

1993: DC8 Guantanamo Bay NAS

■ General context

- Cargo flight
- Norfolk-Guantanamo Bay Naval Air Station
- 3 crew members

■ Situational context

- Stall during turn to final
- Bank in excess of 50°
- PF (Cpt) **ignored**:
 - ◆ **Repeated** callout regarding speed decreasing by FE
 - ◆ **Stall warning** that activated for 5" before stall
- Crash 500m short of runway



1993: DC8 Guantanamo Bay NAS (con'd)

■ Causes (NTSB)

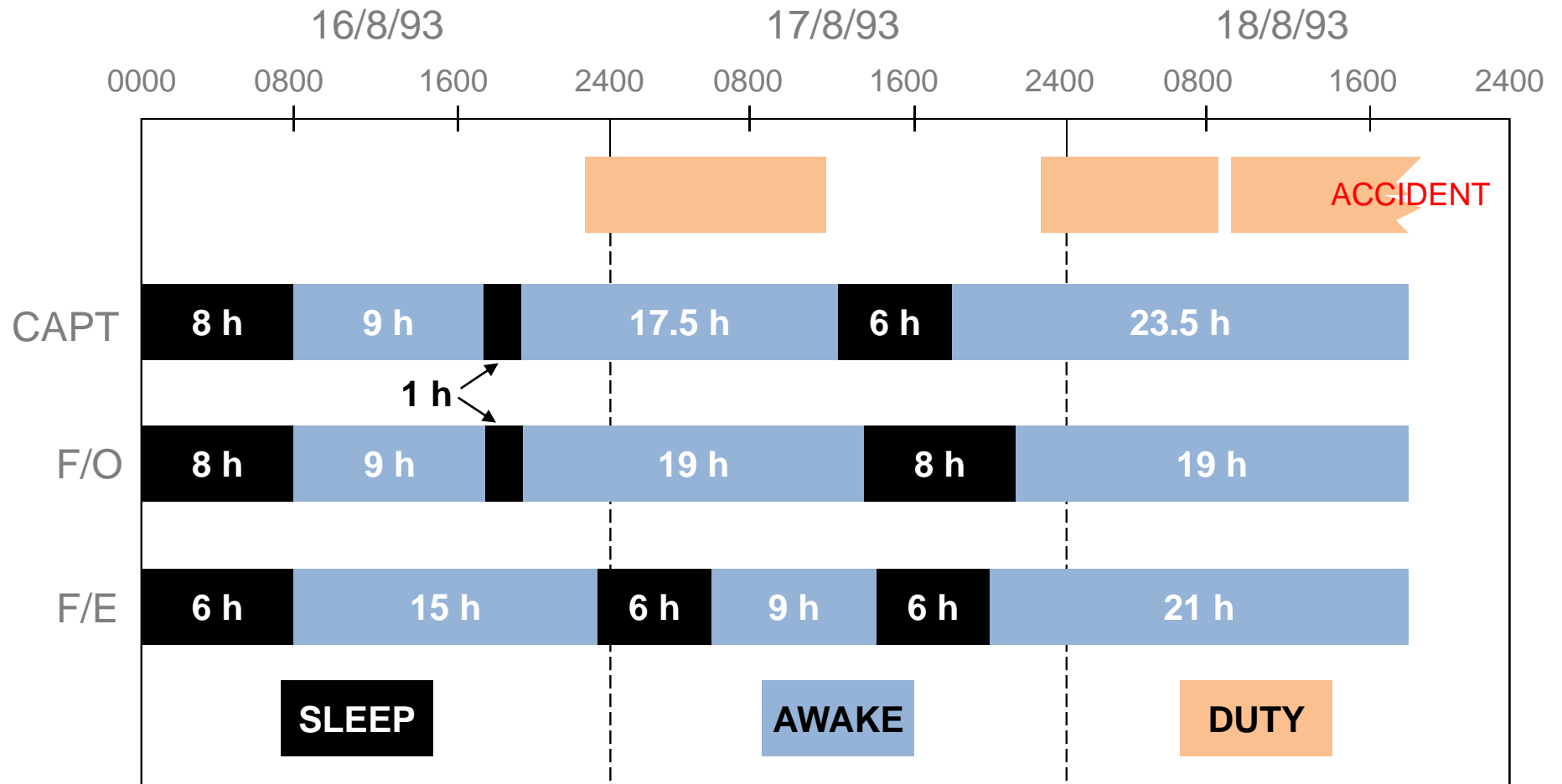
- Captain failure to:
 - ✗ Recognize the deteriorating flight path
 - ✗ Maintain situational awareness
 - ✗ Avoid a stall while in steep bank turn
 - ✗ Execute immediate action to recover from a stall
- Flight crew experienced a **disruption of circadian rhythms** on the previous patterns
- **Fatigue** adversely affected:
 - ✗ Judgment
 - ✗ Decision making
 - ✗ Flying abilities

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Crew sleep / wake / duty

	Captain			FO			FE		
	Awake	<i>Sleep</i>	Duty	Awake	<i>Sleep</i>	Duty	Awake	<i>Sleep</i>	Duty
Last 65 H (≈ 3 days)	50	<i>15</i>	31	47	<i>18</i>	31	45	<i>20</i>	31
Last 48 H (2 days)	41	<i>5 + 2 nap</i>	30	38	<i>8 + 2 nap</i>	30	30	<i>18</i>	30
Last 24 H	23:30	<i>0:30</i>	18	19	<i>5</i>	18	21	<i>3</i>	18

1993: DC8 Guantanamo Bay NAS Crew circadian pattern



1993: DC8 Guantanamo Bay NAS (end)

■ Causes (end)

● Contributing factors

- ✗ Inadequacy of the flight and duty time regulations
- ✗ Extended flight/duty hours
- ✗ Fatigue of the crew members
- ✗ Inadequate company CRM
- ✗ Inadequate training for special operations
- ✗ Navy failure to assess operability of strobe light

■ Consequences

- A/C destroyed by impact and post fire
- The 3 crew members sustained serious injuries