear plastic, waterproof 'envelope'. Having this reference on-hand will preclude your having to remember the many steps in what can become an extensive process.
- c. *Terrain Map.* Gather a collection of terrain charts/road maps/regional approach plates for your area of operations and have them available for easy access. When you are in receipt of information about a mishap, make a photocopy of the map. You can also obtain such maps from any number of World Wide Web sources. When you arrive at the

mishap site, indicate the location on your map. **If possible, mark the flightpath of the aircraft from the point of entry into the area covered by your map to the point of impact.** Having this diagrammatic and easily retrievable information may prove critical when implicating terrain or man-made obstacles in the mishap.

- d. *Aircraft Fuselage/Cockpit/Cabin Diagrams.* Collect general schematic fuselage and cockpit diagrams of the aircraft with which you work. Fuselage diagrams should include general fore, aft, and side views of the aircraft. Cockpit views should be detailed enough to show the locations of all displays, controls, and aircrew seats. Finally, aircraft cabin diagrams can provide you with a good overview of passenger seating and main bay cargo storage spaces. As you perform the HFE analysis, you should use these diagrams as reference templates.

### 3. Overview Of Crash Site.

- a. One of the most critical parts of the human engineering investigation is to assess the general layout of the mishap scene. This should be done as soon as possible; even from the earliest moments of mishap, there is the problem of disturbed and missing items that may affect subsequent accuracy of the investigation. Take notes, either written or by hand held microcassette recorder, and, if possible, ensure that the official photographer takes both color photographs and videos of HFE-related subjects.
- b. Walk throughout the entire site, making certain not to touch or otherwise disturb any evidence. Look at the position of the aircraft from many different angles, noting the extent of the damage, the scatter pattern of its components. Try to establish how the aircraft impacted the terrain, noting the situation of the terrain itself, especially height cues (open field, rolling hill, mountainous, forest, water, etc.). It is during this process that you should make an approximation of angle of attack and speed of impact, noting damage to any structure that the aircraft may have impacted during its descent (i.e., houses, towers, tress, etc.). Note whether the final resting position of the aircraft is inverted, on its side, or right-side up.

### 4. Cockpit Inspection.

Next, an inspection of specific cockpit components (i.e., instruments, lighting, fuselage/canopy braces, etc.) will provide an idea as to whether or not these may have contributed to the mishap. Before you actually start the inspection, ensure that your doing so will not disturb the overall position and stability of the cockpit. In the case of an aircraft having canopy-based ingress/egress, **DO NOT ENTER THE COCKPIT UNDER ANY CIRCUMSTANCES!** For aircraft without canopies (those where entry/egress is normally through doors or hatches) enter the aircraft flightdeck only when your safety and mishap state of the cockpit can be ensured. If this is not possible, make as much of your inspection as possible from outside the fuselage.

- a. **Cockpit Overview.** Before commencing a detailed inspection of the cockpit, note it's general condition; specifically, it's position (i.e., inverted, nose-down, on its side, upright, etc.), the extent of the damage (in the range from completely intact to totally destroyed), and the nature of that damage, especially any impact-related deformations of the braces, bulkheads, and components.
  - i. Next, begin your inspection of specific cockpit components as outlined in the following paragraphs. It is important here to remember that in the course of your inspection, **DO NOT ATTEMPT TO DISMANTLE OR RECONSTRUCT ANY COCKPIT COMPONENTS FOR ANY REASON.** If you cannot obtain a certain piece of critical information without tampering with the component, then make a note of that fact for investigators who will later perform a detailed inspection during the off-site engineering investigation.
- b. **Design/Location of Instruments and Controls.** Faulty and inadequate designs of cockpit displays and controls have often been cited as factors contributing to a mishap, especially those associated with stressful situations and high workload operations. Use the set of cockpit schematic diagrams as an aid in your examination of the instrument panels and components, especially when describing the extent and locations of damage. If possible, note the locations of those controls and avionics components, which may have become detached from their original positions.
  - i. **Displays/instruments.** Mishap narratives have suggested that instrument design deficiencies or

improper placement of displays in a cockpit can result in problems associated with the 'performance triad'; that is, the perception of displayed information, the interpretation / understanding (cognition) of that information, and the response to that information. This has further lead to the subsequent improper use of cockpit instruments and displays.

- On occasion, certain aircrew will find specific instruments annoying, distracting, or unreadable in certain lighting conditions. In other cases, these instruments fail to provide certain types of critical information ("gauge") that pilots require. One method of getting around these problems has been the use of 'homemade fixes'. Typically, these fixes include covering an instrument either in part or entirely. For 'gauge' information, pilots will occasionally adhere tape onto the faces of analog instruments to indicate upper and lower condition limits. Still others will 'post' various types of information on or near various instruments and controls. Such 'homemade fixes' have in the past been shown to have lead to certain mishaps. Be sure, therefore, to note any unauthorized alterations, modifications, or 'fixes' made to any instruments (i.e., shades over or blocking instruments, disabled switch guards, etc.).
  - When examining instruments and displays with limited damage, you should note some of the readings on the primary instruments (i.e., ADI position, altitude, airspeed, vertical velocity, fuel state, etc.). Although these may have been altered by the force of impact, such information can aid in later understanding of aircraft state shortly prior to and at the moment of impact. Also indicate whether any caution/warning flags were displayed and if power is still available, note whether any caution/warning lamps were illuminated.
- ii. **Controls.** Poor design and placement of controls may preclude their operation under certain circumstances. Yoke or hand gripped stick controllers may prove confusing, anthropometrically inadequate, or too complex to be used in emergency situations.



Cockpit panel controls may be of poor design (i.e., similar shape, proximity, color, etc.) so as to preclude a crewman's ability to locate and operate that control. Mishap narratives have shown that such problems have resulted in the inadvertent or delayed operation of various critical switches and controls, whether as a deliberate act by the crewman or accidentally as a function of body movement or a control being 'snagged' by a piece of flight gear.

- At the mishap site, you should examine hand and panel controls for state (i.e., location of throttles, positions of switches and switch guards) and damage. In the latter, note the condition of the control yoke/stick and rudder pedals/brakes, as position and damage to these are both indicators of whether control inputs were being made at impact. These indicators can later be compared with flight gear damage (i.e., tears to gloves, shoe/boot indentations, shattered helmet eye shields, etc.) and evidence of physical injury to the feet, legs, arms, hands, and skull to help make the assessment. Further, if the remains are still seated in the cockpit, note whether their hands are on controls or their feet on rudder/brake pedals).
  - In order to determine whether or not there may have been inadvertent control activation, note the presence and location of ancillary flight gear (i.e., checklists, kneeboards, and survival vest contents), especially if they are physically in contact with a control.
- c. **Lighting.** The HFE investigation must also include knowledge of lighting conditions at the time of the mishap. Primarily, the investigator wants to determine what effects if any ambient and direct lighting may have had on the ability of the aircrew to (1) continuously visually monitor cockpit data, (2) perceive/interpret instrument and caution/warning indicator information which may have suggested a problem, and (3) observe anomalies physically on or in the aircraft.
- i. Using time-of-day and meteorological data, the investigator should be able to determine whether ambient lighting (i.e., sunlight, glare, or reflections,

etc.) may have impeded the pilot's ability to read certain displays. Another way to determine this is by the presence of improvised "anti-glare shields" fastened above or to the side of certain displays or instruments. Usually, the use of this type of homemade fix reflects the existence of a contrast problem whereby the instrument face (in the case of older analog instruments) or the liquid crystal/light emitting diode display is washed out by direct sunlight (solar washout), even when display brightness is set at maximum. Further, although solar washout may be transient, some pilots may forget about the shade or will choose not to remove it when the problem no longer exists. The shade provides temporary relief from solar washout, it may prevent the pilot from reading parts of the same instrument or display as well as information from other displays.

- ii. Other indices of instrument/display illumination-related problems are associated with direct lighting; the illumination of instruments by internal lamps. Brightness levels can be adjusted by the pilot to meet particular ambient lighting requirements. For example, as mentioned above, when there is a problem with solar washout, brightness is usually adjusted to maximum. In aircraft cleared for missions requiring night vision device (NVD) use by aircrew, direct lighting is usually made compatible with NVD sensitivity limits. However, mishap narratives have revealed that pilots flying in such aircraft still experienced.
  
- d. ***Cockpit/Cabin Egress and Ejection.*** There are a number of human engineering factors associated with the ability of aircrews and passengers to safely and expeditiously egress from an aircraft. If egress from the mishap aircraft was attempted while still in flight, the HFE investigator must assess whether or not aircrew or passengers had attempted to get to exits or hatches, noting any physical obstacles they may have faced in doing so. In aircraft equipped with ejection seats, the investigator must note whether or not canopy/hatch jettison may have impeded escape or caused injury. Finally, personal survival equipment (if available) should be inspected for use and operational effectiveness. What follows is a more detailed discussion of some of these

factors.

- i. **Physical Restrictions:** If the cockpit and/or cabin are intact, the investigator may find that there were certain elements of fuselage design, which may have interfered with an individual egressing the aircraft without injury. Examples of such fuselage design elements include the blockage of cabin aisles by removed emergency hatches, the presence of "step over" bulkheads (requiring an individual to literally step over a doorway or sill to enter or leave the cockpit), warped bulkheads which may have blocked egress, large electronic interface access panels, support gear (i.e., galleys and their contents, stowage bins and lockers, etc.) or 'fold away' seats which, upon impact, may have become dislodged from fuselage restraints and blocked the egress path.
- ii. **Hatches/Canopies:** Check to see whether aircrew or passengers had made any attempts to remove fuselage hatches, doors, or the cockpit canopy. Note the positions of all door/hatch operation mechanisms or manual canopy eject handles. Note whether deformation of the fuselage may have prevented successful removal of the doors or hatches. Also note whether the canopy is in place and, if opened, the extent to which it remained open after the mishap.
- iii. **Seat Condition:** The post-mishap condition of seats and restraints are often good indicators of whether their design helped prevent or contribute to injury. Further, mishap narratives have shown that under certain conditions, design elements of specific seats and restraints can inadvertently snag and operate cockpit controls.
  - During your inspection of the cockpit and/or cabin, note whether each seat remained intact or was in some way deformed. If the latter, note the nature and extent of deformation. It is also critical to report whether the seat had collapsed or had torn loose from its moorings to the fuselage.
  - If the mishap involved a **helicopter**, make sure to note whether or not the seat had stroked; in

particular, describe the extent of the stroke. Stroking is a mechanism by which vertical seat movement helps to partially absorb certain impact forces. A fully stroked seat (together with the Aeromedical analysis) will help to determine the impact forces on the individual occupying the seat. If the seat is partially stroked (that is, did not travel the entire length of the mechanism), note the extent of the stroke and whether or not any cockpit equipment (i.e., electronics boxes, survival gear, ancillary equipment, etc.) may have impeded movement of the seat.

- In certain helicopter cabins, passenger seats are mounted to aircraft bulkheads and floors by metal arms and wires attached by spring-loaded clips to fuselage frames. Check these seats to see if they had lost integrity and had detached from any of their mooring points. Note the extent of damage to the seat material (usually canvas) and the metal support frame.
- In aircraft where **ejection seats** are located in the cockpit, first ensure that the seats have been "safed"; that is, where authorized personnel have taken measures to preclude the activation of all ejection systems (i.e., seat charges, spring-loaded rails, etc.). **DO NOT ATTEMPT TO GO NEAR THE COCKPIT UNTIL THE EJECTION SEAT HAS BEEN SAFED!** Even when safed, do not sit in the seat or in any way attempt to activate a control on or near the seat. As with other aircraft systems, the on-site inspection of ejection seats should be visual only!
- Check the seat for deformation, tears to the seat pillow/headrest fabric, damage to the metal seat pan and support frame, the condition of the ejection handles (or similar devices which initiate the ejection), seat-restraint separation rings, and all other controls that change seat position. In particular, the investigator wants to note whether there were any pieces of cockpit gear that may have snagged any of these actuators.

iv. **Restraints:** Restraint systems provide the only means of retaining occupants in their seats; a function most critical during turbulent or uncontrolled flight as well as in survivable mishaps. Further, when used correctly, such restraints help to minimize injuries during ejection. If the restraints were improperly fastened or not used at all, this finding may be substantiated by off-site medical examination. In some cases, despite proper use, material failure can result in the restraint coming apart during impact at the fastener connection points (i.e., single-point buckles, 4-point metal 'hook and eye' latches, 5-point twist connectors, etc.), at bulkhead/seat mooring points, or in the case of degraded fabric, at any point on the belts themselves.

- The HFE inspector should therefore examine all seat restraints (both in the cockpit and cabin) for their integrity, and whether or not they successfully served their purpose. If the occupant is still in his/her seat at the time of your inspection (whether in the aircraft or restrained to a fixed cockpit, cabin, or expended ejection seat), note whether or not there might have been any attempt to activate the restraint operating mechanisms; the seat-mounted handles which release or lock restraint movement and the fastener connection release handles/dials. It is possible that malfunctions in either mechanism may have prevented occupant-seat separation. Note any fractures or breaks in connector mechanisms, any tears or separations in the belt fabric, and whether or not the belts remained moored to the fuselage or seat.

v. **Helmets:** In military aircraft where helmets must be worn, note whether there is any damage to the helmet shell and visor (making sure to note whether or not the visor was in the down protective position). If an oxygen mask is required, note whether or not it is fastened in place on each crewman. These procedures are critical as severe damage to specific areas of the face and skull may indicate that upper torso restraints failed thereby allowing the pilot/co-pilot to rotate forward and strike the control yoke or stick. If the crash forces were minimal, and the restraints failed (or were in the unlocked position, thus allowing freedom of

movement). The helmet, visor, and oxygen mask should have provided some protection against stick or yoke **impact, and slight if any injury**. If crash forces were high and the upper restraints failed, one should be able to observe greater damage both to the protective gear and crewman directly attributable to high G impacts with controls or the instrument panel.

## References

The following are references that can aid the investigator in the performance of a human factors engineering investigation of an aircraft mishap. This is by no means an exhaustive list, however the publications noted below will provide the core of critical information required for the HFE investigation.

Government Instructions and Guides: NASA NHB-1700.1-2  
NASA Safety Manual Vol. 2, Guidelines for Mishap Investigation  
**NAVAIR 00-80T-116-1\*** Guide to Mishap Investigation  
**NAVAIR 00-80T-116-2\*** Investigative Techniques  
**NAVAIR 00-80T-116-3\*** Safety Investigation Workbook  
**OPNAVINST 3750.16** Participation in a Military or Civil Aircraft  
Accident Safety Investigation  
STANAG 3531 FS Investigation of Aircraft Accidents  
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## **Appendix Y: Memorandum of Understanding (MOU) With Local Civil Authorities (CONUS)**

1. When an Active Duty member dies outside the boundaries of a Military installation or if that Military installation is not exclusive federal jurisdiction, the remains cannot be recovered or transferred from the place of death to some other location by Military personnel without the expressed permission of local civil authorities. In order that full accord exists regarding the control of Active Duty deaths (disaster and non-disaster) on or off the installation, the Flight Surgeon should work with the local Military Treatment Facility Mortuary Affairs Officer to ensure that a current effective MOU is established between the Military installation and the medical examiners or county coroners and local law enforcement authorities as deemed appropriate. Remember that some regular use ranges cover more than one county so a number of MOUs may be needed to support one base. The MOUs' provisions are negotiated in the best interest of the Military to the extent possible.
  - a. The MOU includes, but is not limited to, the following items:
    - i. Search and recovery of remains.
    - ii. Identification and pathological examinations.
    - iii. Custody of the remains.
    - iv. Personal property
    - v. Transfer of the remains from the scene or place of death
    - vi. Expenditures for professional services for the medical examiner or coroner; do not obligate any funds without proper authority (e.g., from the President of the Mishap Board)
    - vii. Signing of death certificate(s)
    - viii. Issuance of burial and transit permits
    - ix. Some states retain concurrent jurisdiction with the United States. In these situations, it is necessary to accomplish the MOU with officials at state level rather than with local officials
2. When an MOU is inappropriate or not possible to accomplish, a memorandum for the record is prepared. The document relates the situation, circumstances, and unsuccessful efforts expended. Such official memorandums for the record will suffice in the absence of an MOU.

## REFERENCES

- OPNAVINST 3750.6 The Naval Aviation Safety Program
- OPNAVINST 1650.8 Cash Awards for Suggestions and Inventions
- OPNAVINST 3130.6 Search and Rescue (SAR) Manual
- OPNAVINST 3440.15 Nuclear Weapons Accident/Incident Response
- OPNAVINST 3710.7 NATOPS General Flight and Operating Instructions
- OPNAVINST 3750.16 Participation in a Military or Civil Aircraft Accident Safety Investigation
- OPNAVINST 4790.2 Naval Aviation Maintenance Program
- OPNAVINST 8110.18 Navy Nuclear Weapons Safety Program
- BUMEDINST 5100.11 Aeromedical Safety Officer Program
- MEDCOMINST 5360.1 Decedent Affairs Manual
- MEDCOMINST 6510.6 Aviation Pathology Program
- DODINST 6010.16 Armed Forces Medical Examiner System
- NAVAIR 00-80T-116-1 Guide to Mishap Investigation
- NAVAIR 00-80T-116-2 Investigative Techniques
- NAVAIR 00-80T-116-3 Safety Investigation Workbook
- NAVAIRINST 4730.5 Engineering Investigation Program
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- STANAG 3318 Aeromedical Aspects of Aircraft Accident / Incident Investigation
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Naval Environmental Health Center, Technical Manual, NEHC-TM91-6, **Advanced Composite Materials;** 1991

Department Of The Air Force Human Systems Center (AFMC), Brooks Air Force Base, Texas, Consultative Letter, AL-OE-BR-CL-1998-0108, **Response to Aircraft Mishaps Involving Composite Materials (Interim Guidance);** Sept 1998

USAF Advanced Composites Program Office, Mishap Risk **Control Guidelines for Advanced Aerospace Materials** Environmental, Safety, and Health Concerns for Advanced Composites; 1993

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USAF Advanced Composites Program Office, **Hazardous Aerospace Materials In Aircraft Mishaps for On-Scene Commanders and Emergency Responders;** May 2000

**AFIP Guidelines for Collecting and Submitting Toxicology Samples** 2002