NTSB National Transportation Safety Board

Fatigue Management: Advancing Aviation Safety Honorable Mark R. Rosekind, Ph.D. Board Member

MAL

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CHAPTER 11-NATIONAL TRANSPORTATION SAFETY BOAID

SUBCHAPTER I-OENERAL

1991, Definitions

SUDCHAPTER 8-ORGANIZATION AND ADMINISTRATIVE

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SUBCHAPTER 1-GENERAL

§1181. Definitions

Section 40102(4) of this tide applies to this chapter.

SUBCHAPTER 3-ORGANIZATION AND ADMINISTRATIVE

§IIII. General organization

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Mission

The NTSB is charged with:

1) determining the probable cause of transportation accidents

2) making recommendations to prevent their recurrence

The NTSB is Responsible for Investigating:

Aviation, highway, rail, marine, pipeline, and hazardous material accidents

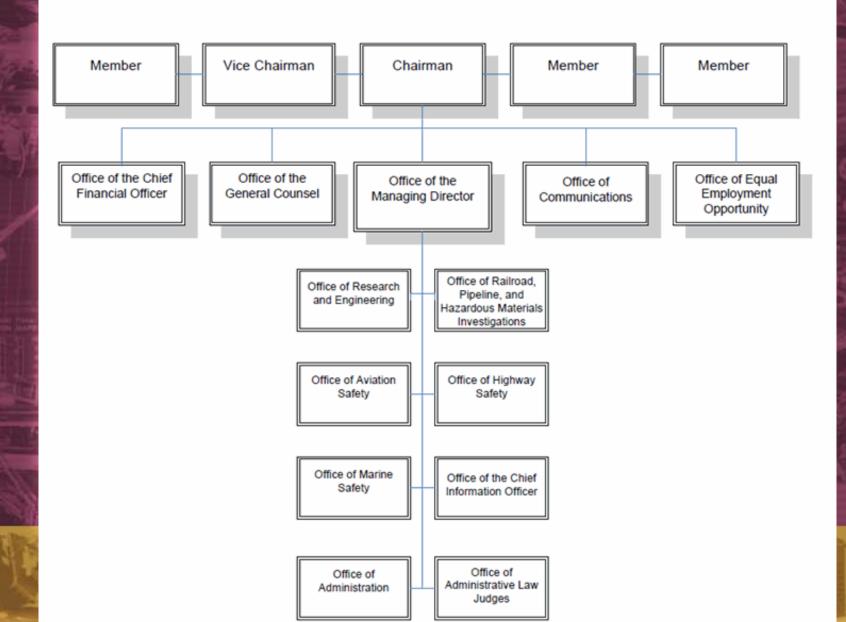
130,000+ accident investigations 13,000+ safety recommendations

• 82% acceptance rate

Major product: safety recommendations

Moral compass and industry conscience





NTSB: The Board

Five Members: President nominates Senate confirms



Mark Rosekind Member



Chris Hart Vice Chairman



Debbie Hersman Chairman



Robert Sumwalt Member



Earl Weener Member



Go! Flight 1002



• early starts, multiple segment days, sleep apnea



Reagan National Airport

 March 23, 2011: 0004 – 0028 EDT - air traffic control service interruption - 2 AC/TRACON unable to establish contact Controller - supervisory controller working alone - 20 years' experience, 17 at DCA - indicated he had fallen asleep - working fourth consecutive night shift (10 pm - 6 am)



Honorable John K. Lauber:

No Accident ≠ Safe Operation



Guantanamo Bay Cuba

First NTSB aviation accident to cite fatigue as probable cause





acute sleep loss, sleep debt, circadian disruption



NTSB

Uncontrolled In-Flight Collision with Terrain AIA Flight 808, Douglas DC-8-61, N814CK U.S. NAS, Guantanamo Bay, Cuba, August 18, 1993

"The National Transportation Safety Board determines that the probable causes of this accident were the impaired judgment, decision making, and flying abilities of the captain and flight crew due to the effects of fatigue..."



Owatonna, MN/July 31, 2008





Owatonna Crew Fatigue Factors

 acute sleep loss (Capt/FO) cumulative sleep debt (FO) early start time (Capt/FO) excessive sleep need (Capt) insomnia (FO) self-medicate/prescription sleep med (FO)



Probable Cause/Contributing Factors

"The National Transportation Safety Board determines that the probable cause of this accident was the captain's decision to attempt a go-around late in the landing roll with insufficient runway remaining. Contributing to the accident were (1) the pilots' poor crew coordination and lack of cockpit discipline; (2) fatigue, which likely impaired both pilots' performance; and (3) the failure of the Federal Aviation Administration to require crew resource management training and standard operating procedures for Part 135 operators."



Recommendations

7. Revise regulations and policies to permit appropriate use of prescription sleep medications by pilots under medical supervision for insomnia.

- 8. Require 14 Code of Federal Regulations Part 135 and 91 subpart K pilots to receive initial and recurrent education and training on factors that create fatigue in flight operations, fatigue signs and symptoms, and effective strategies to manage fatigue and performance during operations.
- 9. Review the policy standards for all common sleep-related conditions, including insomnia, and revise them in accordance with current scientific evidence to establish standards under which pilots can be effectively treated for common sleep disorders while retaining their medical certification.

10. Increase the education and training of physicians and pilots on common sleep disorders, including insomnia, emphasizing the need for aeromedically appropriate evaluation, intervention, and monitoring for sleep-related conditions.





Fatal Airline Accidents (Examples) (fatigue cited)

- 8/97 Guam: 228 fatalities
- 6/99 Little Rock AK: 11 fatal
- 10/04 Kirksville MO: 11 fatalities
- 8/06 Lexington KY: 49 fatalities
- 7/08 Owatonna MN: 8 fatalities
- 2/09 Buffalo NY: 49 fatalities



Fatigue Risks

Fatigue can degrade every aspect of human capability.



Fatigue Risks

• degraded 20 - 50%+:

- reaction time
- memory
- communication
- situational awareness

- judgment
- attention
- mood

• increased:

irritabilityapathy

attentional lapsesmicrosleeps



Fatigue Risks

awake/alert

reduced performance

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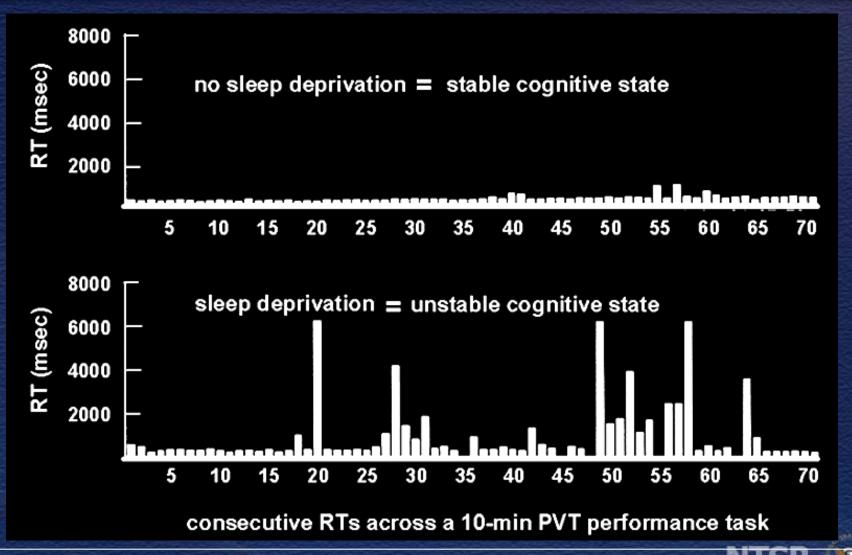
variability



asleep

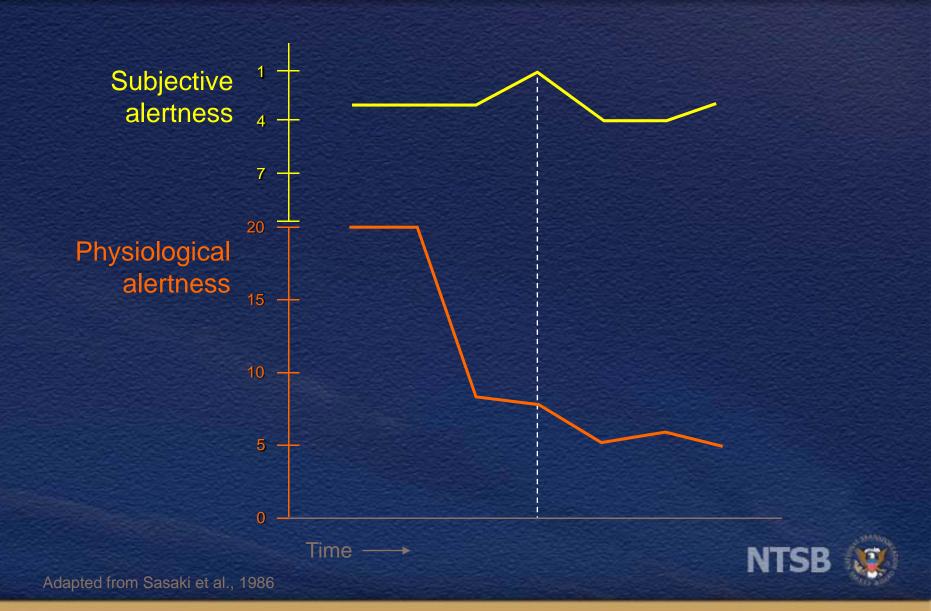
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Fatigue and Reaction Times



Doran SM, Van Dongen HP, Dinges DF. Sustained attention performance during sleep deprivation: evidence of state instability. Archives of Italian Biology: Neuroscience 2001;139:253-267.

Alertness Reports Often Inaccurate



The Challenges . . .

 Diverse operational requirements Individual differences Complex physiology History ("that's how its always been") Economics



The Challenges Preclude . . .

A simple solution

A single solution

One-size-fits-all

• "Magic Bullet"



NTSB Fatigue Recommendations

MOST WANTED since 1990 190+ fatigue recommendations



Complex Issue: Requires Multiple Solutions

Scheduling Policies and Practices

Education

Organizational Strategies

Raising Awareness

Healthy Sleep

 Vehicle and Environmental Strategies
 Research and Evaluation





Education/Strategies

 Develop a fatigue education and countermeasures training program

Educate operators and schedulers

• Include information on use of strategies: naps, caffeine, etc.

Review and update materials



Hours of Service / Scheduling

 Science-based hours of service Allow for at least 8 hours of uninterrupted sleep Reduce schedule irregularity and unpredictability



Fatigue Management Systems

- Develop guidance based on empirical and scientific evidence for operators to establish fatigue management systems
- Develop and use a methodology that will continually assess the effectiveness of fatigue management systems



Success requires . . .

A culture change that supports different attitudes and behaviors



Ongoing Challenges and Opportunities

 Continue progress Shared responsibility Transfer science to operations Comprehensive program approach Evaluate and improve No magic bullet!





