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REGIONAL FOCUS

Accident and Incident Investigation for the Latin America and Caribbean Region

Wednesday 21, 28 July and 4 August 2021 08:00 – 09:30 EDT





Mr. Shayne Campbell

Safety Programme Manager

CANSO





Mr. Jason Demagalski

Human Performance Team Manager

FAA



Reflection

JUST DO WHAT You're supposed to

VERONICA ROTH

"It is unacceptable to conclude an investigation of an event with the statement: 'If only the flight crew or maintenance crew had done what they were supposed to do'"

Phil Condit, Former CEO, Boeing 1994

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Health & Wellness

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Human Factors



Do we have the right people

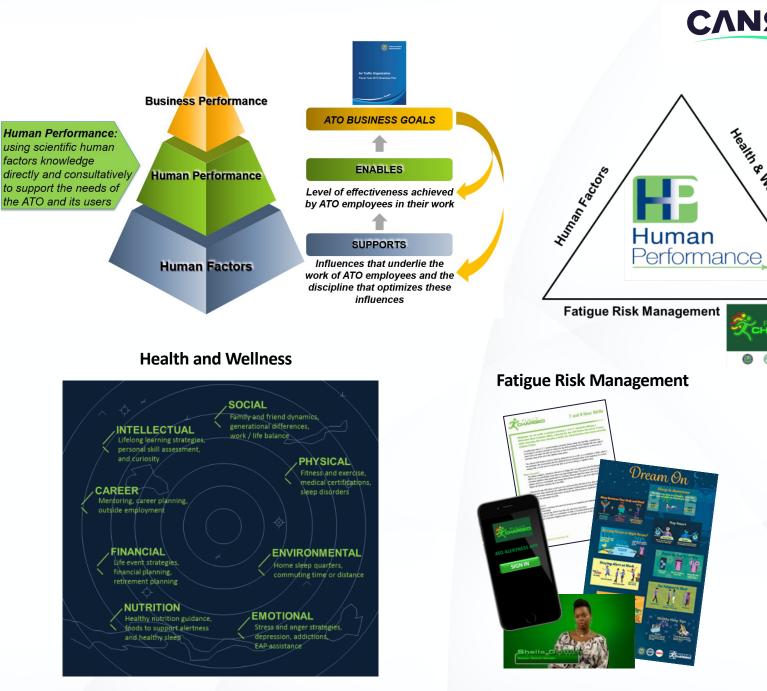
> with the right information

and the right tools

> with the right motivation

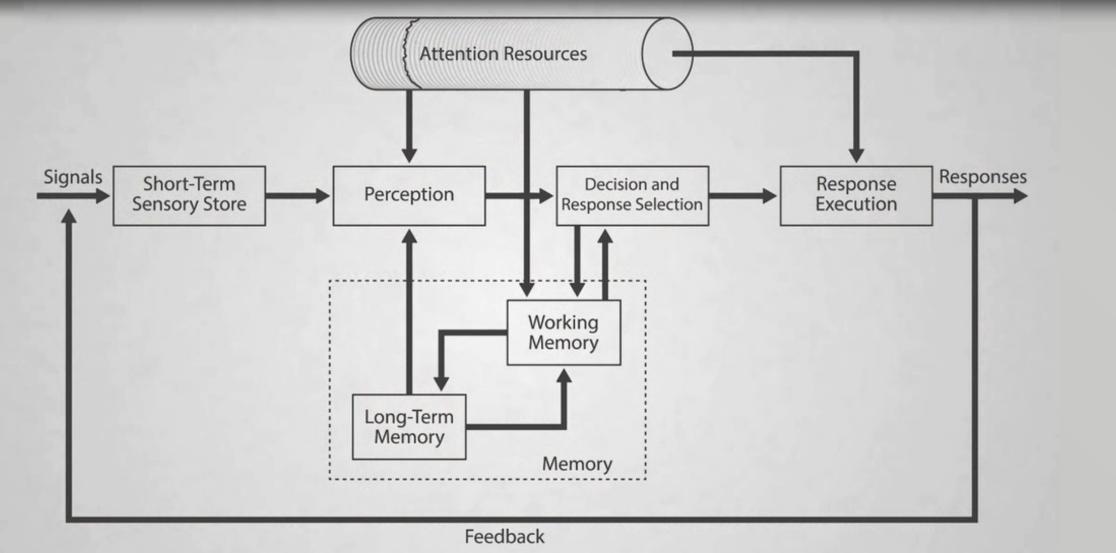
in the right roles and the right skills

and the right role models to do the job?



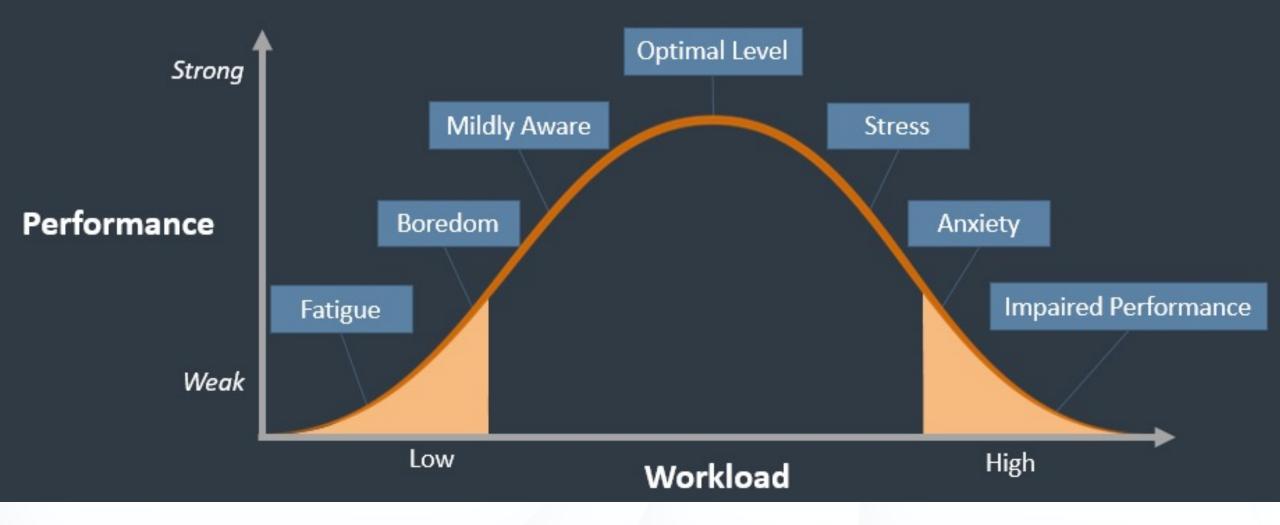


Human Information Processing





Effects of Workload on Performance





Memory

- Memory is necessary to:
 - Perceive what our senses detect

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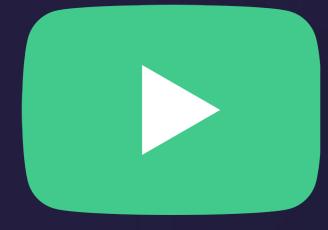
- Help us select the right decision
- Implement actions
- The way you store information in memory influences how well, and how quickly, you can remember it later
- One type of memory is time and capacity limited



Long Term Memory

- Long term memory (LTM) has an almost unlimited capacity and has a time-frame from a few seconds to several years (perhaps permanently).
- Episodic LTM relates to personal narratives such as where you went on holiday last year, or what you had for breakfast.
- Semantic LTM holds general, factual information about the world, including concepts, rules and procedures, and language.









Cognitive Biases

Expectation Bias	Confirmation Bias	Automation Bias
Tendency to perceive what we expect to perceive	Tendency to search for information that confirms your preconceptions	Tendency to make errors when decisions are handled by automated aids
You expect a pilot to repeat back the altitude you just provided "Climb and maintain 1500" The pilot actually repeats back a different altitude "Roger, climb and maintain 1900"	You tell your supervisor all runways are clear, but he asks you to scan again You know the runways are clear, but you do the scan anyway and fail to see a maintenance truck moving onto the runway	Omission errors occur when you don't notice when the automation failed (e.g., TCAS does not alert you to a conflict) Commission errors occur when you don't notice an active mistake by the automation (e.g.,TCAS incorrectly alerts a conflict and you respond without verifying the conflict)
But what you perceive is 1500, not 1900		



Human Error

• We all make errors of different kinds

- An unintentional action
- An unintentional decision
- A mistake in processing information
- A lapse in situation awareness
- A miscue due to cognitive interruption
- Error is not intentional
- Errors often result from poor system design, procedures, or insufficient training



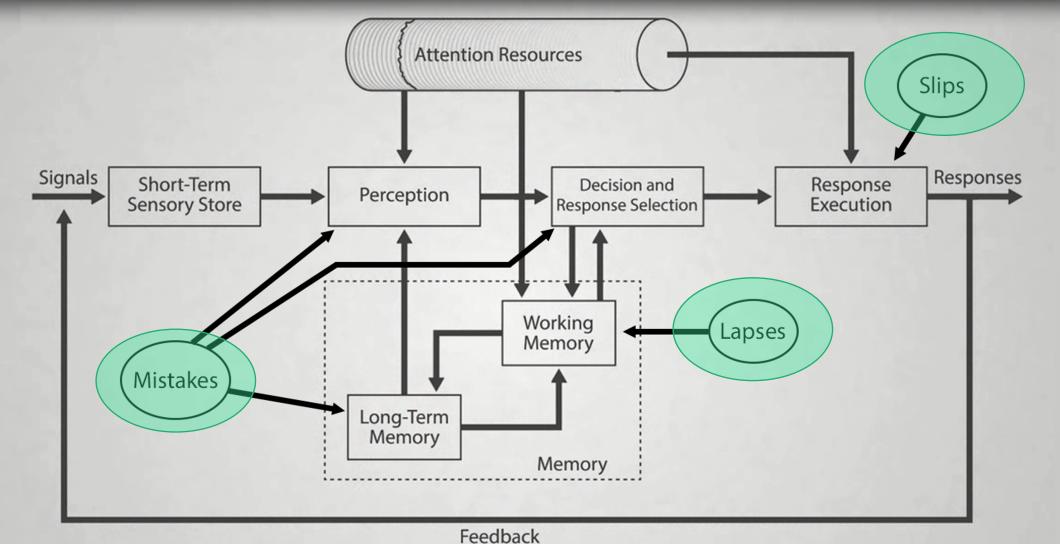


Errors are consequences not causes... Discovering an error is the beginning of a search for causes, not the end. Only by understanding the circumstances ... can we hope to limit the chances of their recurrence.

-James Reason



Human Information Processing



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AT 120 DEGREES

Why Do We	Make
Internal Causes	External Causes
Communication Complacency Lack of knowledge Distraction Lack of teamwork Fatigue Competence Recency	 Poor environmental conditions Inadequate human engineering design Inadequate training Poor supervision Technological changes Task or procedure changes
Incident involvement Social pressure / Norms Workload Lack of assertiveness Stress Assumptions Inadequate workspace or layout	i think they meant the date

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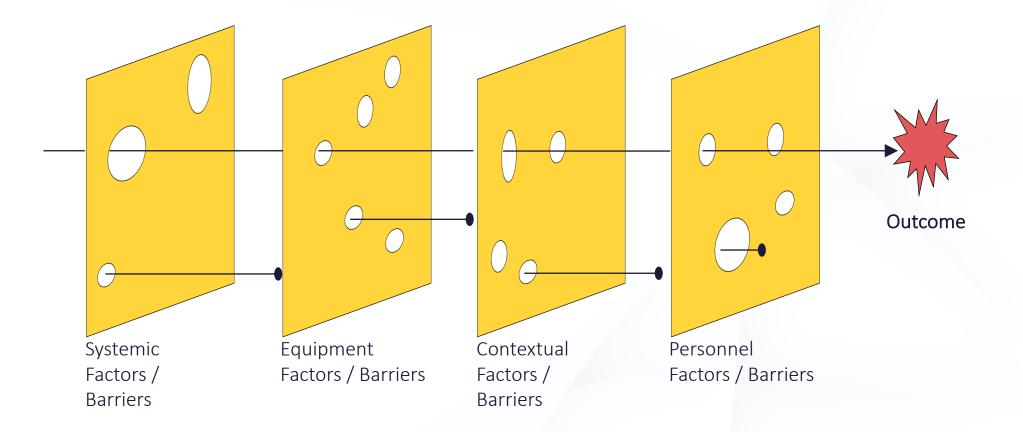
Fundamental Attribution Error:

Estimating the Influence of Situations on Behavior

	Failures	Successes		
Other people	They are dumb, incompetent	They got lucky!		
Ourselves	We were unlucky!	We are smart, competent		



Reason's Swiss-Cheese Model





Human Factors Checklist

Feggetter, 1982

Cognitive System

- 1 Human Information Processing System
 - Senses
 - Perception
 - Attention
 - Memory
 - Decision
 - Action
 - Monitoring
 - Feedback
- 2 Visual Illusions

- 3 False Hypothesis
- 4 Habits
- 5 Motivation
- 6 Training
- 7 Personality
- 8 Fear (Military)
- **Social System**
- 9 Social Pressure
- 10 Role
- 11 Life Stresses



Human Factors Checklist Continued Feggetter, 1982

•12 Physical Stress

- Physical Condition
- State of Nutrition
- Drugs
- Smoking
- Alcohol
- Fatigue
- Sleep

•14 Policy and Procedures

- Normal
- Non-normal

•13 Environmental Stress

- Altitude
- Speed and Motion
- Ambient light
- Glare
- Disorientation
- Temperature
- Lighting Levels
- Vibration

•15 Ergonomics Aspects

- Design of Controls
- Design of Displays
- Anthropometrics
- Presentation of Material



Willful Violations

SPEED

LIMIT

YOUR SPEED

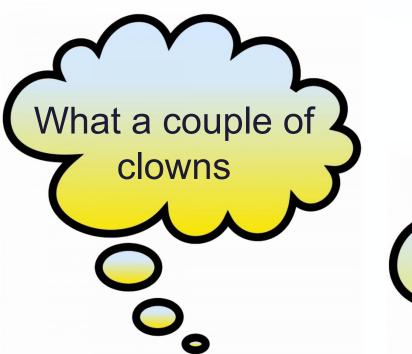
- Willful and knowing disregard of the rules, regulations, policies, or procedures
- Deliberate intent and motivation
- Bending of the rulesAdaptations







Signs of Potentially Biased Thinking by Investigators



That was a stupid decision

They should have seen that coming a mile away



Investigator Biases

 Hindsight bias: Knowing the outcome of an event has an influence on the way the analysis is done.

 Attribution bias: A tendency to infer causes of behaviours (e.g., to link an operator's error to an operator's incompetence).

- Frequency bias: to over (or under) estimate the probability of occurrence of a particular event.
- -Selectivity bias: to ignore those facts which do not quite fit the pattern expected.
- -Group conformity: to agree with the majority decisions in the group of investigators



Outcome Bias

Our evaluations of others' decisions are disproportionately influenced by outcome

- Many decisions are sub-optimal, but...
- Sometimes a bad decision works out and
- Sometimes a good decision leads to disaster

Issues with Current and Future State Operational Levels



	Normal	Draw Down Posture	Near-Term Ramp Up	Long-Term Ramp Up
Traffic Levels & Complexity	 Normal traffic levels Normal complexity levels Normal GA/commercial mix 	 Reduced levels Reduced complexity Flipped GA/commercial mix 	 Ramp up in traffic levels Relative complexity increase Increased commercial 	 Slow return to increased traffic levels and complexity Increased commercial
Facility Staffing Levels	 Normal/full op staffing Normal Team Resource Mgmt (TRM) mix 	 Lower op staffing levels required Large combined sectors Different TRM mix 	 Increase in op staffing levels Combined sectors Return to some previous TRM mix 	 Full op staffing levels Return to normal TRM mix
Work Schedules	 Rotating five day schedule Rotating six day schedule 	 Rotating, five in facility and ten out of facility 	 Rotating, five in facility and five out of facility 	 Rotating five day schedule Rotating six day schedule
Safety Risk Mgmt	 Known hazards, managed risks Safety assurance Image Reg Reg Reg Reg Reg Reg Reg Reg Reg R	 Known hazards, managed risks New hazards, new risks New mitigations 	 Known hazards, managed risks New hazards, new risks New mitigations 	 Known hazards, managed risks New hazards, new risks New mitigations
Controller Performance	 High cognitive engagement High human performance 	 Lower engagement Different teams Complacency Skill automation loss Slips, lapses Lifestyle changes 	 Increasing cognitive engagement Skill/learning degradation Lifestyle changes Fatigue 	 High cognitive engagement High human performance New habits Proficiency/currency drift



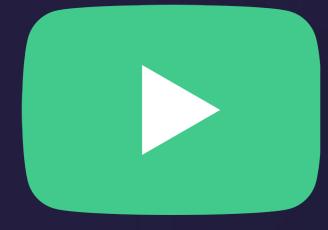
Human Factors Analysis of Significant Event



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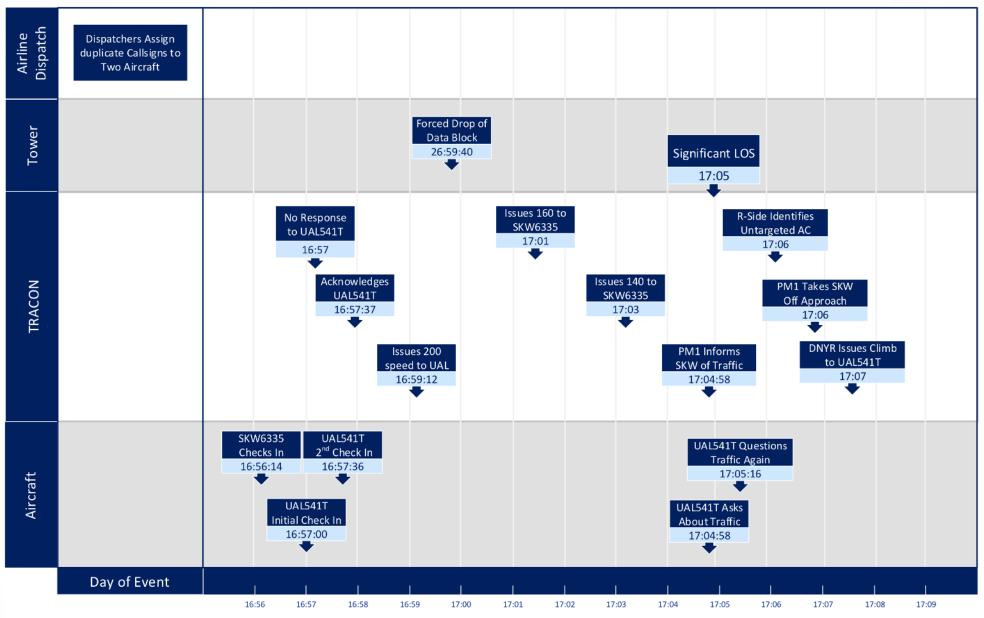








Factual Event Timeline

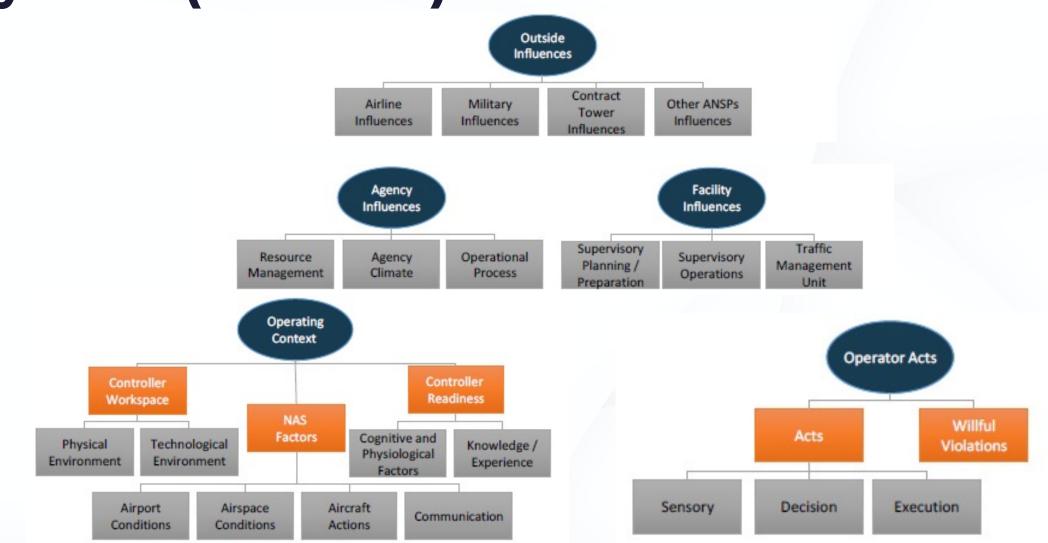


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Air Traffic Analysis and Classification System (AirTracs)

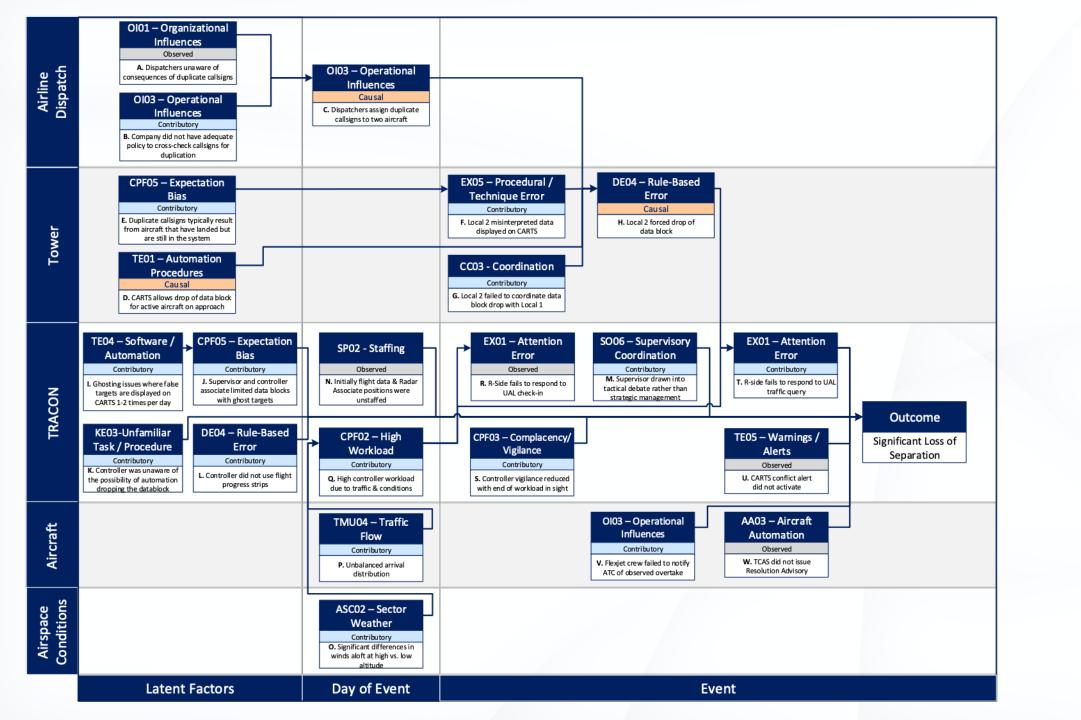


AirTracs

Version 4.0

(Operator Actions		Operat	or Cont	ext		Facility Influences
	•		Controller Workspace		Controller Readiness	Super	visory Planning / Preparation
	Acts	Physica	Environment	Cognitiv	e and Physiological Factors	SP01	Facility Procedures
Sensory	and the second	PE01	Workstation / Work Area	CPF01	Working Memory / Distraction		a SOPs
Se01	Auditory Perception	PE02	Lighting	CPF02	Workload		b LOAs
Se02	Visual Perception	PE03	Noise Interference		a High Workload		c Checklists / Manuals
Se03	Temporal Perception	PE04	Vision Restricted	1	b Low Workload	SP02	Staffing
Decision	1			CPF03	Complacency / Vigilance	SP03	Equipment Readiness
De01	Alert Comprehension	Technol	logical Environment	CPF04	Automation Reliance	SP04	Training
De02	Knowledge / Planning	TE01	Communication Equipment	CPF05	Expectation Bias	Super	visory Operations
De03	Prioritization	TE02	Display / Interface	CPF06	Fatigue	5001	Sector Combination
De04	Tool / Equipment Use	TE03	Software / Automation	Knowled	dge / Experience	\$002	Position Combination
Executio	on	TE04	Warnings / Alerts	KE01	On-the-Job Training/Developmental	\$003	Controller Assignment
Ex01	Controller Technique	TE05	Data Block	KE02	Trainer Intervention	5004	Oversight / Assistance
Ex02	Attention Act	TE06	Flight Progress Strips	KE03	CPC Experience	S005	Sector/Airport Configuration
Ex03	Communication Act	TE07	Field Equipment	KE04	Unfamiliar Task/Procedure	S006	Supervisory Coordination
Ex04 Inadvertent Operation			NAS Interactions			a Intra-Facility	
		Airport	Conditions	Aircraft	Actions		b Inter-Facility
	Violation	APC01	Combined Positions	AA01	Deviation	Traffic	Management Unit
Willful \	/iolations	APC02	Ground Vehicle Traffic		a Procedures	TMO	Weather Response
V01	Willful Violations	APC03	Aircraft Traffic	1	ATC Instructions / Clearance	TMO	2 Special Use Airspace
		APC04	Airport Weather	AA02	Unexpected Aircraft Performance	TMO	Traffic Management Initiatives
	Outside Influence	7 i	a Visibility / IMC	AA03	Aircraft Equipment/System Operation	TM04	Traffic Regulation / Delivery
· ·	Juiside influence	1	Wind	AA04	Responding to Abnormal Situation		
0101	Airline Influences		Other Weather	AA05	Go Around		A service Influences
0102	Military Influences	APC05	Signage/Lighting/Ground Markings	AA06	Flight Planning		Agency Influences
0103	Contract Towers		Construction	AA07	TCAS RA Response		
0104	Other ANSPs	APC07	Layout/Design	Commu	nication	Resou	rce Management
0199	Other Influences	APC08	Runway Conditions	CC01	Controller-Flight Deck Communication	RMO	Equipment/Facility Resources
		Airspac	e Conditions		a Readback / Hearback		2 Human Resources
	101 C 101 C 101 C	- 1 -	Combined Sectors		Phraseology / Call Sign		y Climate
	Outcome	ASC02	Combined Positions		Information / Clearance	_	Culture
Level	Description		Sector Traffic		Frequency Congestion		Policy
0	No Event		Traffic Level		e Responsiveness		tional Process
1	Near Airspace Violation		Traffic Complexity	CC02	Controller-Controller Communication		Procedures / Operations
2	Airspace Violation		VFR Traffic		a Position Relief Briefing		a NAS Procedures (7110.65)
3	Near LOSS / RI		Restricted Airspace		Handoff / Point-Out		b Charts / Routes (STAR, SID)
4	LOSS / RI		Sector Weather/Turbulence		Aircraft Information		Oversight
5	Collision	1007 7 10	Sector Design		Phraseology		Response to Event / Report

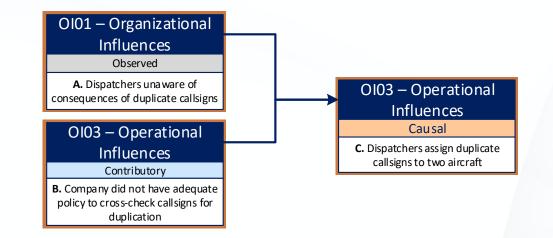




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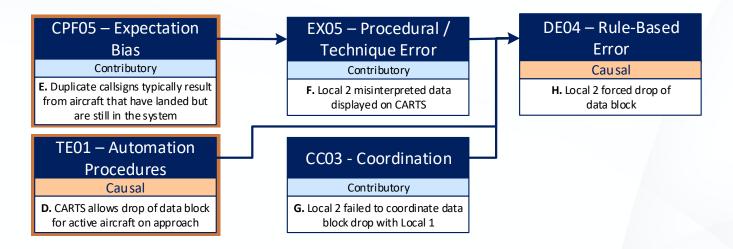
United Airlines Dispatch



- Two UAL dispatchers independently assigned the same call sign of UAL541T to two different flights
- Lack of training on potential impact of assigning duplicate call signs
- Lack of procedures to crosscheck call signs for duplication



Tower

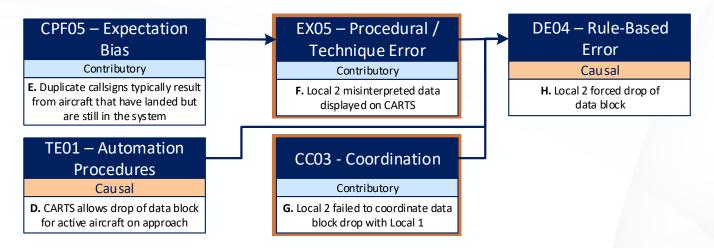


- Duplicate call signs occur frequently at the tower
 - Aircraft will remain in system after landing
 - Tower controllers force the system to drop the data block
- Lack of standard procedure for handling duplicate call signs or data blocks in CARTS

- CARTS allows controllers at a facility to drop a data block not under his or her control



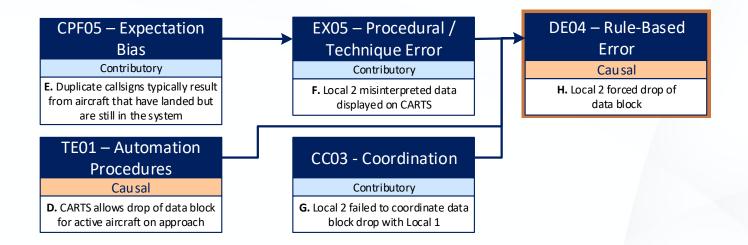
Tower



- Local 2 misinterpreted CARTS display of UAL541T duplicate call signs
 - Believed the UAL541T had already landed but remained in the system
- Local 2 did not coordinate UAL541T with Local 1
 - Local I was responsible but did not have time to investigate
 - Local 2 wanted to help Local 1 during a busy time

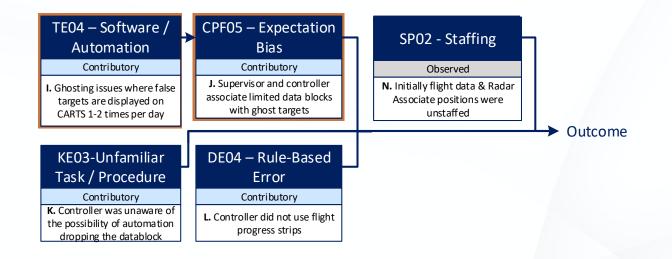
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Tower



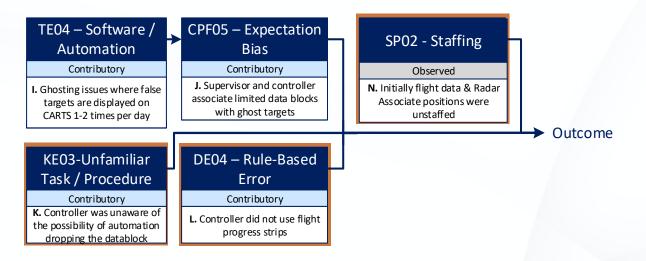
- Local 2 forced dropped the inbound UAL541T data block from CARTS
 - Performed a "track-drop-slant(\)-ok" command





- Initial activation of Fusion system resulted in many issues of ghosting
 - Occurred approximately 1 to 2 times a day
- Ghosting issue coupled with frequency of occurrence resulted in TRACON controllers' expectation bias
 - Misdiagnosed UAL541T limited data block as ghost target





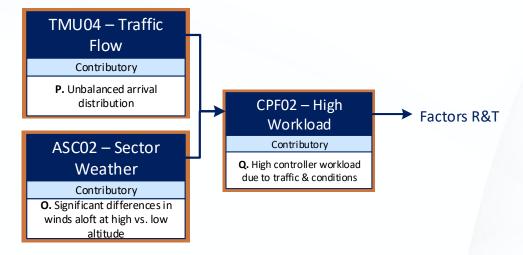
 Lack of TRACON controller training and briefings on automation reliability and limitations

- Difficult for controller to adequately identify and respond to data block dropping out of system

- Radar Controller was not using flight progress strips
 - Flight progress strips serve as short-term memory aid
- FLM did not staff the flight data or radar associate positions
 - Primary airport Area is short-staffed
 - Primary airport Area controllers work more overtime than other TRACON areas

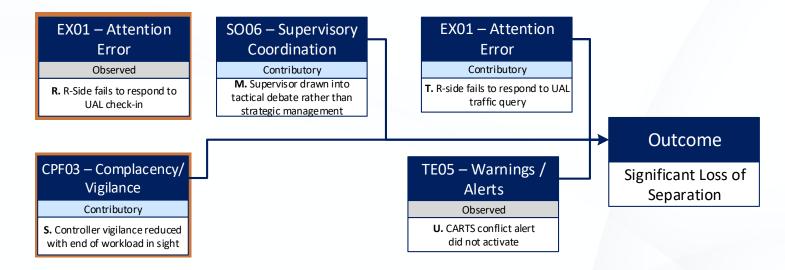


TRACON Controller



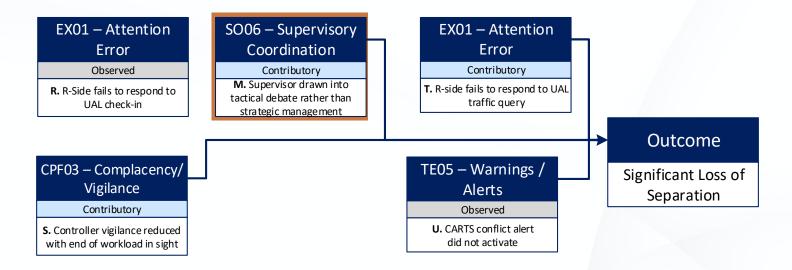
- Unbalanced arrival distribution of Radar Controller arrivals
 - Maximum of 60 aircraft per hour
 - Believed more than 15 aircraft entered sector in 15 minutes prior to event
- Sector weather led to compression of finals
- Resulting in high workload during busy period
 - Combination of weather and unbalanced arrival distribution





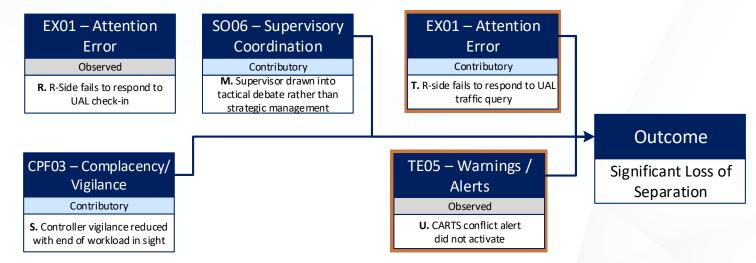
- Radar controller did not respond to initial UAL541T checkin
 - Attention was focused on compressed finals
- Radar controller was anticipating a reduction in workload with the end of a traffic rush
 - UAL541T was last in stream
 - Did not request radar associate assist





- Radar controllers were investigating the believed ghost target (UAL541T)
- FLM did not check the system to confirm or deny the status of ghost target
 - Drawn into tactical discussion with controllers

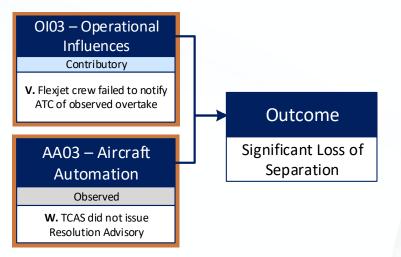




- Radar controller did not respond to UAL541T traffic query
 - Attention was focused discussion of believed ghost target
- Conflict alert did not activate
 - None of the activation parameters were met
- Radar controller identified ghost target as UAL541T dropped data block
- UAL541T in slow overtake situation with SKY6335
 - Significant loss of separation minima event



Other Influences



- Flightcrew of Flexjet did not notify ACT of observed overtake
 Informed ATC after the event of awareness of unsafe situation
- Neither UAL541T nor SKW6335 received a TCAS-RA
 - None of the activation parameters were met

THANK YOU



SHAPING OUR FUTURE SKIES





QUESTIONS AND ANSWERS





Mr. Shayne Campbell

Safety Programme Manager

CANSO

Next webinars

- Wednesday 28 July: Event Investigation Process (Microsoft Teams) invitations sent by Chime Agu
- Wednesday 4 August: Accident Investigation and Transition from Compliance to Risk

08:00-09:30 EDT // 12:00-13:30 UTC

THANK YOU



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