GFA Safety Seminar – Gawler Mar 2016

Human Factors

With a focus on "Maintenance" activity

Any one of us can err....

- "Human Factors" in gliding occur and impact because of we / us (people) involvement.
- "Human Factors" have the potential to exist in all aspects of gliding Daily Inspection, Glider repair, Annual Inspection, Scheduled or Routine maintenance, Flying, Pilot maintenance activity, Trailering/Hangaring/repairing gliders, etc etc.
- "Human Factors" can't be eliminated –
 because humans remain fallible but they
 can be somewhat controlled, if the
 appropriate attention is applied.

- Not desirable to eliminate all "Human Factors"
 - there are some good examples where HF's have have resulted in positive outcomes (and get widely applauded), including:
 - Capt. Chesley Sullenburger and the A320 Airbus onto the Hudson River, after a bird strike.
 - I wonder did someone ask/list "What went right".
 - Capt Richard Champion De Crespigny in the Qantas A380 which suffered an uncontained engine explosion soon after T/O.

US Airways Flight 1549



#2 Rolls Royce Engine, A380



Positive Human Factors

- These two events and many similar resulted in NO FATALITIES and (at worst) only minor injuries.
- The focus here is on Airworthiness and inspection HF aspects for Pilots, Daily Inspectors, Annual Inspectors, etc
 - A simple oversight during a DI could be as disasterous as a simple oversight during an Annual Inspection.
 - The DI may be the last opportunity to find any existing fault

- The "appropriate attention" could be provided by the use of;
 - Checklists & written procedures
 - Independent Review and Checking
 - Training
 - Maintaining currency
- Maintenance/Airworthiness activity could be
 - Daily Inspection the last opportunity to arrest.
 - Annual or Routine Maintenance.
 - Pilot Maintenance (repairing a puncture).

Human Factors

- Maintenance is a major aspect in every form of aviation, including gliding.
- In the very Distant Past "work" included fitting a shoe onto a horse, where failure had almost no impact or consequence (the horse shoe fell off), and - involved very few people.
- Today, impacts maybe far more reaching airliners with many hundreds of people aboard (A380).

Benefits in Automation

- In aviation, many safety & reliability improvements have been achieved – a lot of these by automation – BUT maintenance is very difficult (if not impossible) to fully automate.
- There are many areas and tasks which cannot be automated – and HUMANS must continue to be intimately involved.

 Maintenance outcomes - both good & bad, continue to rely heavily on Human hands,

minds and inputs, BUT

Human's remain awfully fallible.

 Two significant "maintenance threats" continue to exist;

1st Significant Threat

- That an actual or potential failure will not be recognised and be corrected (either partly or fully) before a real failure occurs
 - ie, an oversight (a Human Factor).
 - Unintentional

An Example

- A crack in a bolt is not identified
 - the bolt is not replaced, and
 - the bolt subsequently fails in service.

2nd Significant Threat

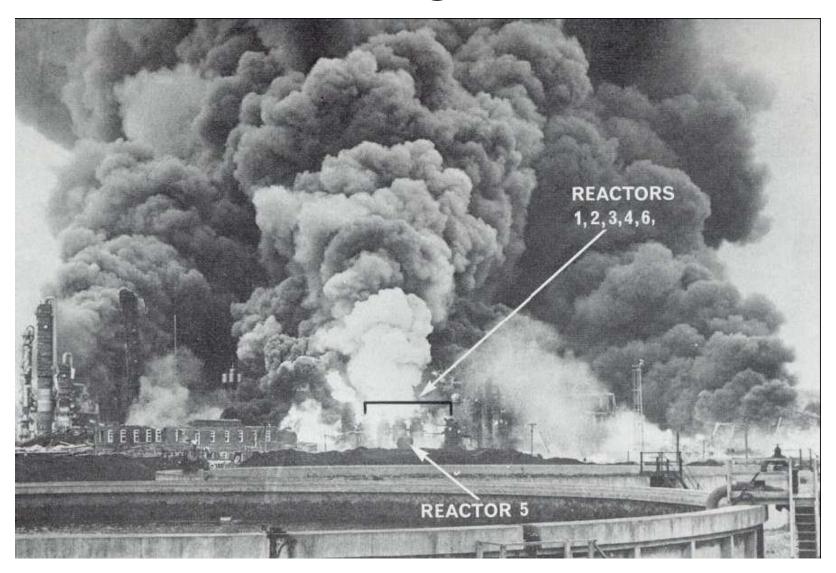
 The maintenance task itself introduces a failure or increases the risk of failure, which may not have occurred if it weren't for the maintenance activity.

An Example

- A good part is inspected <u>but</u>
 - is wrongly reassembled, or
 - is wrongly reinstalled, or
 - Is damaged on reassembly / reinstallation following the inspection,
- The part subsequently fails after a return to service.
 - another "Human Factor".

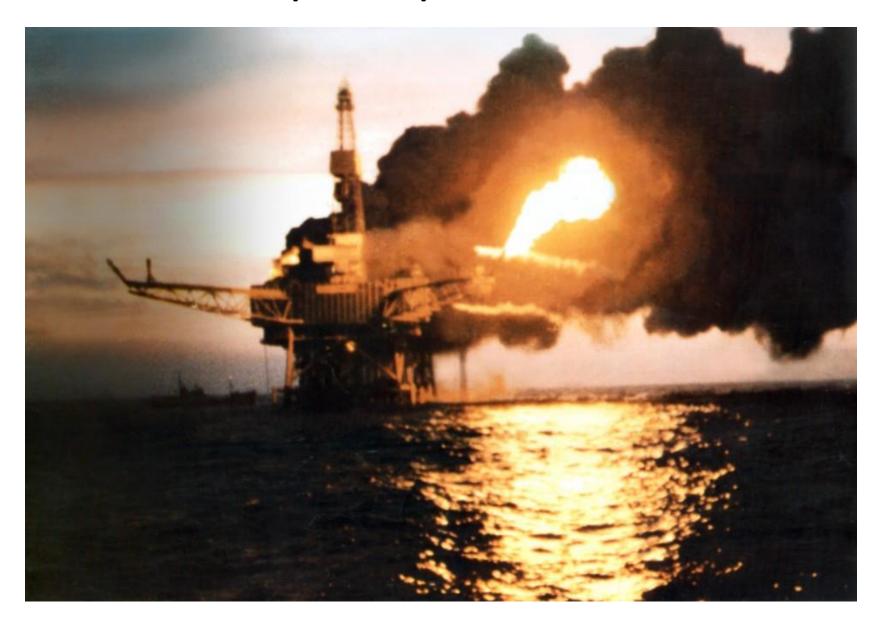
- Some significant, historical "Maintenance Error"
 (ME) Human Factor events include;
 - Flixborough cyclo-hexane facility in UK,
 uncontrolled, non approved modifications, 1974.
 - Bhopal, India, methyl-iso-cyanate release, 1984.
 (Non approved modifications), killed thousands.
 - Piper Alpha, North Sea, uncontrolled maintenance activity, 1988. (Unapproved modifications to systems and Procedures).
 - Space Shuttle "Challenger", poor maintenance practices (o'rings).

Flixborough, 1974



3/22/2016 John Hudson

Piper Alpha, 1988



- Human "ME" incidents are not generally random events committed by wayward and/or careless, irresponsible individuals.
- These events are also committed by some
 very good, highly experienced and competent
 individuals in excellent organisations with
 the best tools, equipment, systems &
 procedures, etc. The very best people can and
 do make some of the very worst mistakes.
- There are many factors influencing Human
 Factor events which are mostly controllable.

Distractions – so easy to control

- Bad in Operations (interrupting Daily Inspections, Pre-T/O Checks, etc).
- Also bad in Airworthiness activity –so easy to do with potentially fatal consequences.
- We must avoid interfering, interrupting, distracting, etc

Checklists and Procedures – use them.

Independent Checks – use them,

Pressure – to get flying.

- It is appropriate to address all "aspects" in a system when considering remedial measures:
 - the individual, knowledge, experience, training, ability, currency.
 - the **team**.
 - the **task**, frequency (W&B), complexity.
 - the workplace, facilities, available light, Tools,
 Procedures (Tool Control), data & information.
 - Training
 - Equipment

- Removal vs Replacement;
 - 2 very frequently repeated activities,
 - Removal of fasteners, then
 Replacement of fasteners, ie to remove inspection covers, engine cowls etc.
 - 2. Dis-assembly of components, then
 Re-assembly and Refitting of components
- Item 1 is generally easier than Item 2 but still many mistakes occur with Item 1.
- Lets consider a very simple example,

A Very Simple Example

Consider this model - 1 bolt, with 8 nuts labelled 1 - 8

- The Task
 - remove the Nuts from the bolt.
 - replace the Nuts, in the original sequential order.
- Only one way to take Nuts off the bolt.
- Re-assembly requires thought, planning, checking, etc.
 - 40,000+ ways of getting this sequence **wrong**8x7x6x5x4x3x2x1=40320 before considering any
 omissions cleaning, measuring, under/over
 tensioning, worn or wrong parts, part integrity, lube,
 etc, etc).

- Top 7 causes of in-flight engine shut-down (IFSD) at Boeing :
- Incomplete installation (33%)
- Damaged on installation (14.5%)
- Improper installation (11%)
- Equipment not installed or missing (11%)
- Foreign Object Damage (FOD) (6.5%) often tools (Tool Control ?).
- Improper fault isolation, inspection, testing (6%)
- Equipment not activated or deactivated (4%)

 What do you notice about the 7 listed engine shut-down causes?

- <u>Use</u> written Procedures and Checklists.
- Independent inspection before equipment is closed up.
- Develop and use a "Tool Control" procedure.
- Allow appropriate time to complete the task.
- Don't assume someone else did all / part of the job – check carefully.
- Don't take short-cuts.
 - Don't accept any VIOLATIONS.
- Conduct Functional Checks- thoroughly.

- Humans "we can't easily avoid actions we did not intend to commit".
- "Everyone needs to be accountable for their errors. If the <u>error maker</u> does not acknowledge and report the error and strive to avoid a reoccurrence, <u>then no lesson has</u> <u>been learned and little or nothing is gained</u> <u>from the experience</u>"
- We must <u>all</u> learn from the errors and experience of others – we won't live long enough to learn all the lessons ourselves.

 Report all incidents – consider them "Free Lessons" - we can all learn from these.

Daily Inspector Rating

- Generally the first Airworthiness Rating a glider pilot obtains.
- The DI should be a lot more that a tyre kicking exercise – it is the last chance to identify any airworthiness issues with the a/c before it flies.
- When conducting a DI, do it thoroughly, systematically WITHOUT DISTRACTIONS.
- DI Examiners expect high standards, don't accept mediocre performances.

HUMAN FACTORS

SAFETY IN GLIDING IS NO ACCIDENT