Pilot Error

“The Untold Story”

Military Air Safety Workshop
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Albuquerque, NM

Michael Buran, SR Manager
Aviation Safety and Airworthiness

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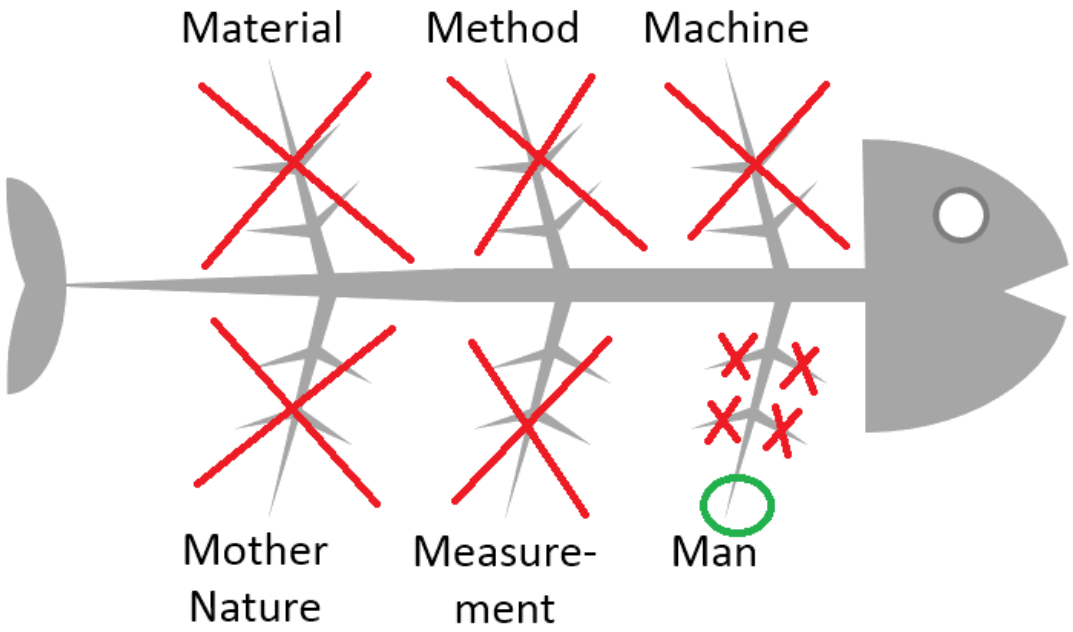
Pilot Error

An average of available statistics show that
Pilot Error is cited as a causal factor
in approximately 2/3rd of all Military Aviation Mishaps.



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Advances

- **In the past 10 years there have been significant emphasis/focus on identifying and categorizing human factors in military aviation mishap investigations**
  - MFOQA (Military Flight Operations Quality Assurance)
  - HFACS (Human Factors Analysis and Classification System)

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Why Do We Investigate

The primary purpose of a safety investigation is to prevent recurrence.

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US Military References

- **1.1.1. Safety investigations and reports are conducted and written solely to prevent future mishaps. (AFI 91-204)**

- **702. A naval aviation mishap signals a failure in the Naval Aviation SMS. It is evidence naval aviation failed to detect and eradicate the hazards that caused a mishap before it was too late. It is not too late, however, to prevent a mishap recurrence. (OPNAVINST 3750.6S)**

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ISSUE

2/3rd of all mishaps cite Pilot Error as a causal factor

and

We now have major programs dedicated to identify Human Factor Issues

and

Our main purpose for conducting a safety investigation is to prevent recurrence

And yet

We are not good about openly discussing/sharing Pilot Error issues in military mishaps other than in terms of "trending"

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Why

1. **Privileged Information Protection**
2. **Natural tendency to keep mishap results within service/country boundaries**
3. **Reluctance to admit the perceived failure one of your own**

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Privilege Information

- **Only applicable to US DoD Mishaps**
- **Established and maintained by case law.**
- **Investigation Board Findings, Causes, Recommendations, Analysis, and Deliberations**
  - **Pretty much covers the entire scope of the Safety Investigation Board**
- **So, Causal Factors of a Safety Investigation Board are under the umbrella of Privileged Information (PI)**

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Boundary Mishap Results – mine…mine…mine

- **Each Safety Organization is developed to serve and protect it's own members**
  - **ESPECIALLY Military safety organizations**

- **Flow of safety lessons learned remain within that organization because they have no legal obligation or command direction to inform "outside" organizations**

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Reluctance to Admit

The usual answer to the question

"Hey, what happened in your accident?"

when Pilot Error was

or

is suspected to have been a causal factor.

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So What Can We Do as Flight Safety Professionals?

Paradigm Shift

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So What Can We Do as Flight Safety Professionals?

- **Privilege Information**
  - **AF and Navy Safety Centers just recently started talking across the fence <u>to each other</u> about sharing and protecting safety investigation information**
  - **As long as case law stands, so will Privilege**

- **Safety leads from common fleet type organizations need to organize and utilize forums/meetings/conferences to discuss specific pilot error designated lessons learned**
  - **Scrub the identifiers and then talk specifics**
  - **"Why did the pilot do what they did"**

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So What Can We Do as Flight Safety Professionals?

- **Historic Boundary limitations**
  - **Arguments have always been:**
    - **They have their system for safety information and we have ours**
    - **Our responsibility is to our own fleet**
  - **Valid points**

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- **Contend that while those arguments are valid,**
  - **As a safety community with a responsibility to our own nation/service organization, we are not fulfilling our duty as safety professionals by leaving this type of information underutilized.**
  - **It should be seen as a responsibility to ensure the safety of all fleet pilots by gathering and/or disseminating pilot error lessons regardless of country or service origin**
  - **Because…most pilots learn by example, especially one that make them "cringe".**

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So What Can We Do as Flight Safety Professionals?

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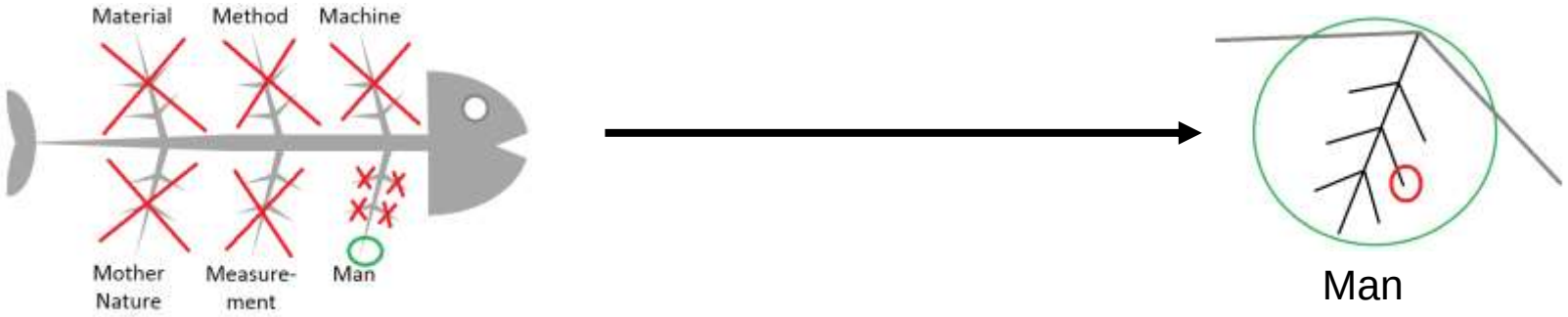
- **Acknowledge the error**
  - **When a human is involved, mistakes will happen…anyone disagree?**
- **Don't let an investigation body get away with pointing a finger and walking away**
  - **Root Cause Analysis…**
    - **There is a reason they pulled the wrong switch,**
    - **Was distracted and didn't hear the warning horn,**
    - **Or fixated on the target and proved once again that the ground has a PK of 1. (Hopefully AGCAS will mitigate this one)**
    - **If they forgot, ignored, disregarded, mistook, misunderstood, or overlooked something; There was a reason, FIND IT, DOCUMENT IT and SHARE IT.**



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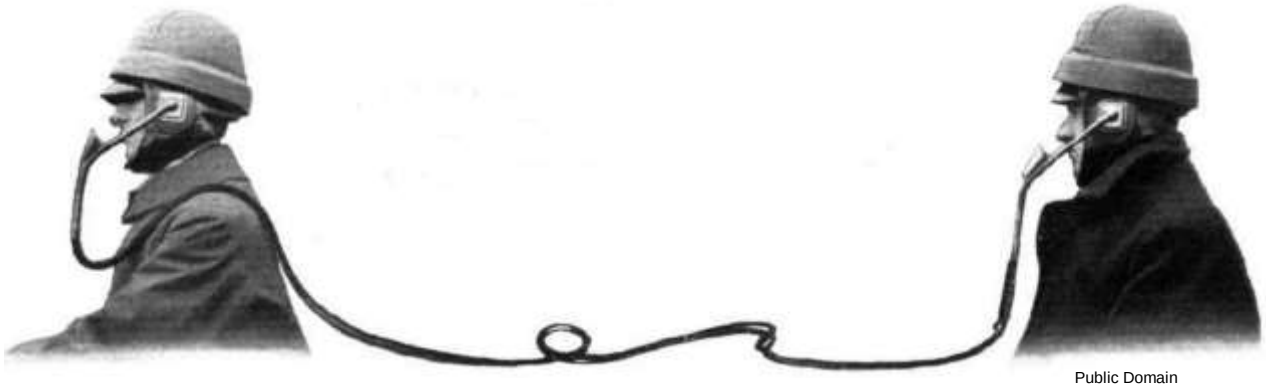
Action

- **KEEP THE CONVERSATION GOING**
  - **CFIT has always been a leading causal factor in military aviation mishaps**
    - **Auto Ground Collision Avoidance System (AGCAS) was on every System Safety top ten list for the last 15 - 20 years**
    - **It is finally being fielded**
    - **This was a decades long effort that should be seen as a Major Safety Victory!**
      - **We can now show evidence of "saves"**
- **Open discussion can help mitigate Pilot Error and should be the next major safety agenda item!**



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Action

- **Utilize every opportunity to talk with counterparts**
  - **<u>ESPECIALLY FACE TO FACE</u>**
    - **Aircraft model System Safety Groups**
      - **Informal side meetings**

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System Safety Groups

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Flight Manual Conferences

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MASI Working Groups

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    - **Flight Manual Conferences**
    - **MASI Working Groups**
    - **Any meeting where other flight safety professionals will be in attendance**

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Flight Safety Professional Hangouts

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And

- **Emphasize the “global fleet” aspect of Pilot Error Lesson Learned to your “Decision Makers”**
- **Because your voice may be the only one in your organization to speak about this:**
  - **Talk with other groups/competencies about it**
    - **MFOQA, HFACS, Flight Manual personal, System Safety professionals, Human Factor professionals**
  - **Get on their meeting agendas and talk about the gap in information to do adequate Operational Risk Assessments**
  - **Sometimes all you need to do is whisper in their ear and plant the seed.**

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Thank You

Questions? Comments?

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