

# Principles of Error Management

## Human Error and Just Culture

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The FAA Safety Team (FAASTeam)



Federal Aviation  
Administration



**We have left undone those things  
whiche we aught to have done, and  
we have done those thinges whiche  
we aught not to have done.**

**Book of Common Prayer, 1559**

# The Four “Ps”

**Philosophy**

**Policy**

**Procedures**

**Practices**

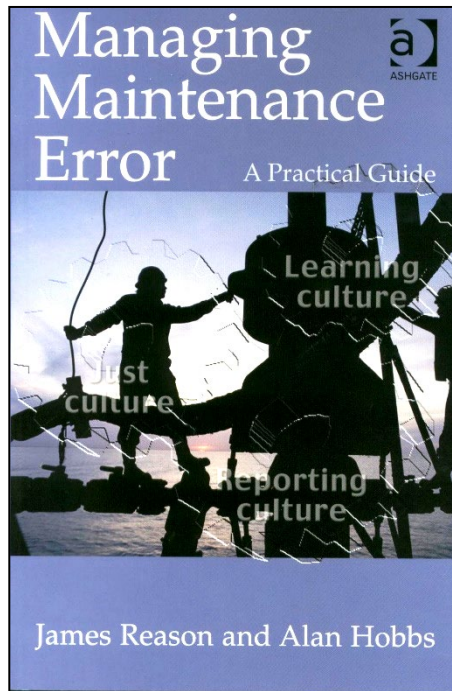




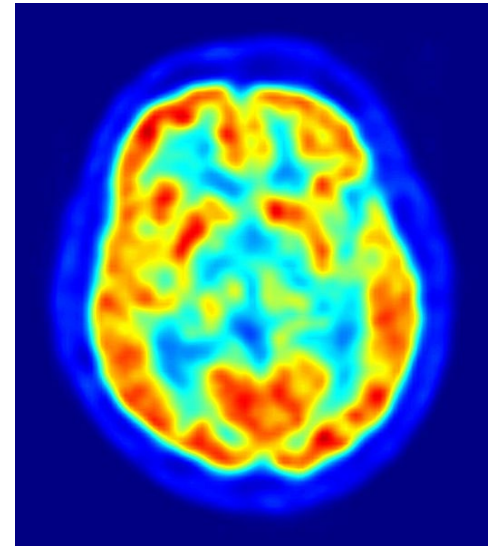
**“Aviation in itself is not inherently dangerous, but to a degree even greater than the sea is terribly unforgiving of any carelessness, incapacity, or neglect.”**

Capt. A.G. Lamplough, British Aviation Insurance Corp. 1930

# Human Error is Both Universal and Inevitable

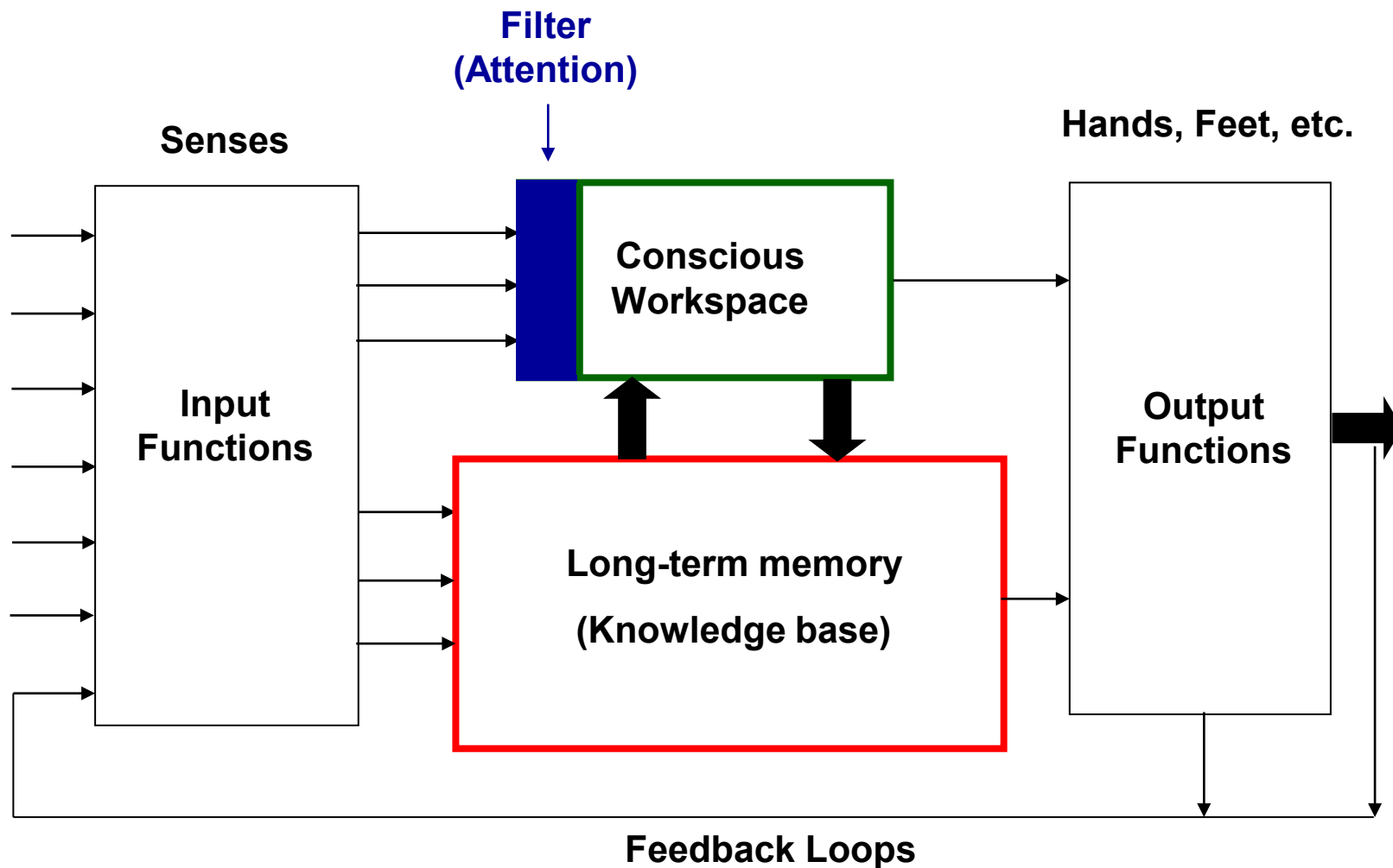


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## It is the Downside of Having a Brain

James Reason & Alan Hobbs (2003)



## A Simplified “Blueprint” of Mental Functioning

James Reason & Alan Hobbs (2003)

## Conscious Workspace

- General Problem Solver
- Limited Capacity
- Contents Available
- Sequential Processing
- Slow and Laborious
- Essential for new Tasks

**Trial and Error**

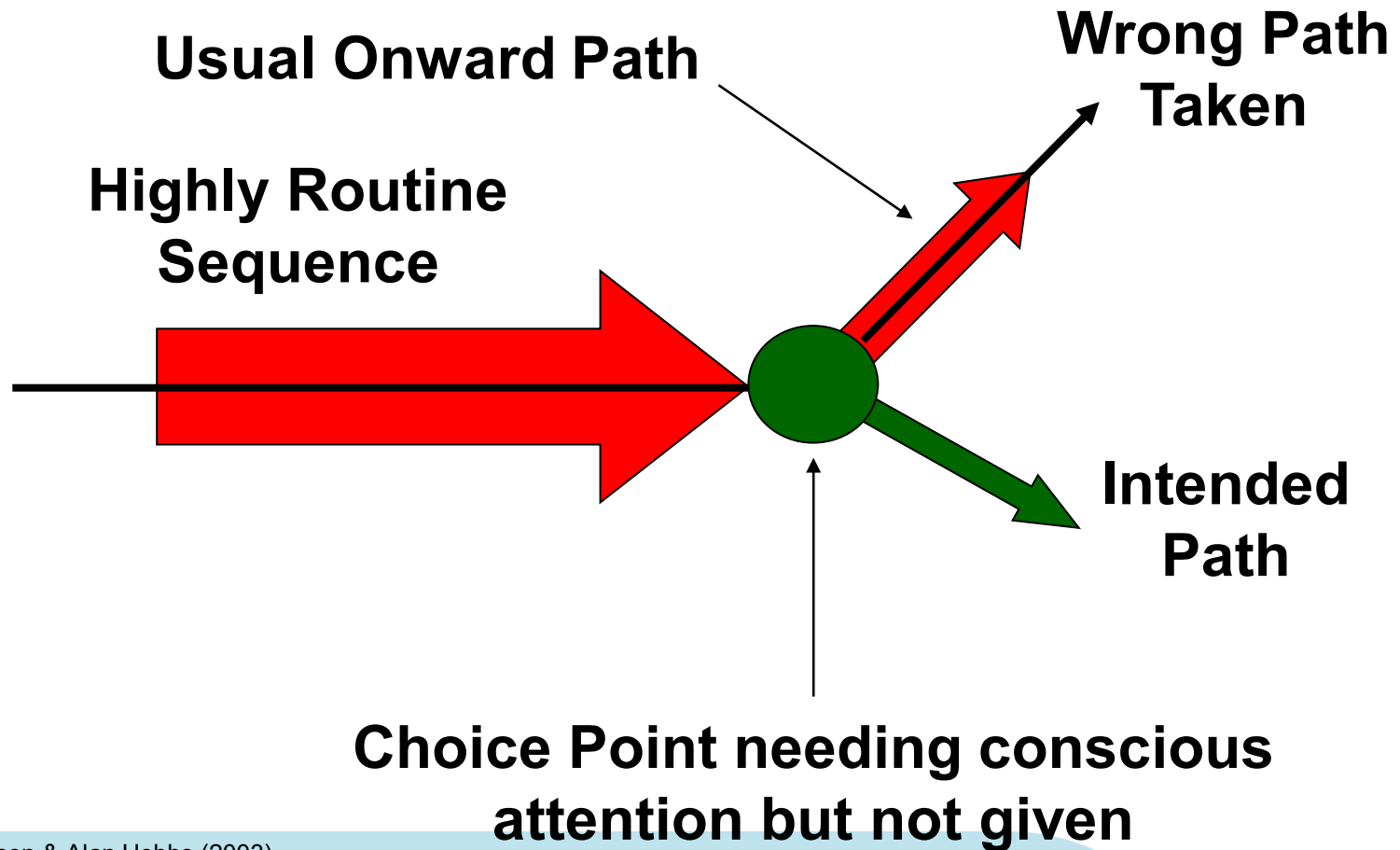
## Long-term Memory

- Vast Collection of Experts
- No Limits to Size or Duration
- Unconscious
- Parallel Processing
- Rapid and Effortless
- Handles Familiar Routines and Habits

**Programming**

James Reason & Alan Hobbs (2003)

# Skill Based Error

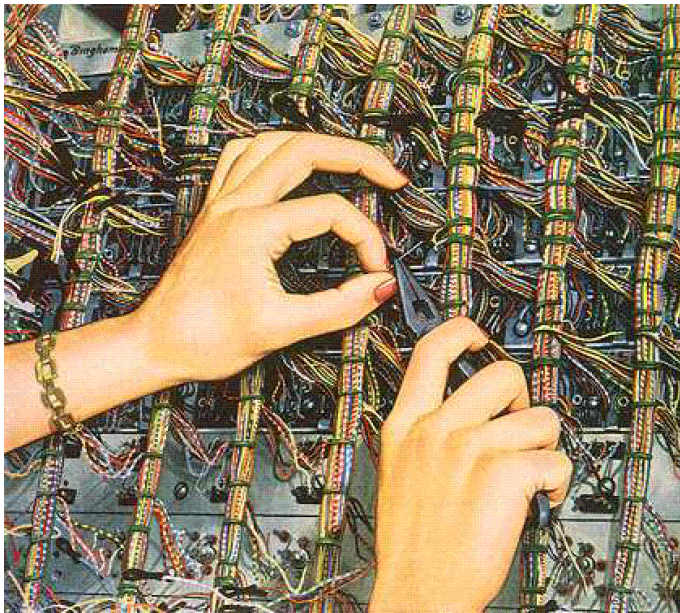


James Reason & Alan Hobbs (2003)



# Bad News

We are “hardwired”  
to make errors



James Reason & Alan Hobbs (2003)

# Good News

Errors are not  
intrinsically bad



# Increase Awareness      Manage

## Human Error + Unforgiving Workplace = Disaster



You cannot change the human condition,  
but you can change the conditions  
in which humans work.

James Reason & Alan Hobbs (2003)

# The Best People Can Make the Worst Mistakes

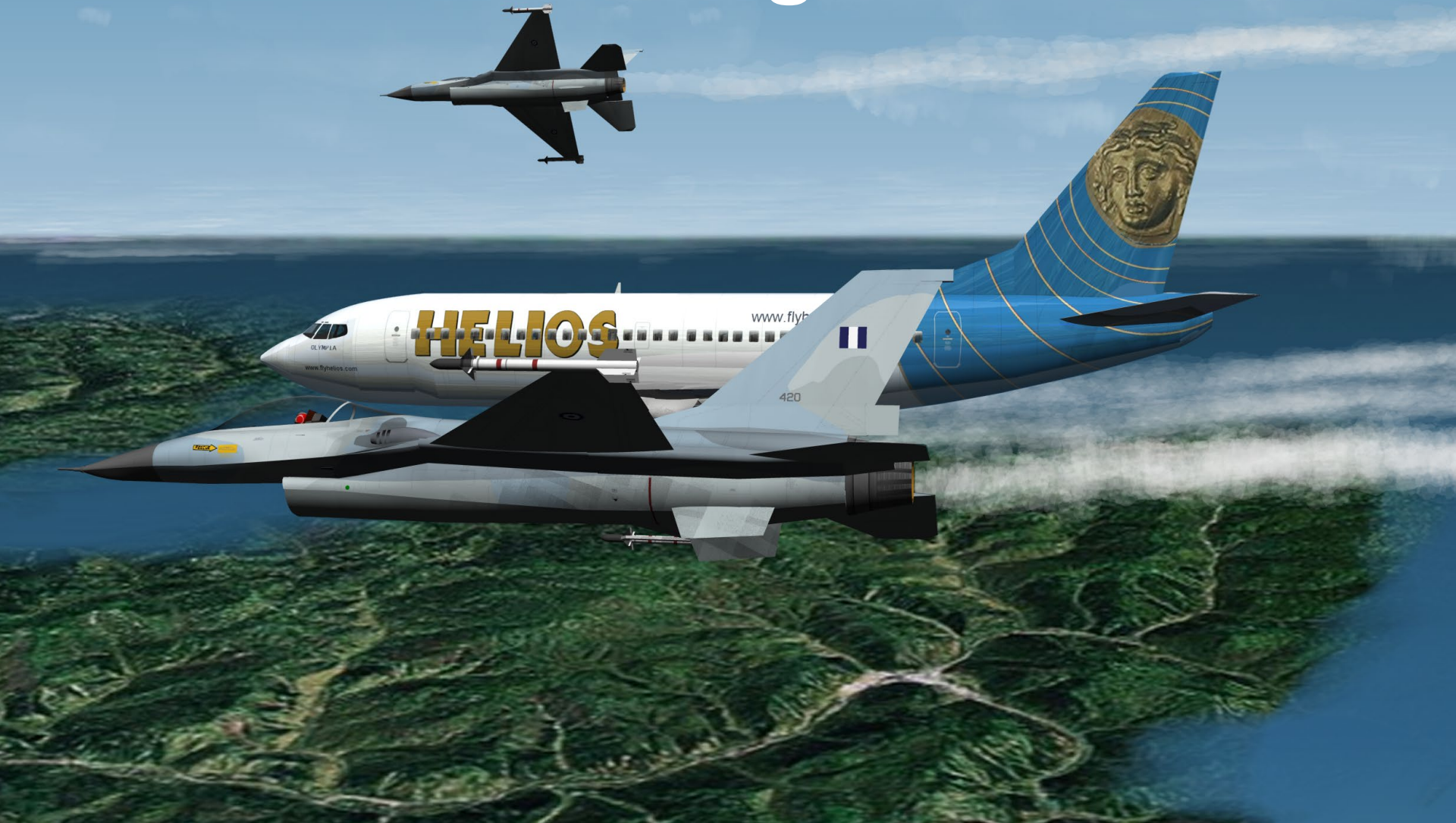
El Paso, Texas  
January 16, 2006



James Reason & Alan Hobbs (2003)



# Helios Flight 522



# Helios Flight 522

TV Remote



Boeing 737 Pressurization Control





# This technician's mistake would effect how many people?



**853 passengers and 20 crew members**

**A380** navigator



James Reason & Alan Hobbs (2003)  
**Managing Maintenance Error**



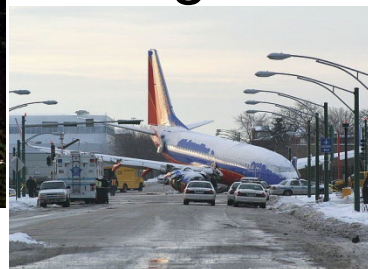
**Federal Aviation  
Administration**

# Many Errors Fall into Recurrent Patterns

Little Rock 6/1/1999



Chicago 12/8/2005



Cleveland 2/18/ 2007



Honduras 5/31/2008



Ottawa 2/17/2008



Jamaica 12/23/2009



James Reason & Alan Hobbs (2003)

# Person Model

- Name
- Blame
- Shame
- Retrain
- Write Another Procedure

Fire the Perpetrator  
Pilot/Technician

**We Ask Who?**

# System Model

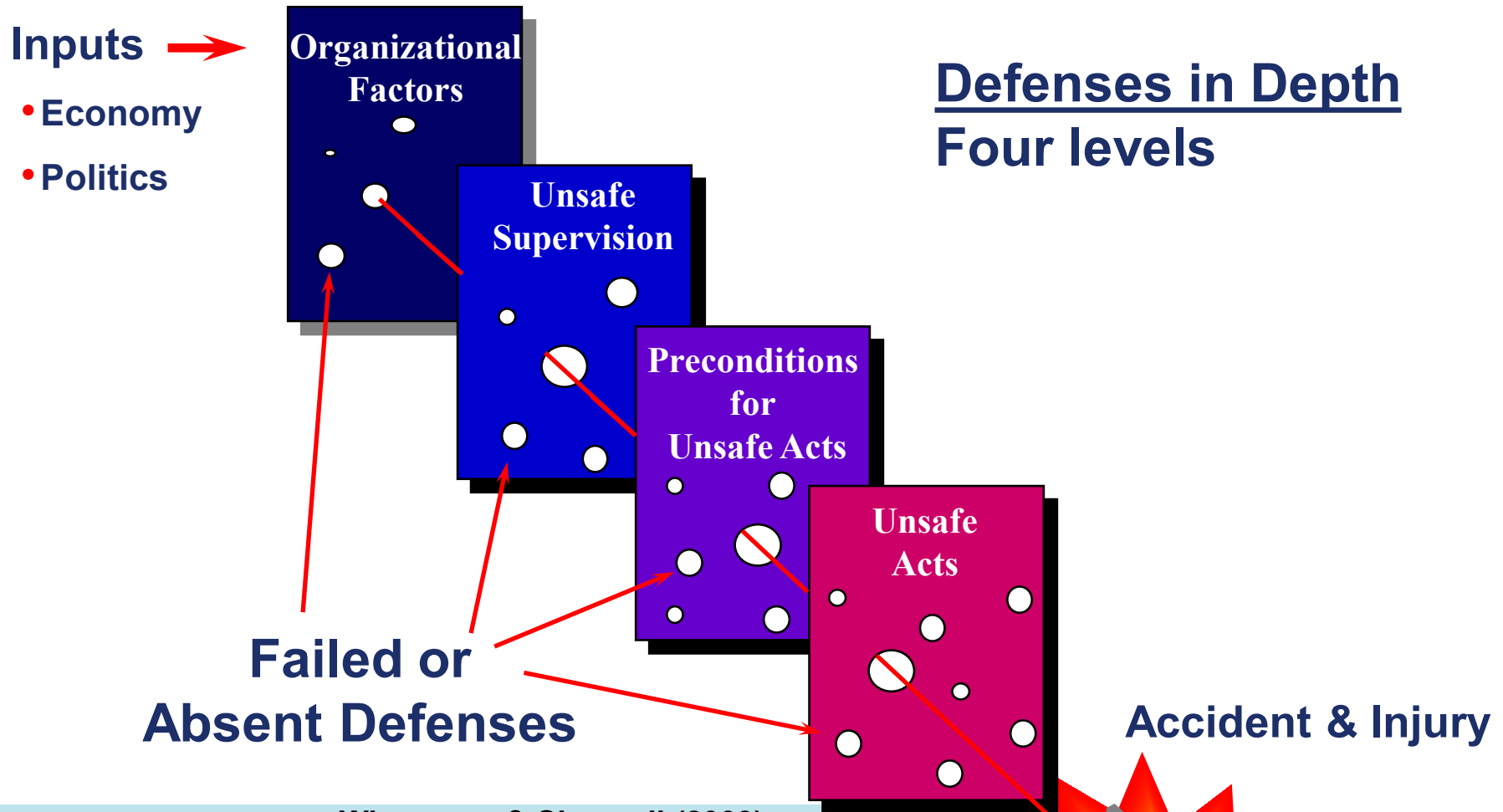
- Remedial Attention focused on the task and the work place
- Organization
- Supervision

**Managing the Manageable**

**We Ask Why?**

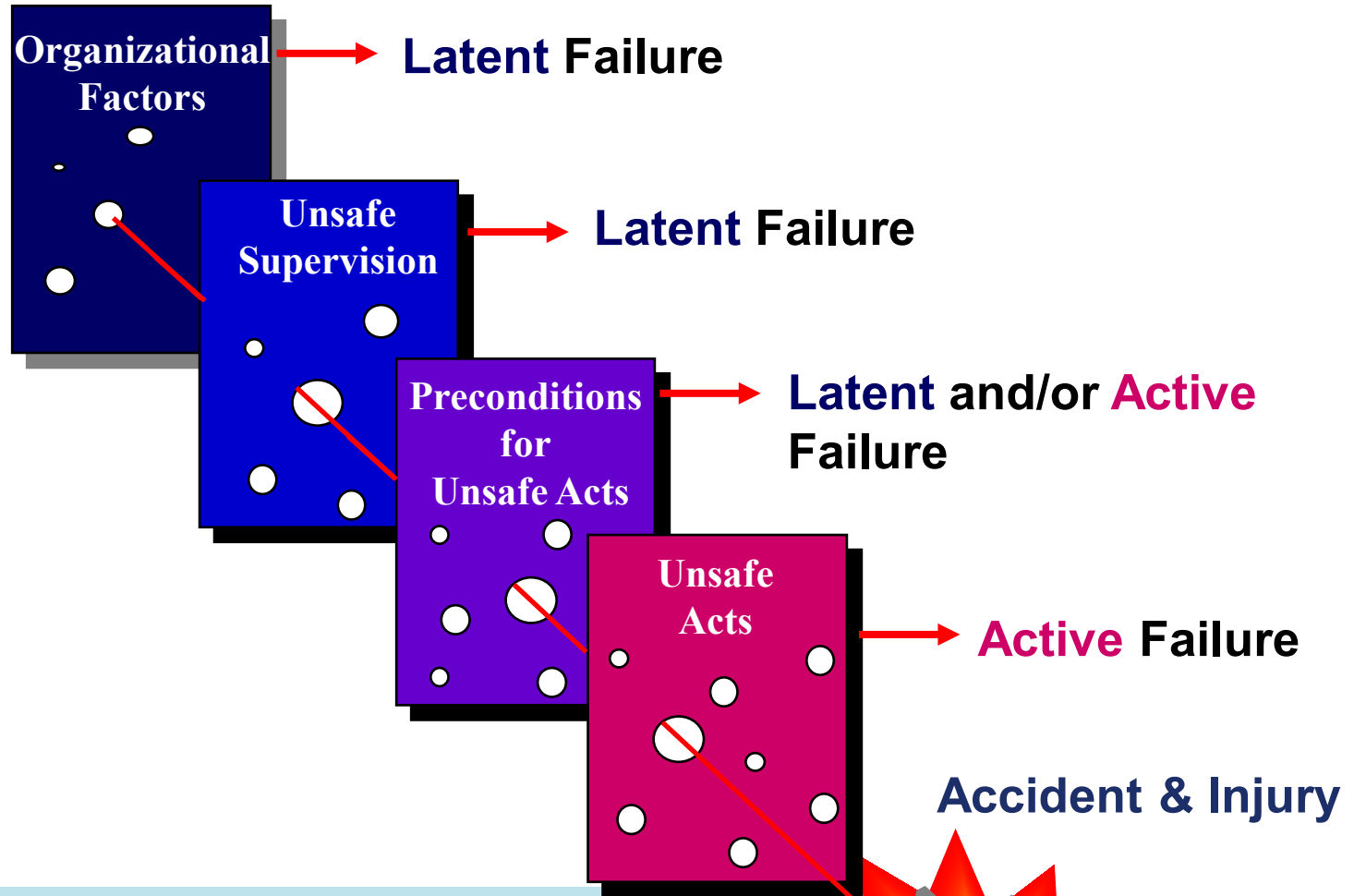
James Reason & Alan Hobbs (2003)

# “Swiss-cheese” Model of Human Error



Adapted from Reason (1990)      Wiegmann & Shappell (2003)

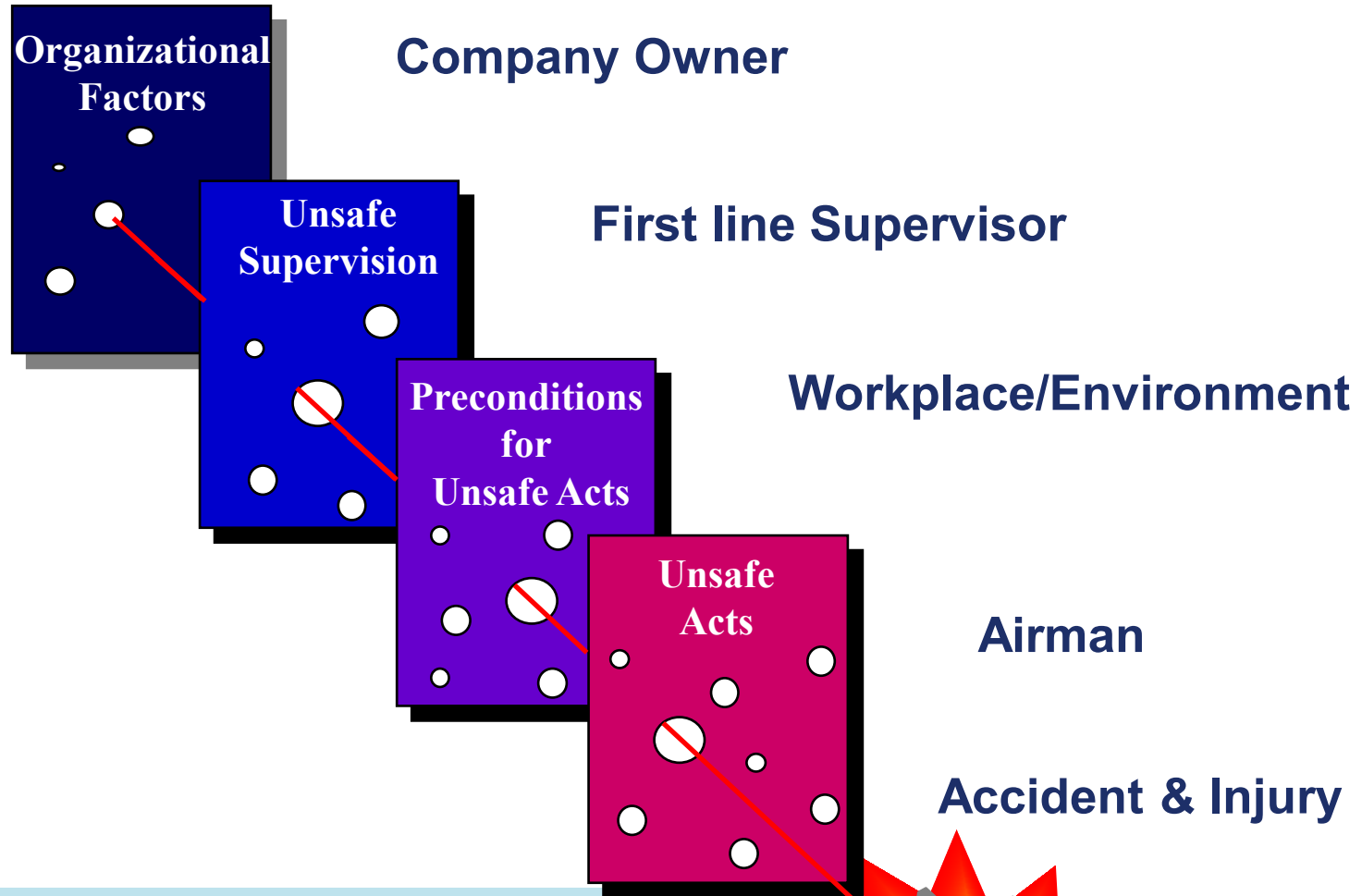
# Failures - Latent and Active



Adapted from Reason (1990)

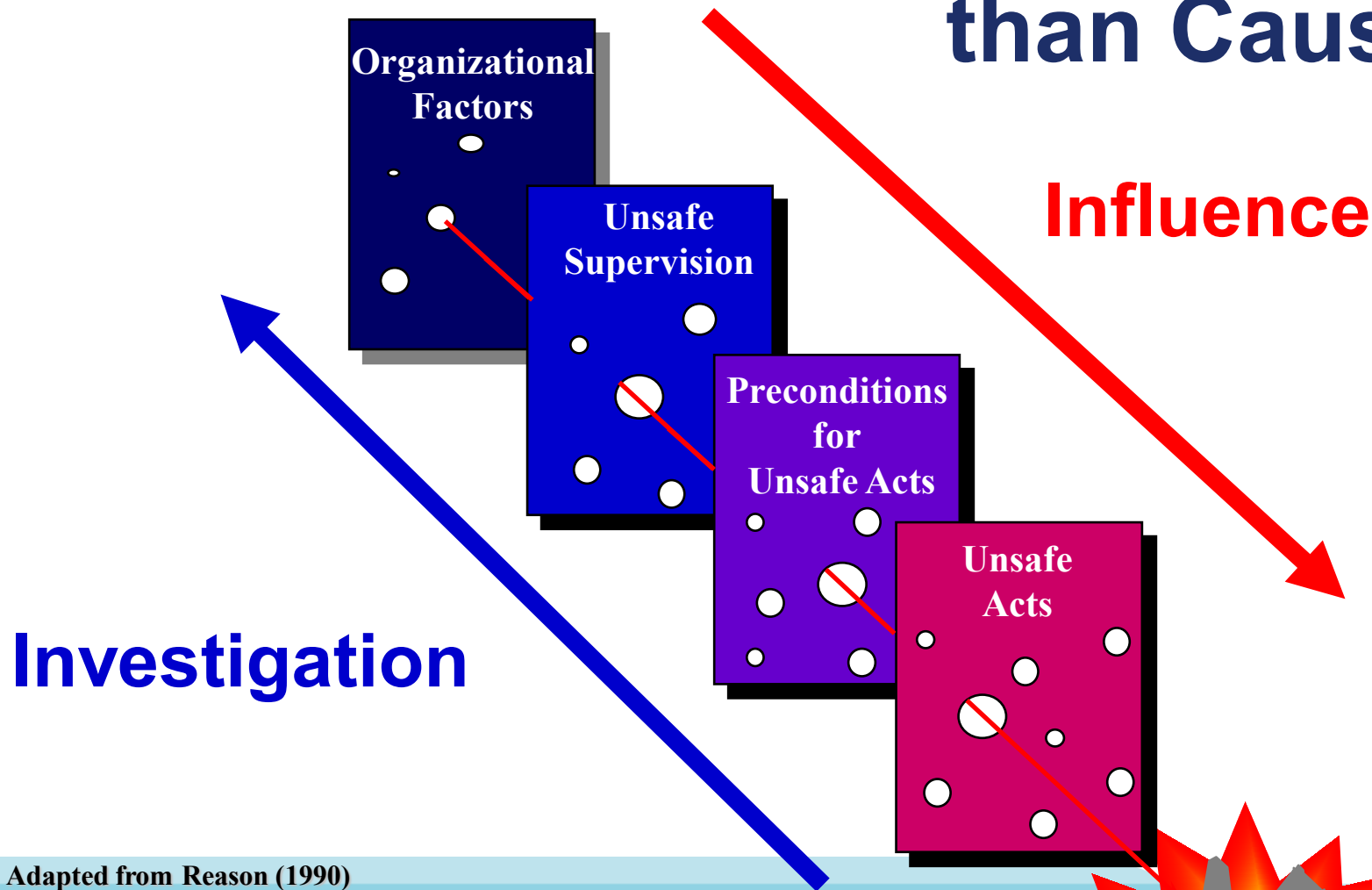


# System Population



Adapted from Reason (1990)

# Errors are Consequences Rather than Causes



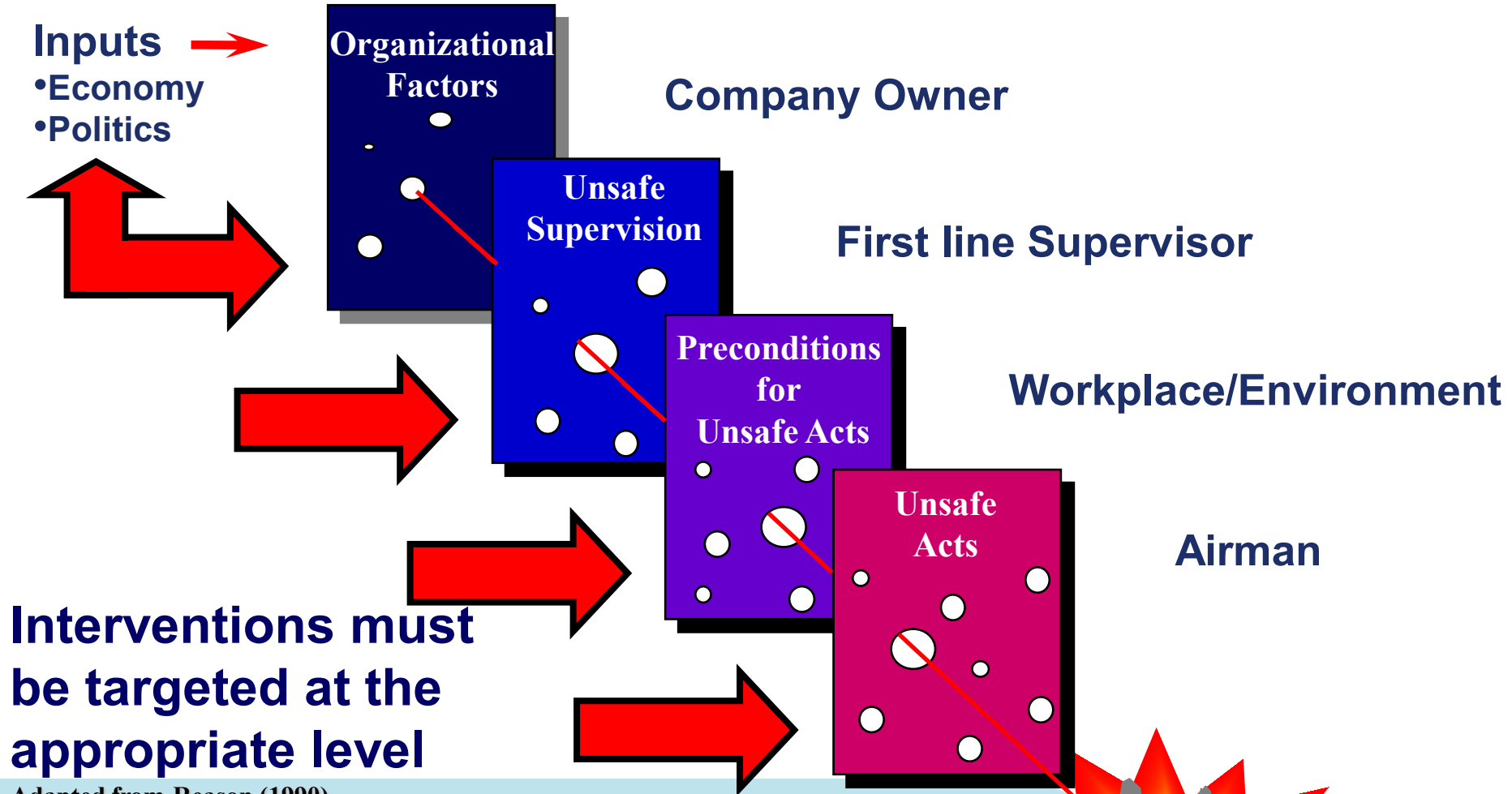
Adapted from Reason (1990)

# Safety significant errors can occur at all levels of the system

A diagram of the Swiss cheese model for error causation. It consists of four overlapping squares, each representing a different level of the system. The top square is light green and labeled 'Organizational Factors'. The second square is olive green and labeled 'Unsafe Supervision'. The third square is tan and labeled 'Preconditions for Unsafe Acts'. The bottom square is magenta and labeled 'Unsafe Acts'. Each square contains several small yellow circles, representing potential errors or hazards. A red diagonal line runs from the top-left corner of the top square to the bottom-right corner of the bottom square, passing through the centers of all four squares, symbolizing the path of a safety-critical error through all levels of the system.

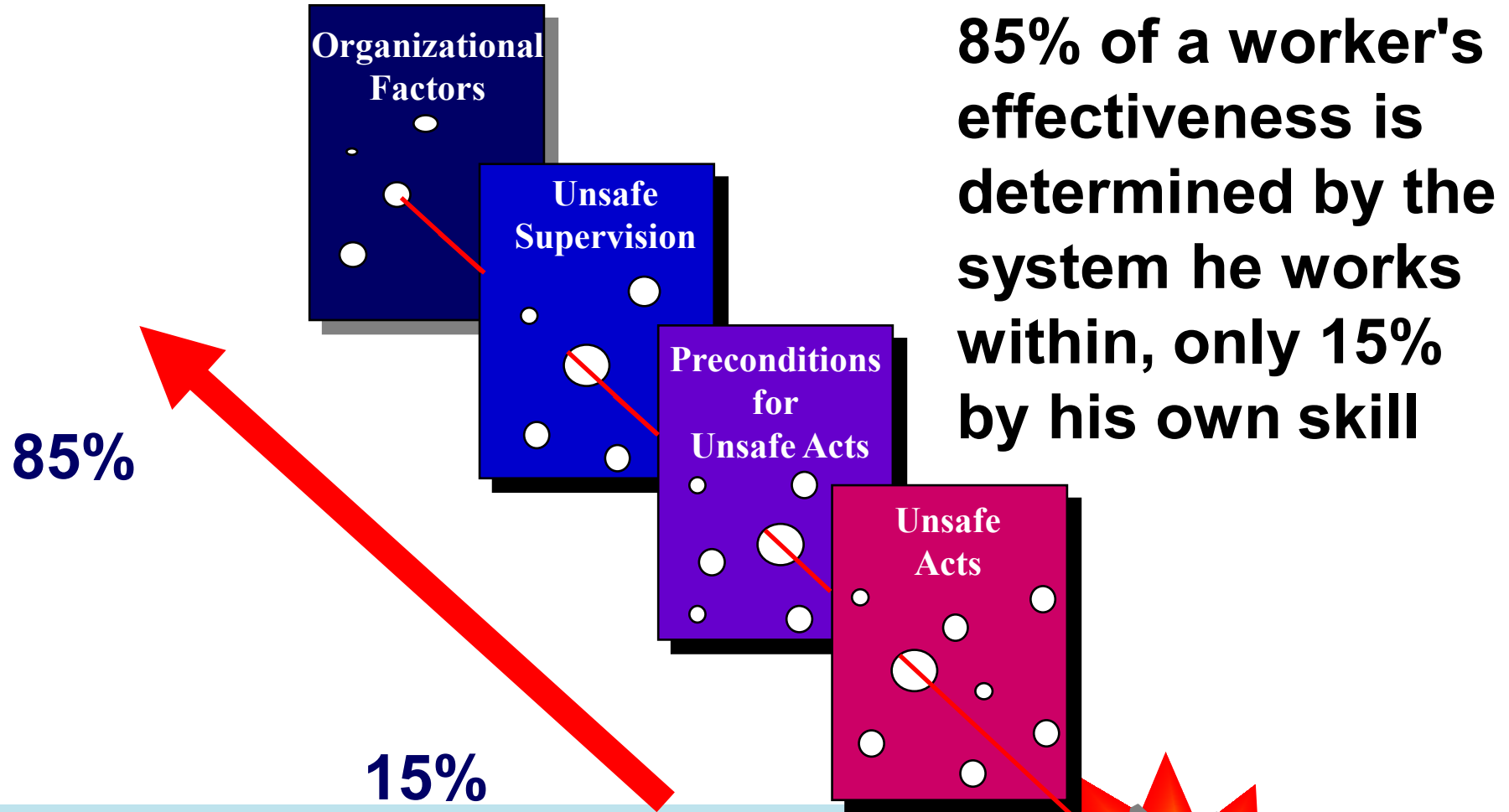
Adapted from Reason (1990)

# There is no one best way



Adapted from Reason (1990)

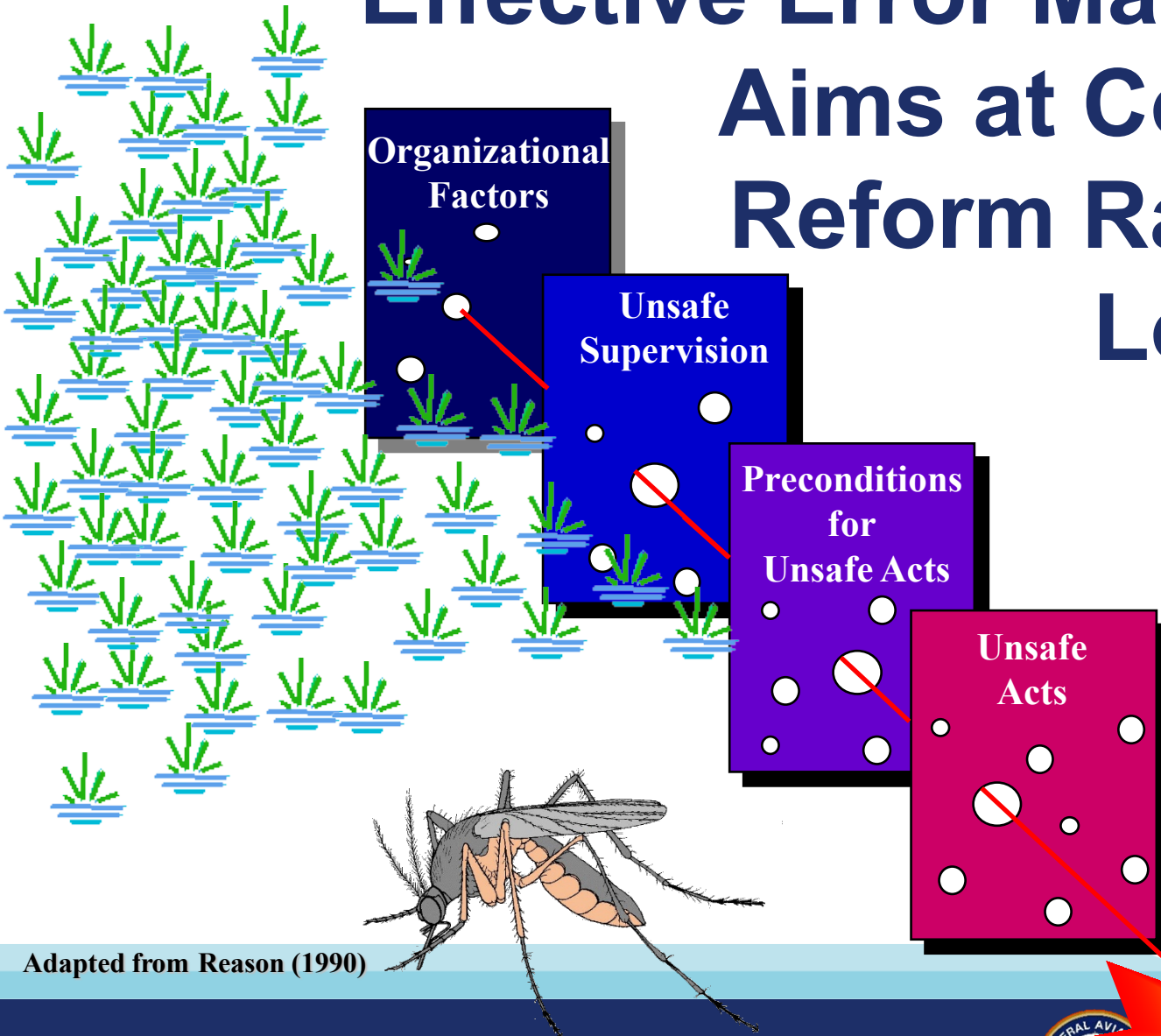
# W. Edwards Deming's 85/15 Rule



Adapted from Reason (1990)



# Effective Error Management Aims at Continuous Reform Rather than Local Fixes



Adapted from Reason (1990)

# Charlotte, North Carolina 2003

**On January 8, 2003, about 08:47 AM, a US Airways Express flight 5481, a Beechcraft 1900D, N233YV, crashed shortly after takeoff from runway 18R at Charlotte-Douglas International Airport, Charlotte, North Carolina.**





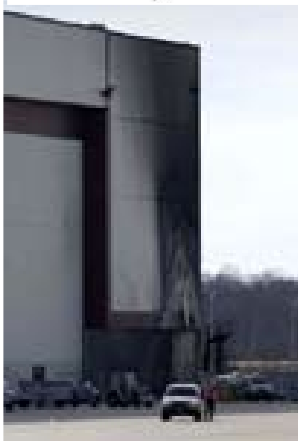
## Doomed path of Flight 5481

Flight 5481, a Beech 1900 twin-engine turboprop, had just lifted off Runway 18 when, according to witnesses, it banked to the left and into a corner of a hangar. Here is the itinerary Wednesday of US Airways Express flight 5481, operated by Air Midwest, Inc., a wholly owned subsidiary of Mesa Air Group:

- Departed Lynchburg, Va., 6:20 a.m. as Flight 5434; arrived Charlotte 7:20 a.m.
- Departed Charlotte 8:30 a.m. as Flight 5481; scheduled to arrive Greenville-Spartanburg 9:15 a.m.



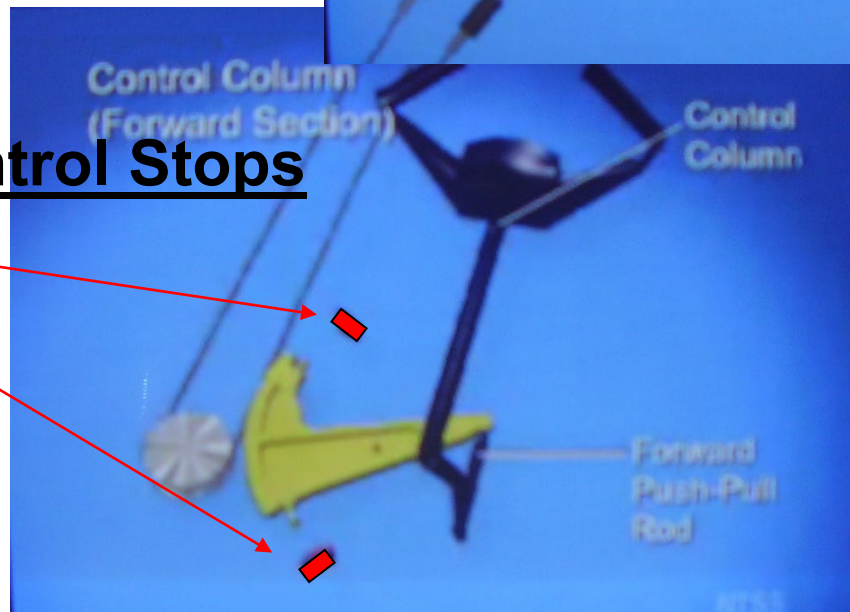
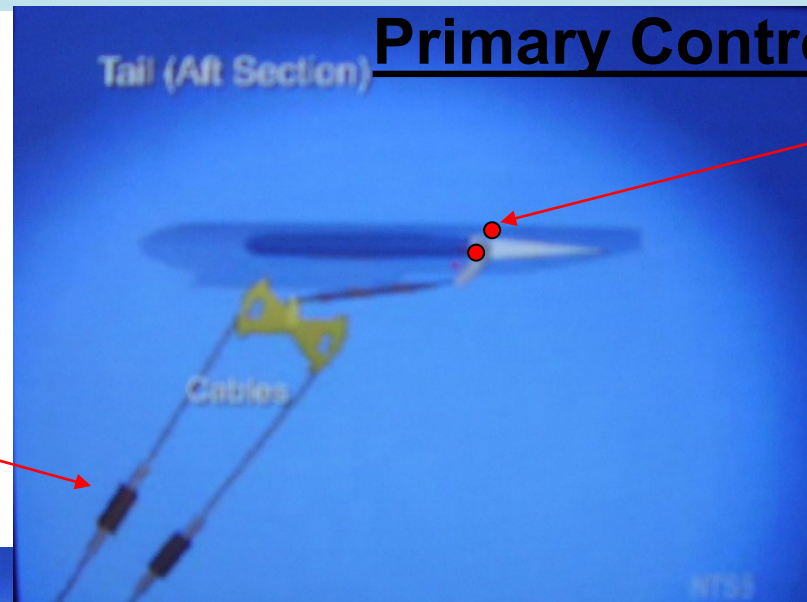
SOURCE: US Airways; Mesa Air



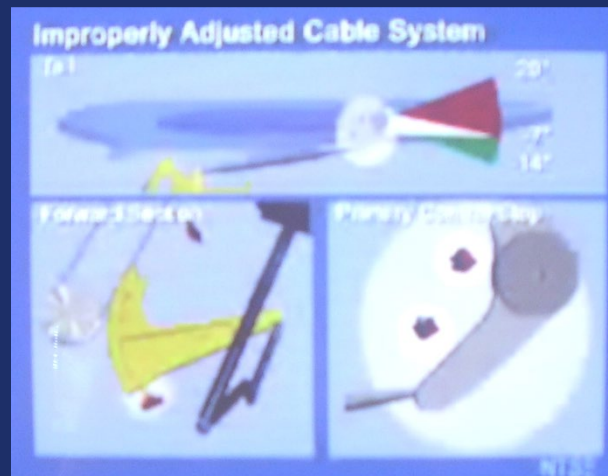
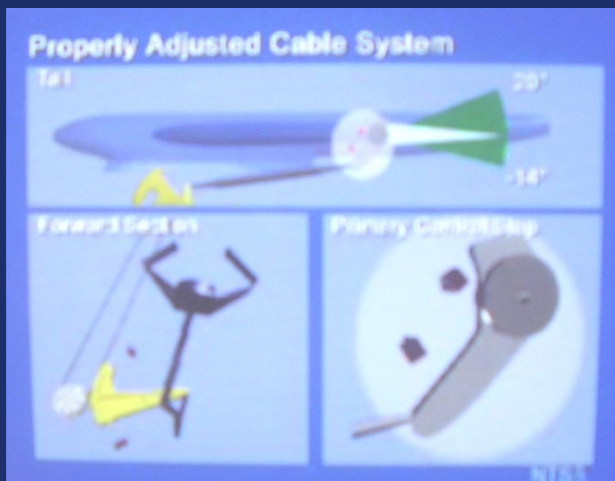
## Primary Control Stops

## Turnbuckles

## Secondary Control Stops









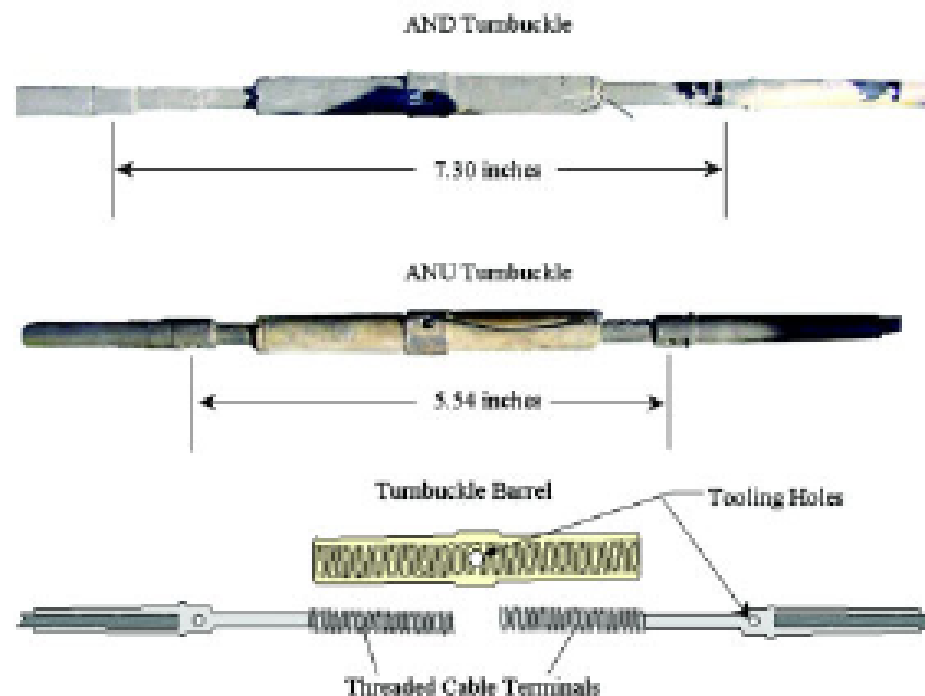


Figure 8. Turnbuckles as found in the wreckage.

The AND turnbuckle was extended 1.76 inches more than the ANU turnbuckle. After the accident, Air Midwest surveyed its entire fleet of 42 Beech 1900D airplanes, which represented 25 percent of the 164 Beech 1900D airplanes active in the North American fleet. Air Midwest data submitted to the Safety Board indicated that, on average, the AND turnbuckle was extended 0.04 inch less than the ANU turnbuckle.

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*“Insufficient training and supervision resulted in the mechanic making mistakes that led to the incorrect rigging and the restricted downward elevator travel.”*

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## **Crewmembers:**

### **Name**

Captain Katie Leslie  
First Officer Johnathan Gibbs

### **Passengers:**

### **Name**

Caitlin Albury  
Nicholas Albury  
Robin Albury  
Sreenivasa Badam  
Mark Congdon  
Keith Coyner  
Forrest Stephen Demartino  
Sylvain Dubois  
Richard E. Fonte  
Gary Gezzer  
Steven J. Krassas  
Richard R. Lyons  
Ima Pearson  
Christiana Shepherd  
Joseph M. Spiak  
Ganeshram Sreenivasan  
Paul Stidham,  
Michael Otto Sullivan  
Ralph Sylvia

### **Age**

26  
28

### **Domicile (Base)**

Arlington, Texas  
Scotts Valley, California

### **Age**

13  
21  
38  
24

### **Hometown**

Marsh Harbor, Bahamas  
Marsh Harbor, Bahamas  
Marsh Harbor, Bahamas  
India  
Baltimore, Maryland  
Coral Springs, Florida  
Dayton, Ohio  
Fort Lauderdale, Florida  
Jacksonville, North Carolina  
Fort Lauderdale, Florida  
Richmond, Virginia  
Lynnfield, Massachusetts  
Las Vegas, Nevada  
Boston, Massachusetts  
Boston, Massachusetts  
India  
Columbia, Maryland  
Philadelphia, Pennsylvania  
Ashland, Virginia



Beechcraft 1900D Maintenance Program Manual  
SIXTH DETAILED INSPECTION PROCEDURES CHECKLIST

DATE: 06/25/00  
PAGE: A-119

#	ZONE	DESCRIPTION	STAMP
AFT FUSELAGE AND EMPENNAGE			
1	280 281 311 312 330 340 320	SKIN - inspect skin for condition and loose or missing rivets. If damage is found, check adjacent structure.	Mech AM 714 Insp DI 701
2		STRUCTURE - Check for cracks, loose or missing rivets and concealed damage.	Mech AM 714 Insp DI 701
3	181 311 312	FLIGHT CONTROL COMPONENTS, CABLES AND PULLEYS - inspect the control system components (pushrods, turnbuckles, and fittings, castings, etc for bulges, splits, bends or cracks.) Check control cables, pulleys and associated equipment for condition, attachment, alignment, clearance, and proper operation. Inspect cables for broken strands or evidence of corrosion per "BE Chapter 23-04-00." Check cable tension per "BE Chapter 27." Temperature <u>55</u> degrees F. 3/16" Elevator Cable Tension: UP <u>57</u> DOWN <u>62</u> 1/16" Elevator Tab Cable Tension: <u>20</u> 3/16" Rudder Cable Tension: LT <u>75</u> RT <u>75</u> 1/16" Rudder Tab Cable Tension: <u>20</u>	Mech AM 704 Insp DI 701 Mech AM 704 Insp DI 701 Mech AM 704 Insp DI 701
4	311 312	FLUDDING - inspect plumbing for condition and attachment.	Mech AM 734 Insp DI 701

62  
52  
119

Figure 1. Detail six work card at the time of the accident.

FORM 8160-1  
DATE 03/06/03  
AIRCRAFT MAINTENANCE RECORD  
AIRCRAFT #: 02230  
MODEL: BEECHCRAFT 1900D  
ACFT F.N.M.: 22632  
ACFT T.Y.:  
ACFT CYCLES:  
NATURE OF ACTION

13 Re-ignite main R-R igniters on R1 Eng  
TAN 8150 74-00-00 0904  
ADT-21  
VT/SN: @ CH 34055 DATE: 1-6-03 MECH: AM 708 INSP: N/A

14 LEFT MAIN FUEL FILTER REMOVED  
N/A FUEL FILTER CASE REMOVED  
REPLACED 180 8150 27-20-10  
LEAK OPS ON N/A  
VT/SN: @ 031455025 @ 4120517-232 DATE: 01-05-03 MECH: AM 708 INSP: DI 701

15 Drill SLT bleed REMOVED Drill SLT  
TRANSCIBED TO 201  
24163  
VT/SN: @ N/A 1533435 DATE: 1-16-03 MECH: AM 714 INSP: N/A

16 Elevator rig pin installed REMOVED Elevator Rig Pin  
FAN 8150 27-20-00  
RIT  
VT/SN: DATE: 1-16-03 MECH: AM 714 INSP: DI 701

17 Rudder rig pin installed REMOVED Rudder Rig Pin  
FAN 8150 27-20-00  
RIT  
VT/SN: DATE: 1-16-03 MECH: AM 714 INSP: DI 701

18 elevator cable has been Adjusted elevator cable  
Tension per 8150 27-30-02  
RIT  
VT/SN: @ 4120517-2 DATE: 1-16-03 MECH: AM 714 INSP: DI 701

Figure 2. Aircraft maintenance record of nonroutine items for January 6, 2003, at the Huntington, West Virginia, maintenance station.

# So, what do we do to these guys?

**A. Revoke their certificates**

**B. Fire them**

 **C. Nothing**

**D. Retrain them**

**Console people who  
make mistakes**

**Coach people who  
exhibit risky behavior**

**Discipline reckless  
people**

**Workcard was not specific**

**Maintenance Manual lacked the procedure to accomplish the workcard task**

**Rigging Procedure did not include a functional check**

**Lack of experience**

---

*“Insufficient training and supervision resulted in the mechanic making mistakes that led to the incorrect rigging and the restricted downward elevator travel.”*

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**Lack of training**

**Lack of Supervision**

**Fatigue/Shiftwork**

**Aircraft was aft loaded**

**FAA's average weight is about 15 lbs. light**

**MX training is not FAA accepted**

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*“Insufficient training and supervision resulted in the mechanic making mistakes that led to the incorrect rigging and the restricted downward elevator travel.”*

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# People cannot easily avoid those actions they did not intend to commit



James Reason & Alan Hobbs (2003)

# Bad Apple Theory

~~Old view~~

System is  
basically safe

Erratic people  
undermine it

Need to be:

- Controlled
- Punished
- Exiled



Current

New view

System is not basically safe

People are well meaning

Human error is

Systematically connected  
to features of people's:

- Tools
- Tasks
- Organization
- Environment

(Sidney Dekker 2006)

# Accountability

## Backward

Find the bad apple

Punish

Dismiss

Liability

Prosecution

Suspend/Revoke

## Deflect Blame

## Forward

Fix the problem

Clean up the mess

Learn

Change

Invest Resources

## Build trust



Sidney Dekker (2007)



# TEAMWORK

**Error management is about making good people excellent**



# Safety Management Systems (SMS) Coming to General Aviation

The Certificate Holder's documented commitment to safety, which defines its safety objectives and the accountabilities and responsibilities of its employees regarding safety.

describing the system, identifying the hazards, and analyzing, assessing, and controlling safety risk.



Processes within the SMS that function systematically to ensure the performance and effectiveness of safety risk controls and that the organization meets or exceeds its safety objectives through collecting, analyzing, and assessing information.

communicating safety information to support an organization's safety performance and safety culture.

<https://www.faa.gov/about/initiatives/gasafetyoutreach>



Federal Aviation  
Administration

# Questions?



# Training and Peace of Mind

- Technical Training
- Safety Related Training
- Document in My AMT

