

Significant Incidents in Human Spaceflight

WHAT IS IT?

Human spaceflight grew out of the Cold War between the United States and the Soviet Union. Competitive struggles laid the groundwork with advances in high altitude flight, rocketry, and human performance. Human spaceflight reached its first defining success more than half a century ago, when Cosmonaut Yuri Gagarin became the first man to orbit the Earth in April 1961. In November 2000, a multi-national crew moved aboard the International Space Station. By November 2011, the former Cold War rivals had collaborated to surpass 10 years of continuous presence in space. Now a new record of continuous space habitation is established daily.

The Significant Incidents and Close Calls in Human Spaceflight chart presents a visual overview of major losses and close calls spanning the history of human spaceflight. It heightens awareness of the risks that must be managed as human spaceflight continues to advance.

HOW DOES IT WORK?

Events on the chart are organized by flight phase and ordered chronologically within each phase. Each event is represented by a small box which includes the mission name, date, a brief description of the incident and any significant result, such as injury or loss of life.

Three types of important events are highlighted: loss of crew, crew injury, and related or recurring events. Events with one or more crew fatalities are considered a loss of crew and highlighted in red. Crew injury or illness and/or loss of vehicle or mission is designated by orange shading. Related or recurring events are grouped together and set apart by yellow shaded boxes. These events have occurred repeatedly, are similar in nature, and may continue to occur today.

WHY DO WE HAVE IT?

The Significant Incidents and Close Calls in Human Spaceflight chart is maintained by NASA Johnson Space Center's Flight Safety Office to raise awareness of lessons that have been learned through the years. It is a visible reminder of the risks inherent in human spaceflight. It is intended to spark an interest in past events, inspire people to delve into lessons learned, and encourage continued vigilance. It can aid in developing "what-if" scenarios and in ensuring the lessons of history are incorporated into new designs. It is being distributed as widely as possible in the hope that future accidents may be prevented.

WHAT IS THE BONDARENKO STORY?

Two fatal events, the Soviet altitude chamber oxygen fire and the Apollo 1 terminal countdown demonstration test, highlight the importance of sharing information. On March 23, 1961 Soviet cosmonaut Valentin Bondarenko lost his life after being severely burned in an altitude chamber fire. The incident occurred during a routine training exercise, when Bondarenko attempted to throw an alcohol swab into a waste basket, but hit the edge of a hot plate instead. The oxygen-rich environment quickly ignited. Rescue efforts were thwarted because internal pressure prevented rescuers from opening the chamber's inwardly swinging hatch for several minutes. By the time the pressure was released and the hatch could be opened, Bondarenko had been hopelessly burned. He died hours later.

Six years later, three U.S. astronaut's lives were lost in a fire during the terminal countdown demonstration test. During the test, the Apollo crew module contained an oxygen-rich atmosphere. An electrical short caused a fire that spread quickly throughout the cabin. Again, rescue efforts were delayed due to the buildup of pressure behind an inwardly opening hatch. Unlike the Soviet altitude chamber oxygen fire, the crew did not die due to burns from the fire, but from cardiac arrest caused by smoke inhalation. However, in both the Bondarenko tragedy and the Apollo 1 incident, high levels of oxygen caused the fires to spread rapidly, and pressure against inward opening hatches slowed rescue efforts. Neither cabin was equipped with effective fire-suppression equipment.

Information about the Bondarenko incident was not known in the U.S. until 1986 – more than 20 years later. Would access to this information have led to design changes that saved lives? Although that question can never be answered, these events underscore the importance of sharing information in the effort to prevent future tragedies.

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SAIC



Legend

Loss of Crew, Crew Injury/Illness and/or Loss of Vehicle or Mission, Related or Recurring event

STS-110 4/8/2002, STS-109 3/1/2002, STS-108 12/5/2001. Incent adjustments to the controller software resulted in SSME underperformance. Crew: 7

STS-91 6/2/1998. Main engine pressure chamber sensor failed. If it occurred later, logic error may have triggered at RTL. Crew: 6

Soyuz TM-9 2/11/1990. DMI insulation torn loose on ascent; contingency EVA repair. Crew: 2

SRB Seal Events (1981-1996). STS-51L (Challenger) 1/28/1986. SRB seal failure. Crew: 7. Loss of Crew

Other SRB gas sealing anomalies: STS-2, 6, 41B, 41C, 41D, 51C, 51D, 51B, 51G, 51F, 51I, 51J, 61A, 61B, 61C, 42, 71, 70, 78

STS-51F 7/29/1985. Temperature sensor problems resulted in SSME1 shutdown at T+5:45. Crew: 7. Abort to Orbit

Soyuz 18-1(18a) 4/5/1975. Electrical fault caused premature firing of half of the 2nd stage separation bolts, resulting in the inability to fire the remaining ones. Slagging failure resulted in abort sequence being used at T=295 seconds. Crew: 2. Loss of Vehicle/Mission

Apollo 13 4/11/1970. 2nd stage center engine shutdown due to pogo oscillations. Crew: 3

Apollo 12 11/14/1969. Lightning strike on ascent. Crew: 3

Gemini 10 7/18/1966. 1st stage oxidizer tank exploded at staging. No discernable effects. Nominal ascent. Crew: 2

STS-112 10/7/2002. T-0 umbilical issues resulted in none of the system A pyrotechnic charges firing. Crew: 6

STS-61C 1/6/1986. System configuration errors resulted in inadvertent drain back of 14,000 lbs of LOX prelaunch, which would have resulted in a Trans-Atlantic Abort Landing. Crew: 7

On-pad Abort Events (1984-1993). STS-41D 6/26/1984. Following a pad abort, LH2 leaked from SSME3, resulting in a fire of the base of the orbiter. Crew: 6

Soyuz T-10-1(T-10a) 9/26/1983. Pad booster fire/explosion. Capsule Escape System used. Crew: 2. Loss of Vehicle/Mission

Other On-pad Abort Events: STS-51F, STS-55, STS-51, STS-68.

STS-1 4/12/1981. SRB ignition pressure wave caused TPS and structural damage. Crew: 2

Apollo 1 (AS-204) 1/27/1967. Crew cabin fire (electrical short + high pressure O2 atmosphere). Crew: 3. Loss of Crew

Gemini 6 12/12/1965. Main engine shutdown. Booster left unsecured on pad. Crew ejected not to eject. Launched 3 days later. Crew: 2

ISS Cargo Mission Failures (2011-2016). Progress M-12M (44P) 8/24/2011. Anomaly in fuel pressurization system led to shutdown of 3rd stage engine. Vehicle failed to reach orbit. Crew: 0. Loss of Vehicle/Mission

STS-117 6/8/2007. Thermal blanket damage. EVA performed to repair damage. Crew: 7

STS-114 5/26/2005. Bird strike on External Tank. Loss of foam from External Tank PAL ramp. TPS gap fillers protruding. Removed during third mission EVA. ET forward separation bolt NSI ejected causing damage to adjacent orbiter structure and TPS. Crew: 7

STS-93 7/23/1999. AT+5 a short on AC1 Phase A resulted in loss of SSME1 Controller A and SSME3 Controller B. SSME3 H2 leak: early LOX depletion and shutdown. Crew: 5

Ascent Debris. STS-124 5/31/2008. 3,500 refractory bricks blown away from flame trench wall during liftoff. Crew: 7

STS-95 10/29/1998. Drag chute door separated during launch and impacted main engine bell. Crew: 7. Other significant ascent debris events have occurred on: STS-116 and STS-125

Late Release Orbiter Tyvek Covers. STS-114, 115, 118, 119, 124, 126

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EVA Incidents Summary (1965-2014). 12 EVAs resulted in crew injury: Gemini 10, Apollo 17, Salyut 7 PE-1, Salyut 7 VE-3, STS-61-B EVAs 1&2, STS-37, Mir FE-9, STS-63, STS-97/4A, STS-100/6A EVAs 1&2, STS-134/ULF6

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Apollo 11 7/21/1969. Engine arm circuit breaker knob broke off. Circuit breaker successfully reset allowing ascent. Crew: 2

STS-44 11/24/1991. Failure of IMU 2 caused MDF to be declared. 10-day mission shortened to 7 days. Crew: 6. Minimum Duration Flight

STS-32 1/9/1990. Erroneous state vector up-linked to flight control system, causing immediate and unpredictable attitude control problems. Crew: 5. Loss of Attitude Control

STS-99 2/2000. High bacterial count in pastflight sample after GIRA installed to removed iodine. Crew: 6

ISS Flight 2A.1 5/1999. Crew sickened in FGB; likely a result of high localized CO2 levels due to poor ventilation. Crew: 7

STS-95 10/29/1998. Preflight sterilization process chemically altered the Low Iodine Residual System resulting in contaminated drinking water. Crew: 7

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STS-104 7/2001. EMU battery leaked hazardous KOH. Discovered during EMU checkout. Crew: 5

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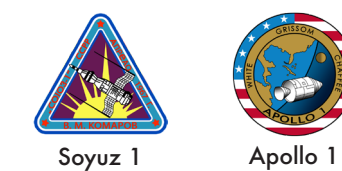
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SR-71, X-15

Soyuz 1, Apollo 1

Soyuz 11, Challenger

Columbia

Medical Evacuations (1976-1987). Mir EO-2, 1987, Crew: 2. One replaced early due to medical condition. Soyuz 7, 1985, Crew: 3. One returned with visiting crew due to medical condition. Salyut 5, 8/25/1976, Crew: 2. Early return of crew due to health effects from suspected toxic gases in space station. Crew illness

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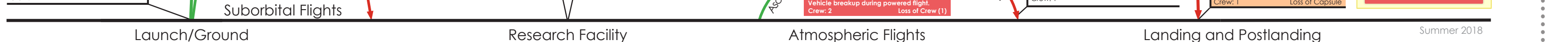
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- Abbreviations and Acronyms. AC Air Conditioner, APU Auxiliary Power Unit, BMP Microimpurities Removal System (Russian), CDRA Carbon Dioxide Removal System, CMG Control Management Gyroscope, CO Carbon Monoxide, CO2 Carbon Dioxide, DM Descent Module, EMU Extravehicular Mobility Unit, EPS Electrical Power System, EVA Extravehicular Activity, FGB Functional Cargo Block (Russian), FSO Flight Safety Office, GIRA Galley Iodine Removal Assembly, GPC General Purpose Computer, GPS Global Positioning System, H2 Hydrogen, IMU Inertial Measurement Unit, ISS International Space Station, ITCS Internal Thermal Control System, KOH Potassium Hydroxide, LH2 Liquid Hydrogen, LOC Loss of Crew, LOV Loss of Vehicle, LOX Liquid Oxygen, MDF Minimum Duration Flight, MetOx Metal Oxide, MMOD Micro-Meteoroid Orbital Debris, N2O4 Nitrogen Tetroxide, NSI NASA Standard Initiator, O2 Oxygen, OM Orbital Module, OSMA Office of Safety & Mission Assurance, PAL Protuberance Air Load, PASS Primary Avionics Software System, PPO2 Partial Pressure of Carbon Dioxide, RCS Reaction Control System/Subsystem, RMS Remote Manipulator System, RTLS Return to Launch Site, SFOG Solid Fuel Oxygen Generator, SMA Safety & Mission Assurance, SM Service Module, SRB Solid Rocket Booster, SSME Space Shuttle Main Engine, SSP Space Shuttle Program, STS Space Transportation System, TPS Thermal Protection System, U.S. United States

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The JSC SMA Flight Safety Office maintains the Significant Incidents and Close Calls in Human Spaceflight graphic to provide continuing visibility of the risks inherent with space exploration and to provide engineers with a summary of past experience. It is hoped this information will be used to learn from the past and make present and future missions safer.