



LUND UNIVERSITY
School of Aviation

Marindagen

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- Maintenance-induced accidents in aviation
- Counteracting accidents
- Human error
- Accident investigations

Human error?



In 1928, there was a serious car accident on the main road between Örkelljunga and Åsljunga. It was a citizen of Örkelljunga that crashed into a business man from Skånes Fagerhult.

At the following trial in Klippan, the Örkelljunga citizen, who was the cause of the accident, received a reduced sentence, since he had been drinking aqvavit and consequently had difficulties to steer his vehicle.



Increasing flight safety



What happened to AA Flight 191?

May 25, 1979



AA 191

- Improper maintenance procedures, forklift used for engine change – excessive strain on pylon attach points,
- Deficiencies in FAA surveillance and reporting systems, which failed to detect and prevent the use of improper maintenance procedures;
- The design of the leading edge slat system, sensitive to the damage, which produced asymmetry,

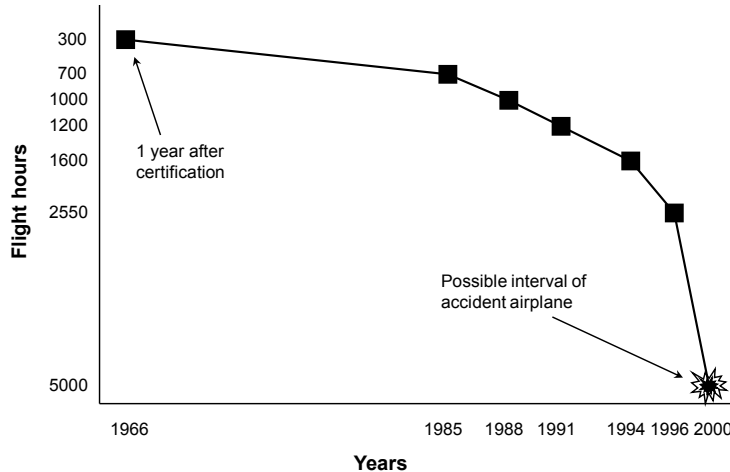
etc....



What happened to Flight 261?

Stabilizer trim actuator

- Uncontrolled expansion of lubrication intervals:
From 300 hrs to every 8th month!



On Jan 31, 2000, Flight 261 becomes uncontrollable and plunges into the sea outside Los Angeles. All aboard were los



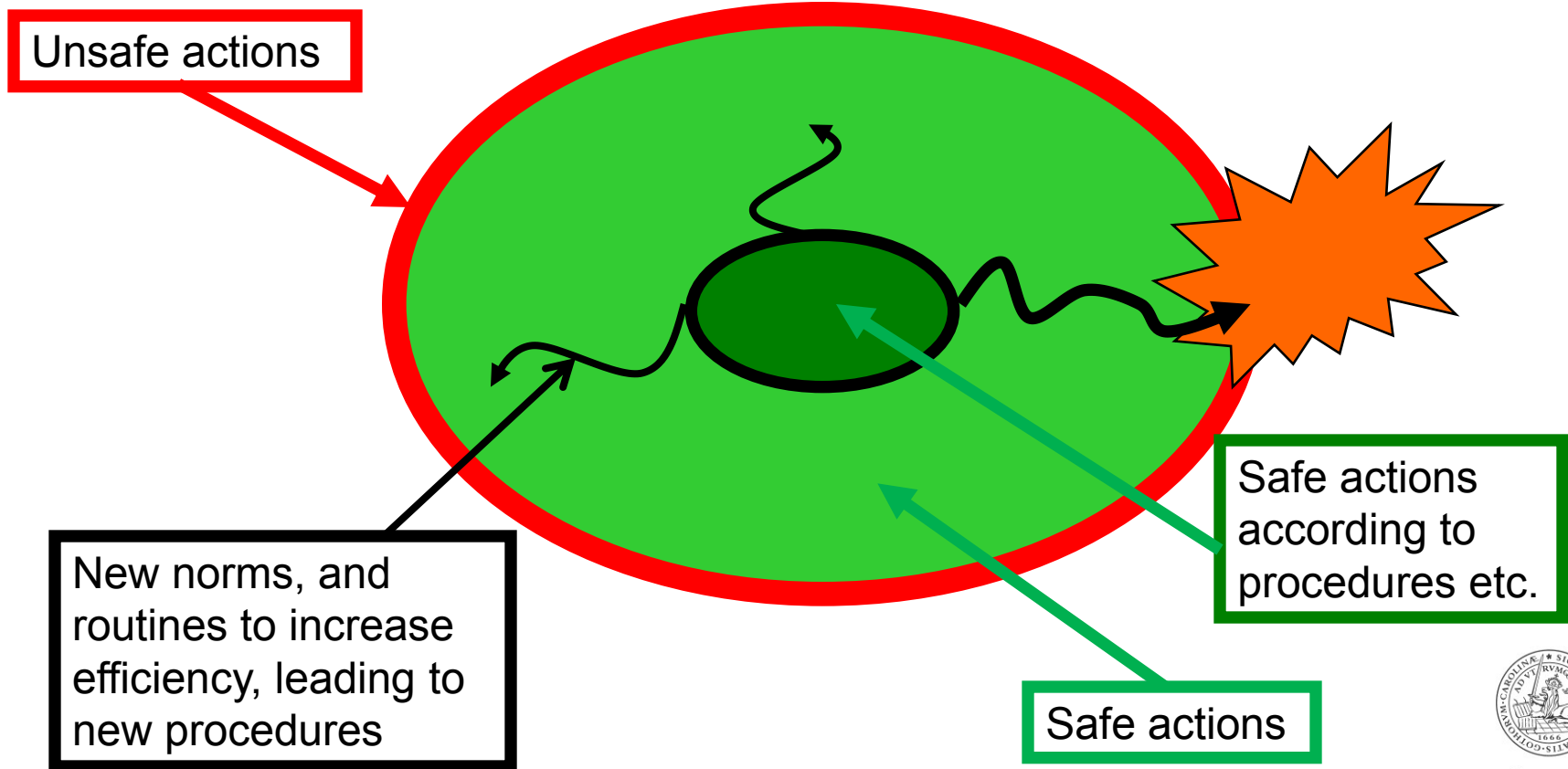
Service intervals

- Up to 1985: each B check: 350 hrs
- From 1985: each other B-check: 700 hrs
- 1987: B-check interval increased to 500 hrs: 1000 hrs
- 1988: B-checks eliminated:
 - Tasks distributed over A and C checks
- Lubrication each 8th A check
(A check every 125 hrs) 1000 hrs
- 1991: A check intervals extended to 150 hrs 1200 hrs
- 1994: A check intervals extended to 200 hrs 1600 hrs
- 1996: Lubrication removed from A check
 - Task card specifies every 8 months 2550 hrs



Drift to failure

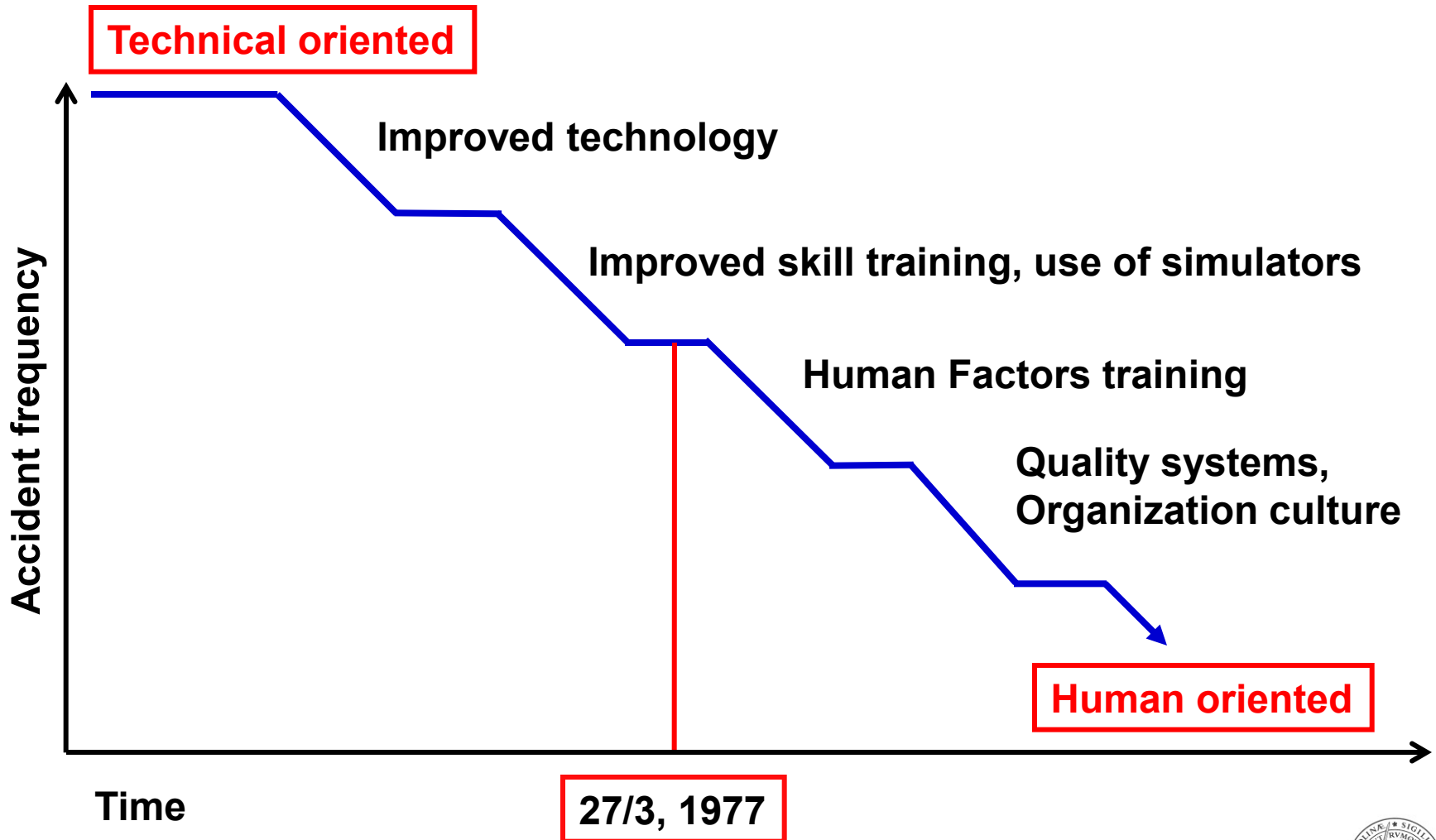
Efforts to become more effective may lead to unsafe acts



**Why didn't you
speak up!?**



Counteracting accidents



Tenerife March 27, 1977 583 people lost their life

PAA:
47,053 hrs
of crew
experience



KLM:
37,931 hrs
of crew
experience

- 17.06.09 **Ah - Roger Sir, we are cleared to the Papa beacon, FL 90, right turn out 040 until intercepting the 325 and WE ARE NOW AT TAKE-OFF!**
- 17.06.18 **OK!**
- 17.06.19 **...and we are still taxiing down the runway - Clipper 1736**
- 17.06.20 **Stand by for take-off, I will call you!**
- 17.06.25 **Papa Alpha 1736 report runway clear**
- 17.06.29 **OK, will report when we're clear**
- 17.06.30 **Thank you**

The Captain applies thrust, A/C starts to roll

- 17.06.32 **Flight Engineer: Is he not clear then?**
- 17.06.34 **Captain: What do you say?**
- 17.06.34.7 **Flight Engineer: Is he not clear then, that Pan American?**
- 17.06.35.7 **Captain: Oh yes (with emphasis)**
- 17.06.48 **Impact**



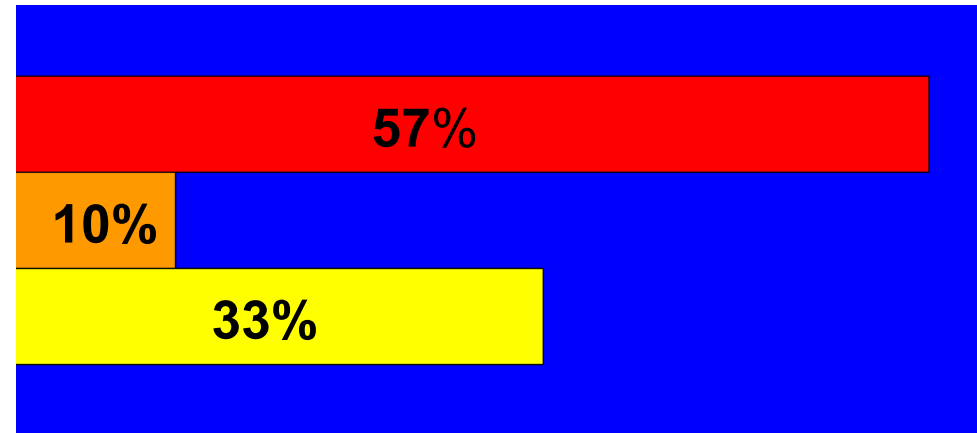
Airline pilot management errors, year 1979

(Source: NTSB)

Pilot management errors:

Lack of skills:

Outside control of pilot:



- Preoccupation with minor technical problems
- Failure to delegate tasks and responsibilities
- Failure to set priorities
- Inadequate monitoring
- Failure to utilize available data
- Failure to communicate intent and plans
- Failure to detect and challenge deviations from SOP's

Technical

and

**intellectual,
emotional**

Attitudes!



Crew Resource Management is...

“The use and coordination of all the skills, knowledge, experiences and resources available to the crew to accomplish or achieve the established goals of safety and efficiency of the flight.”

**Crew Resource Management and
Maintenance Resource Management
are mandatory in aviation**



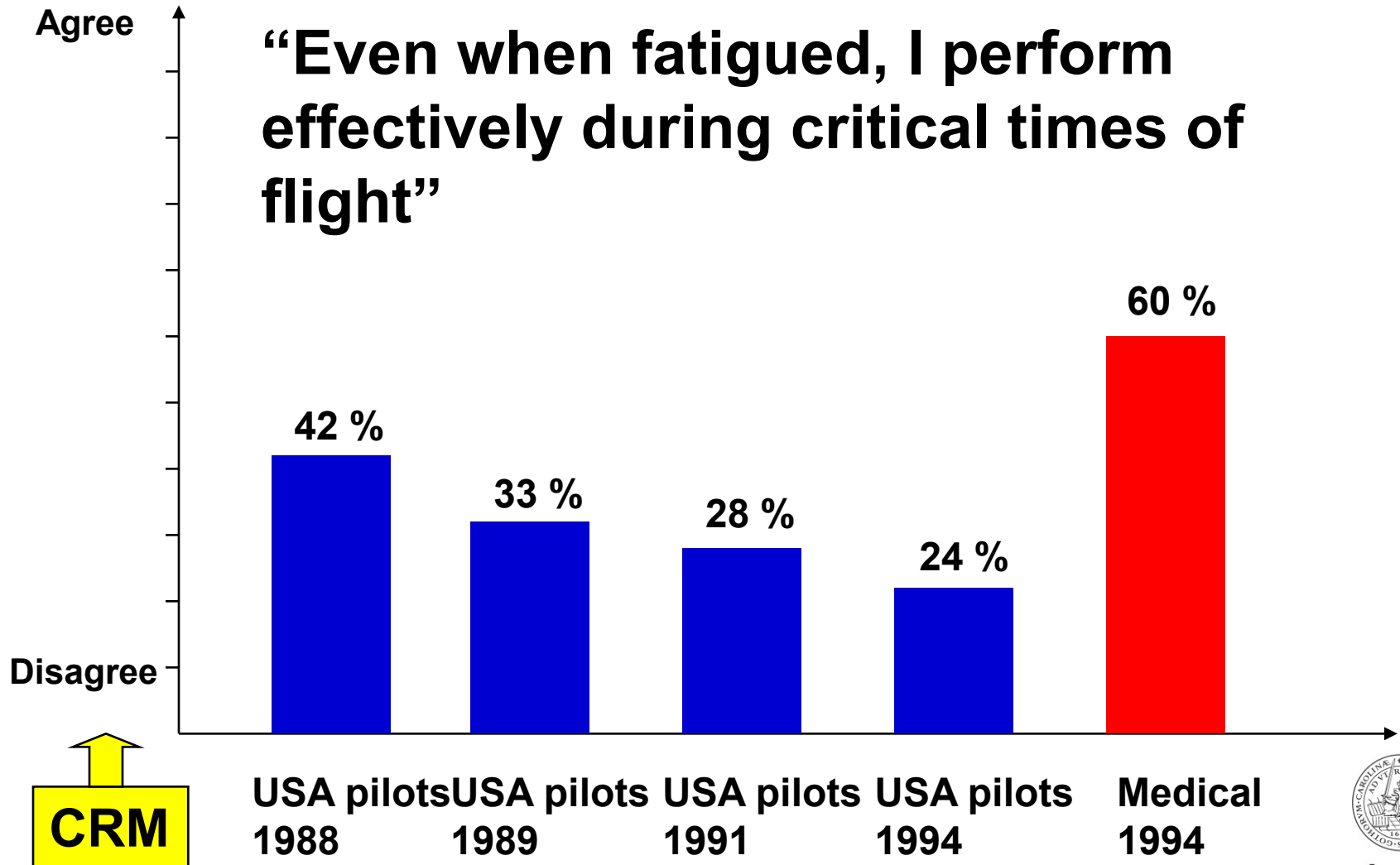
What is Crew Resource Management?



”Of course I believe in crew resource management, I’m the management and you are the resource!”



Attitude change



Some error types

Normative errors:
Errors in assuming a role

Technical errors:
Errors in a role

Latent errors

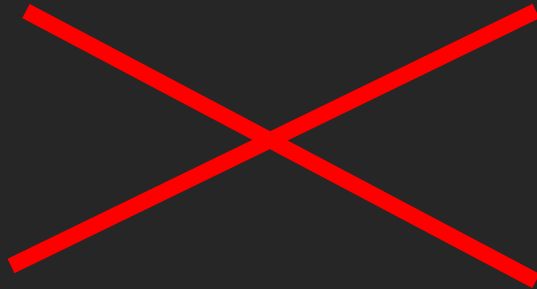
Active errors



What happened to Flight 2574?



Flight 2574: Replacement of de-icing boots



First shift

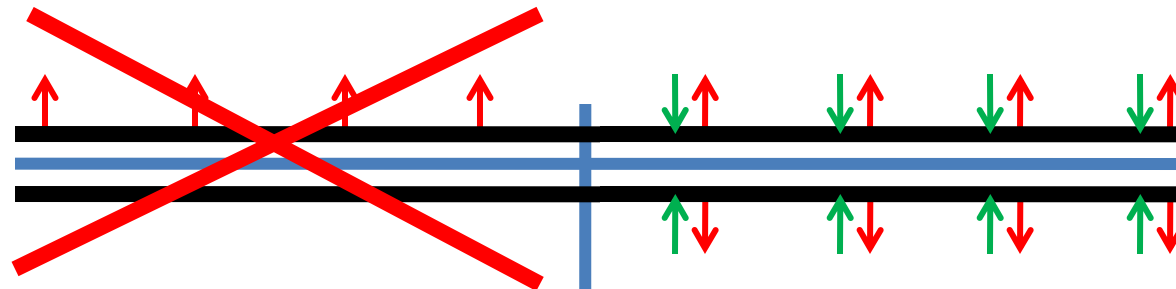
Second shift

**”Right side later!
Release!”**

**Outdoor
Darkness**



Flight 2574: Replacement of de-icing boots



First shift

Second shift

**"Right side later!
Release!"**

**Outdoor
Darkness**



Flight 2574: Why?

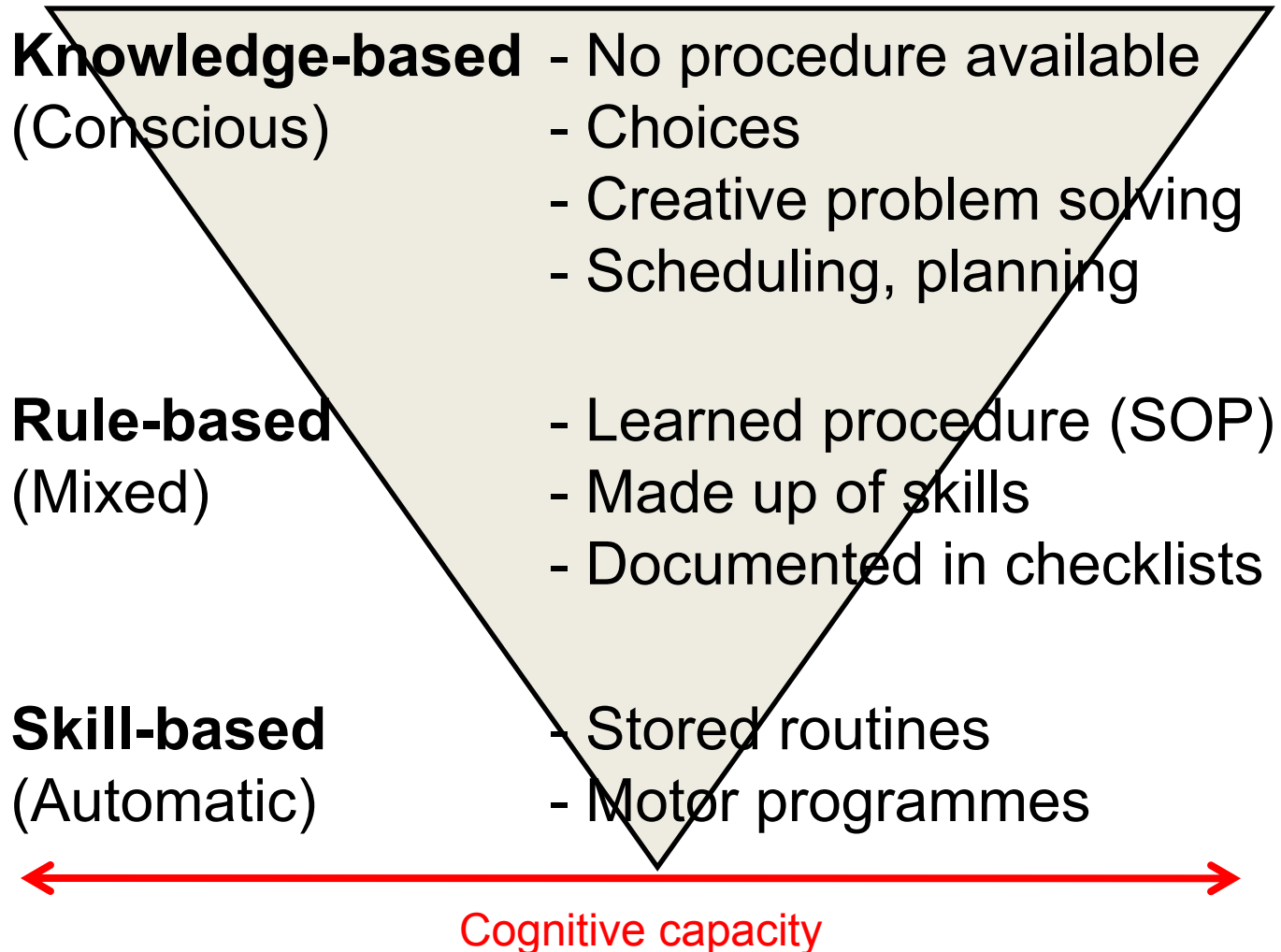
- Due to:**
- Miscommunication
 - Time constraints
 - Poor turnover
 - Work outside in darkness

...the aircraft brakes up in flight on Sep 11, 1991 at 1003.

3 crew and 11 pax are killed



Decisions



Decisions and human error

Knowledge-based

- Incomplete analysis
- Target fixation

”Mistakes”

Rule-based

- Wrong procedure
- Forgotten action

”Lapses”

Skill-based

- Wrong sequence
- Wrong timing
- Wrong action

”Slips”



Reasons for errors

- Bad communication
 - Fatigue
 - Stress
 - Improper attitude
 - Lack of training
 - Lack of experience
 - Lack of information
 - Bad tools
- etc.



Counteracting errors

- Training
 - Non-technical skills
 - (Technical skills)
 - Recurrent training

- Checklists
 - SOP's

- Just culture



OCT25-JAN 99 EMERGENCY CHECKLIST md-11 41.1 Page 9
ALERT AND NON-ALERT

AIR CONDITIONING SMOKE

ECON P/B _____ OFF

SMOKE DECREASES _____

NO: No further action required.

END

AIR SYSTEM P/B _____ MANUAL

ECON P/B _____ ON

PACK 1 _____ OFF

SMOKE DECREASES _____

NO: BLEED AIR 1 _____ OFF

1 - 3 ISOL _____ ON

DO NOT activate BLEED AIR 1 or PACK 1 for remainder of flight.

END

PACK 1 _____ ON

PACK 3 _____ OFF

SMOKE DECREASES _____

NO: BLEED AIR 3 _____ OFF

1 - 3 ISOL _____ ON

DO NOT activate BLEED AIR 3 or PACK 3 for remainder of flight.

END

PACK 3 _____ ON

PACK 2 _____ OFF

SMOKE DECREASES _____

NO: BLEED AIR 2 _____ OFF

1 - 2 ISOL _____ ON

DO NOT activate BLEED AIR 2 or PACK 2 for remainder of flight.

END

PACK 2 _____ ON

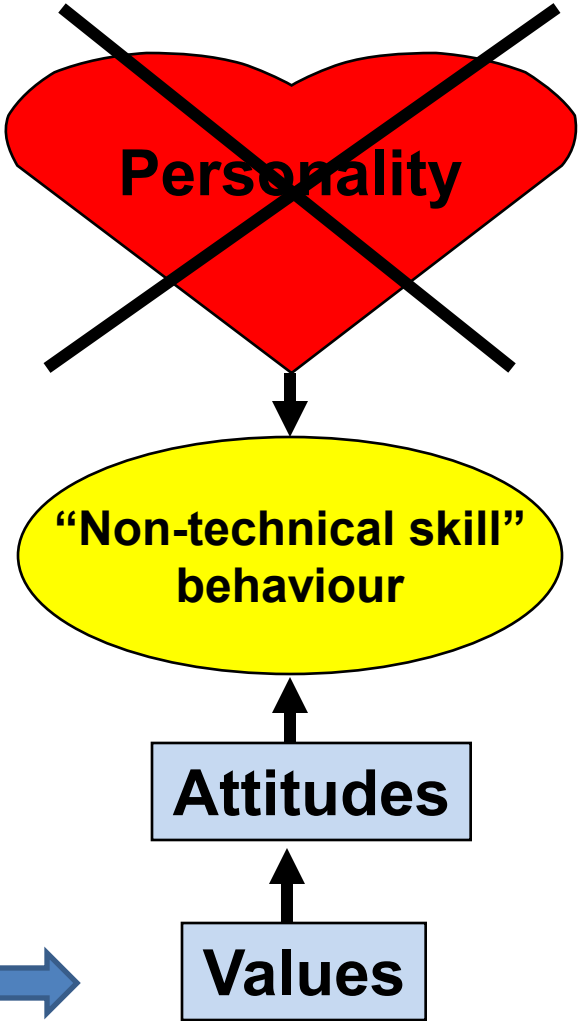
Smoke is not of air conditioning origin.
Refer to EMERGENCY Procedure - SMOKE / FUMES OF UNKNOWN ORIGIN.

END

MD-11 41.1 Page 9



**To change
behaviour**



CRM, MRM 

Success factor: Repeated frequently!



Contents of a 3-day MRM course

1. Introduction
2. Basic Aviation Psychology
3. Attitudes and behavior
4. Culture awareness
5. Communication
6. Workload
7. Situation awareness
8. Leadership and group dynamics
9. Decision-making
10. Human error
11. The “Dirty Dozen”
12. Automation

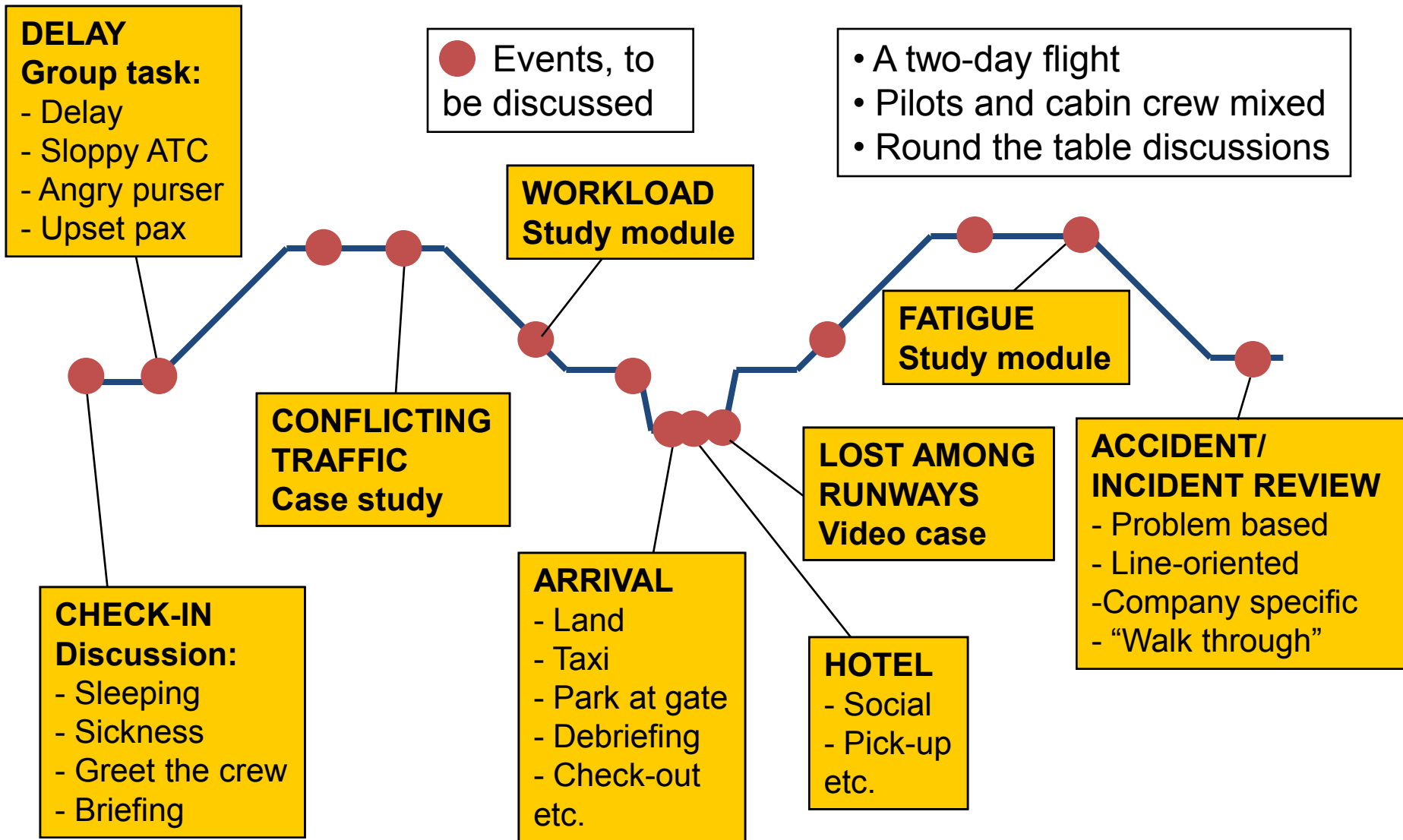


Training methods

- Facilitation – not instruction!
- Lectures
- Group work
- Simulations / Role –play
- **Walk-through cases**
- **“Dry sessions”**
- Case studies



Recurrent CRM: “Dry flight”



Training method: Walk-through case

1. A situation, for which no SOP's exist
2. What should the team do?
3. What the team did in reality
4. Why did they make this decision?
5. Next phase
and so on...



"The Dirty Dozen"

(Gordon DuPont)

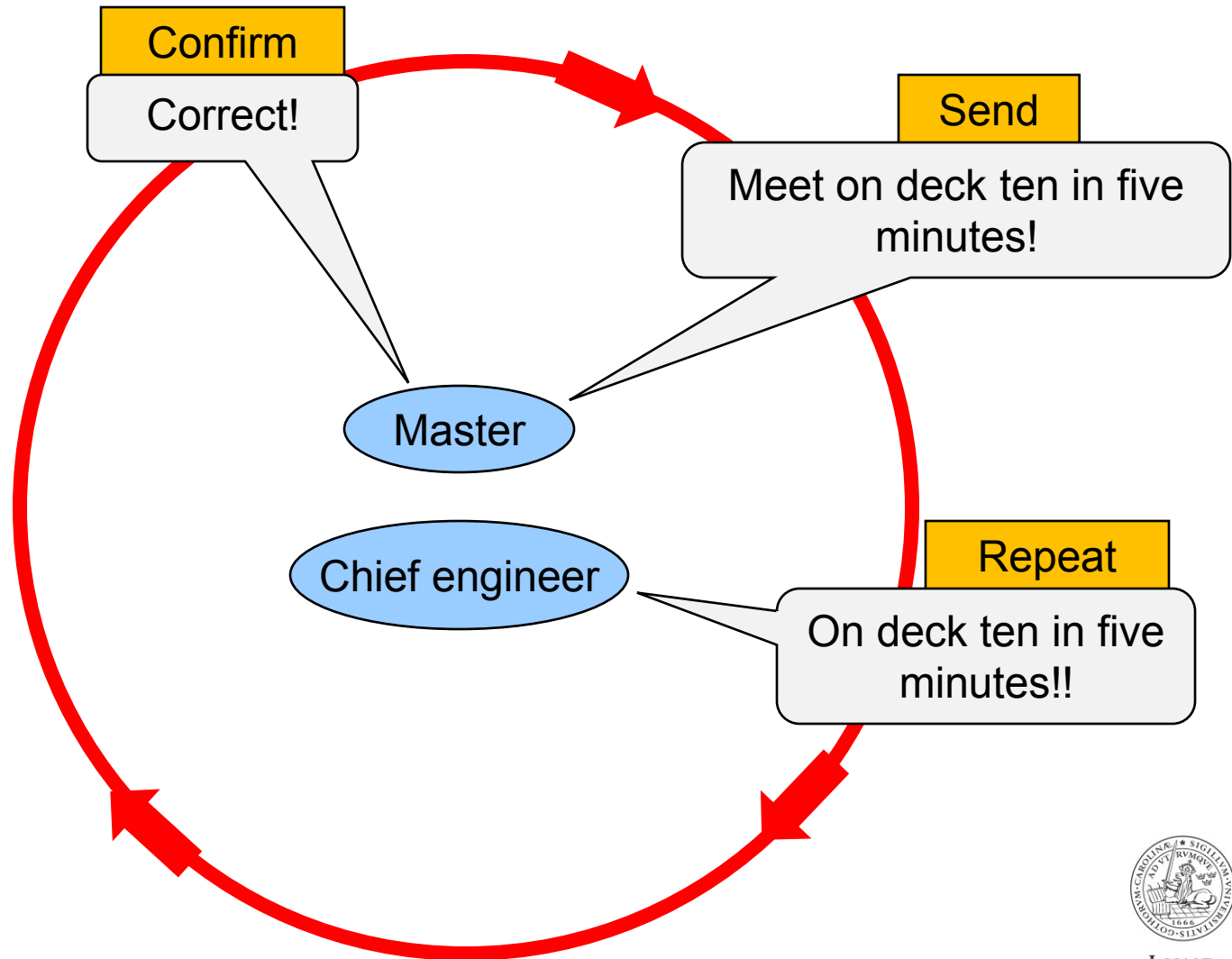
1. Lack of communication
2. Lack of teamwork
3. Norms
4. Pressure
5. Complacency
6. Lack of knowledge
7. Lack of awareness
8. Lack of resources
9. Distraction
10. Lack of assertiveness
11. Fatigue
12. Stress



Dirty 1: Lack of communication



Closed loop communication



Dirty 5: Complacency

”A state of confidence and contentment leading to a gradual deterioration in performance with loss of critical self-appraisal”

Symptoms

- Unrealistic self-confidence
- Less desirous to remain proficient
- Personal safety less important
- Decides “on the spot”
- Decline in physical condition)



Dirty 7: Situation Awareness – what is it?



'SA means that the pilot has an integrated understanding of factors that will contribute to the safe flying of the aircraft under normal or non-normal conditions.'

'SA is the availability of a coherent and understandable representation of the situation that is continually updated according to the results of repeated estimation of the situation.'

'SA refers to the accuracy of an operator's mental picture of the operational environment, and their ability to respond appropriately to changes in this.'

“Knowing what’s going on, so you know what to do.”



Dirty 7: Situation Awareness

Indicators of wrong SA

- Unannounced actions or deviations from made plans
- Team communication may decrease
- Uncertainties are not resolved
- People may feel complacent

But: There may be no indications at all!!

Wrong SA is not the same as confusion!



Just culture: Safety and accountability

- Reporting of errors supports learning and increases safety
- Punishment reduces willingness to report
- Everything can not be accepted



The Bad Apple Theory

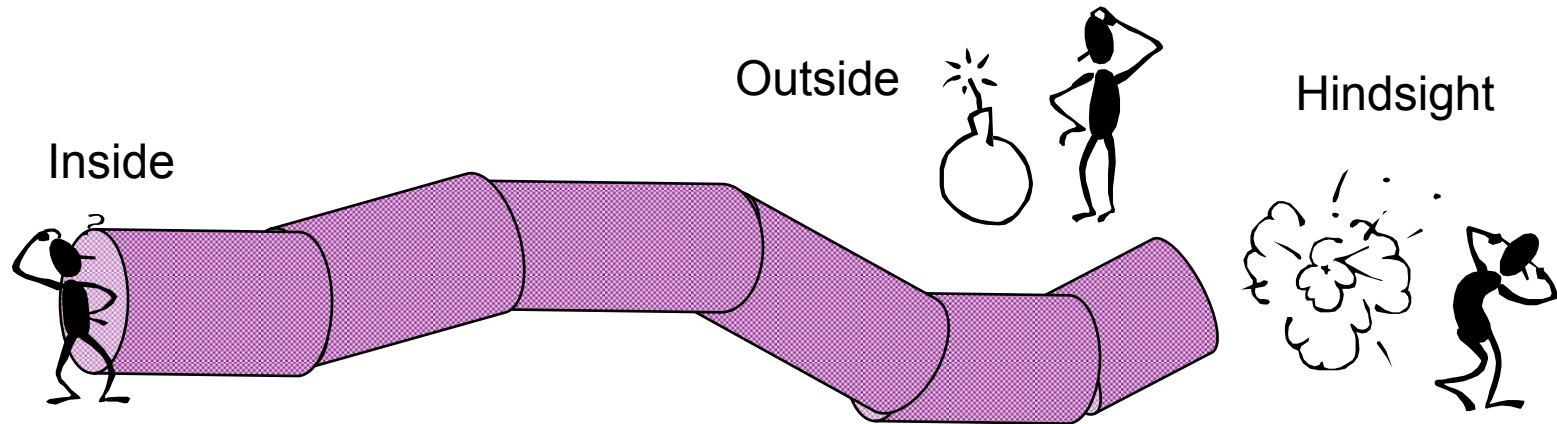


New view:

- Systems are not automatically safe.
- People do their best to create safety and meet conflicting goals
- Human error” is the **starting point** of the accident investigation



”Local rationality principle”



People do what makes sense to them at the time, given their

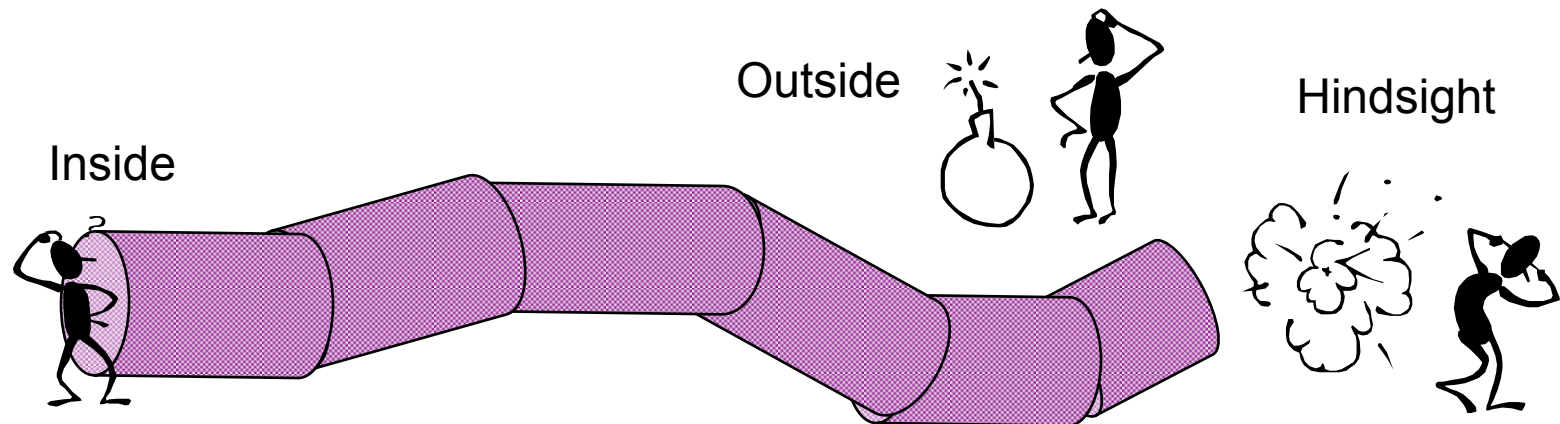
- Goals
- Knowledge
- Training
- Experiences
- Attitudes
- Communication abilities
- Information
- Physical condition (fatigue)
- Stress
- Focus of attention
- Tools
- etc.



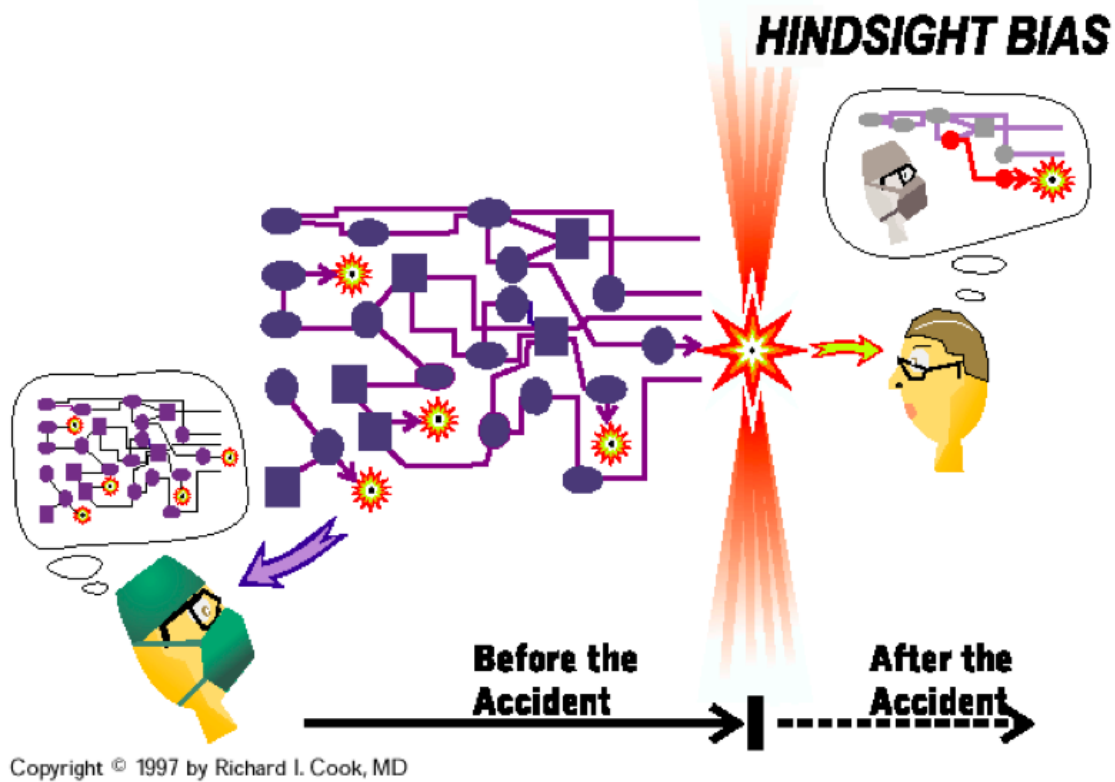
Accident investigation

The point is not to find where people went wrong

It is to understand why their assessments and actions made sense at the time



In hindsight



Against action - obvious
Pro action – not so obvious

The resilient team

- Does not take success in the past as a guarantee for future safety
- Keeps the discussion about risk alive
- Listens to all ideas and inputs
- Prepared to invest in safety
- Problem-solving is continuous, no "thematic vagabonding" or "cognitive fixation"
- Allows changes



Are we prepared to change?

“Without changing our patterns of thought, we will not be able to solve the problems we created with our current patterns of thought.”

Albert Einstein

Thank you!

