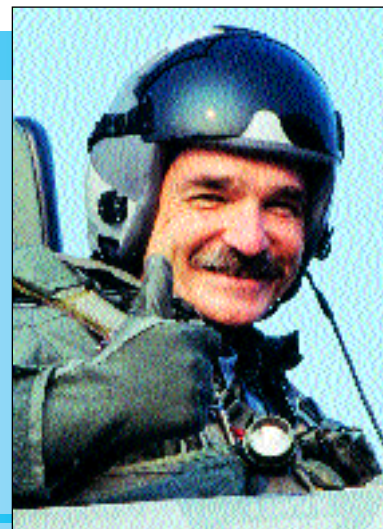


What If . . . ?

Brainstorming Safer Ways to Fly

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What if . . . you and your crew, during workups for cruise or deployment, went back to the fleet replacement squadron to do all your annual Naval Air Training and Operating Procedures Standardization (NATOPS) testing, instrument checks and weapons qualifications—as a team—in the simulator?

What if . . . in order to screen for command of a squadron, you must have been an Aviation Safety Officer or Safety Department Head?

What if . . . you wore flight gear that allowed you to “feel” the attitude of your aircraft without having to look at instruments or displays?

What if . . . as skipper, you assessed (using operational risk management techniques) that the risk of performing a special mission in an upcoming exercise outweighed the training benefits to your crews and, best of all, you knew you would have the support of the wing to turn down this additional tasking?

Sound like radical thinking? Maybe, but you can bet that a personal copy of a NATOPS manual in the hands of every aviator sounded pretty radical 35 years ago. Now we take it for granted as an integral component of our aviation safety program. Why all of this “out of the box” thinking? Is there something wrong with our safety programs? Isn’t our mishap rate as good as it’s ever been?

The fact is that Naval Aviation (Navy and Marine Corps) experienced its fifth safest year ever in Fiscal Year 1996, with a rate of 2.39

Class “A” flight mishaps per 100,000 flying hours. The bad news is that these mishaps equated to the loss of 45 shipmates and 39 aircraft. This is equal to one or two squadrons of flyers and nearly half an air wing’s complement of airplanes. We destroyed only one less aircraft than we are scheduled to buy in 1997. If we look at how far we’ve come in Naval Aviation safety, we can be proud of how drastically things have changed since the 1950s when we lost an average of two planes a day. But focusing on where we have been is precisely what our Chief of Naval Operations has asked us *not* to do!

Admiral Johnson has challenged us to “steer by the stars . . . not by our wake.” His four stars—Operational Primacy, Leadership, Teamwork, and Pride—can guide us to our goal of accident reduction. “Steering by the stars” means that we focus ahead on what *can* happen and not on what *has* happened. This is not to say that the lessons learned from the past don’t still apply. Clearly, they do. But it means that we file them under “lessons learned,” press on and start thinking of new (and perhaps radical) ways of achieving our goals.

It’s been more than a year since the tragedy in Nashville, Tenn. Three civilians, two aviators and an F-14 *Tomcat* were lost. A review of the causal factors of that incident and dozens of previous flight mishaps revealed that since 1990 human error has been a contributing factor in about 80 percent of all Class “A” mishaps.

VAdm. Brent Bennett, Commander Naval Air Force, U.S. Pacific Fleet, and the Air Board set a goal of cutting the 1996 Class “A” mishap rate in which human factors were a contributing element by half within three years and by 75 percent within 10 years. How we are “steering” towards this new goal is the subject of our feature story by RAdm. Robert Nutwell (p. 12). He has been chairing a Human Factors Quality Management Board (HF QMB) established last year to study past mishaps and to make recommendations for reducing our mishap rate.

Some of the “what ifs” above are the result of brainstorming by folks out in the fleet—just like you—who have been working with the HF QMB on new approaches to solving old problems. An example of how one person’s radical thinking may change the way we operate appears in the story about the flight gear that can help you feel “Which Way is Down?” (p. 16). Do you have some “what ifs” for the HF QMB to consider? Turn to page 12 and start thinking radically.

Fly safe. Be the best!