



A STAMP Case Study

Comair 5191 LEX Accident

First STAMP/STPA Workshop and Conference
MIT April 17-19, 2012

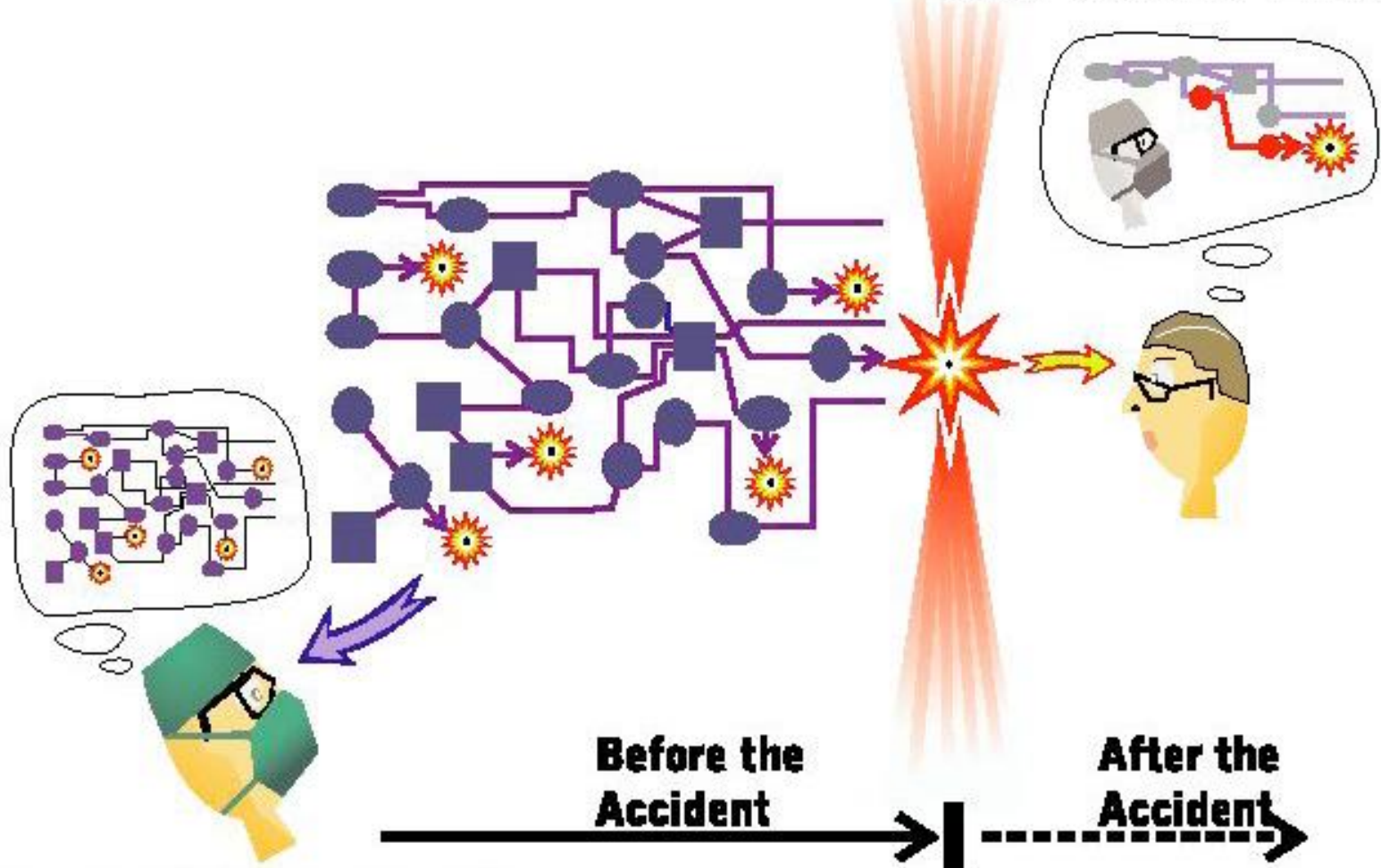
Overview

- STAMP complementary HF concepts
- 5191 accident overview
- Some STAMP model revelations
- Conclusions
- Q&A

Human Factors New View

- **Local rationality**—each person acts according to what make sense at the time.
- **Variability of Human action** is consequential in successes *and* failures
- Analysis after the occurrence always possesses more information than known at the time of occurrence.

HINDSIGHT BIAS



High Level Context: The Flight

- Comair 5191 operated for Delta Air Lines
- Lexington, KY to Atlanta, GA
- Scheduled Departure 0600
- Unintended Runway 26 departure attempt
- Accident occurred 0606, September 27, 2006

System Hazard Mitigation

- It's easy to stop at Hazard ID and containment



- Move beyond—set the system up to succeed

High Level Context: The Environment

- Night Visual Operation

- Dark, before sunrise

- No moon

- Light southerly winds

- 8 mile visibility

- Scattered Clouds at 12,000 ft.

High Level Context: The LEX Airport

- Runway Safety Area Construction
- North Runway Threshold movement (325'sw)
 - 7 days prior to Accident
- Altered Taxi route to Runway 22
- Altered Signage and lighting
- Perfect regulatory compliance
 - Unaware of the unconstrained safety hazards

High Level Context: The Airline Culture

- First bankruptcy reorganization
- Implied fleet reduction
- Imposed contract concessions
- Threatened Furloughs
- Crew “topic of conversation”
 - Preflight and taxi

Proximate Event Chain

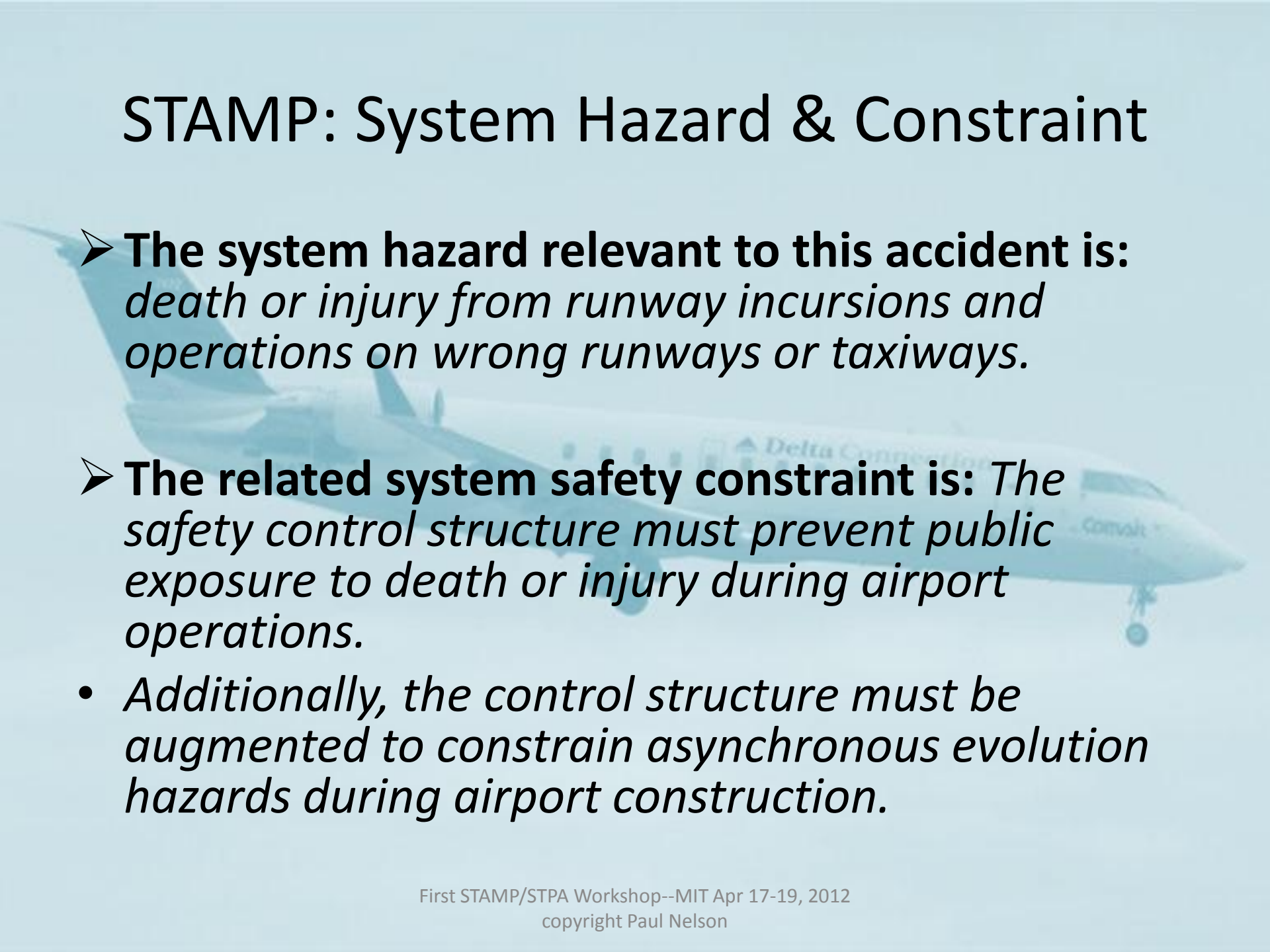
- Typical Flight Prep (20min)
- FO's: T/O brief -**"lights out all over the place"**
- Taxi brief -"taxi Rwy22, its a short taxi".
- During taxi : 40 sec nonessential conversation, FO performs before T/O flow (44 actions/conf.).
- Capt. stopped short Rwy26(**Rwy22**).
- T/O clearance
- Capt. trans controls to FO.
- FO comment: **"dat is weird with no lights"** =>Capt. **"yeah"**
- V1, Rotate, Whoa
- 4 sec. CVR rec. ends
- 49 people dead.



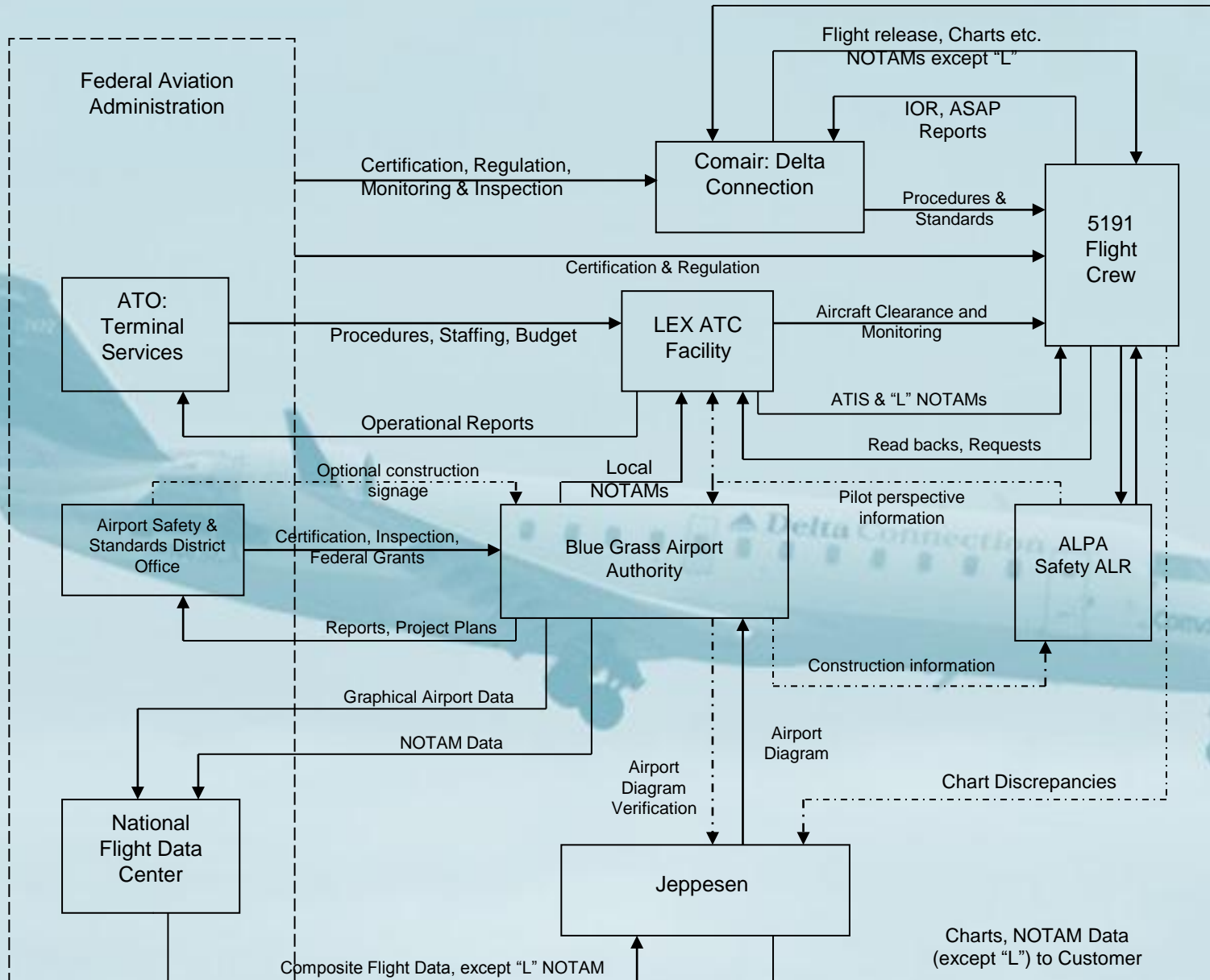
Accident Scene



STAMP: System Hazard & Constraint

- 
- **The system hazard relevant to this accident is:** *death or injury from runway incursions and operations on wrong runways or taxiways.*
 - **The related system safety constraint is:** *The safety control structure must prevent public exposure to death or injury during airport operations.*
 - *Additionally, the control structure must be augmented to constrain asynchronous evolution hazards during airport construction.*

Basic Aviation Safety Control Structure



-----> = missing feedback lines

Flight Crew: TAXI

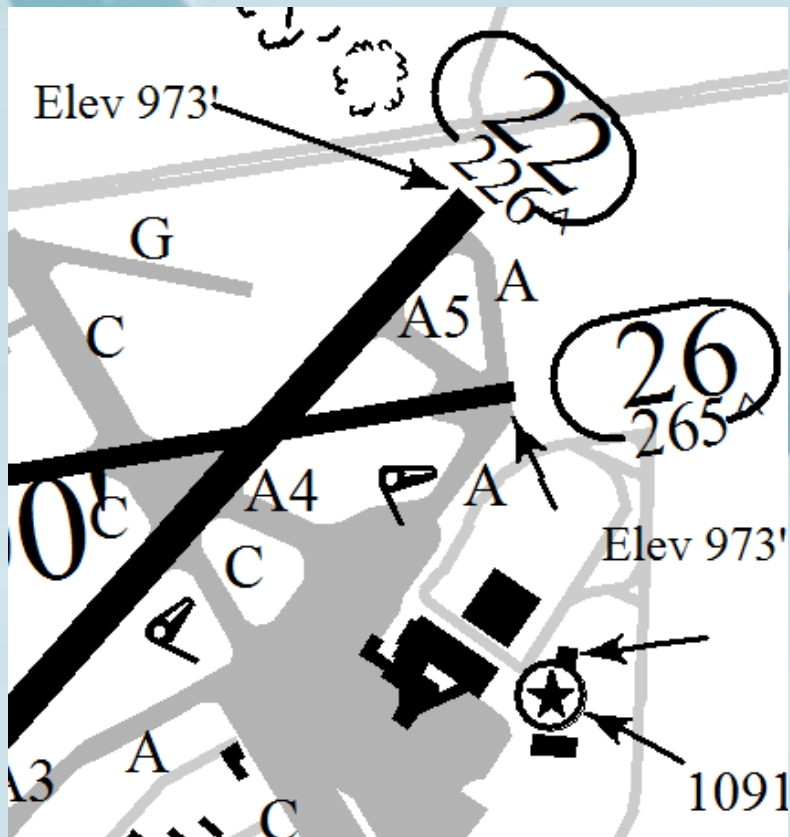
- Taxiway A had been changed
 - Rwy 22 Threshold moved 325' SW
 - Taxiway A5 renamed A (new route to Rwy 22)
 - Slight left turn—70 degree turn across runway 26
- Route as cleared and expected
 - “taxi runway 22 via A(lpha)”
 - Clearance good for old and new routes to Rwy 22

Flight Crew: Rwy 22 (Rwy 26) visual context

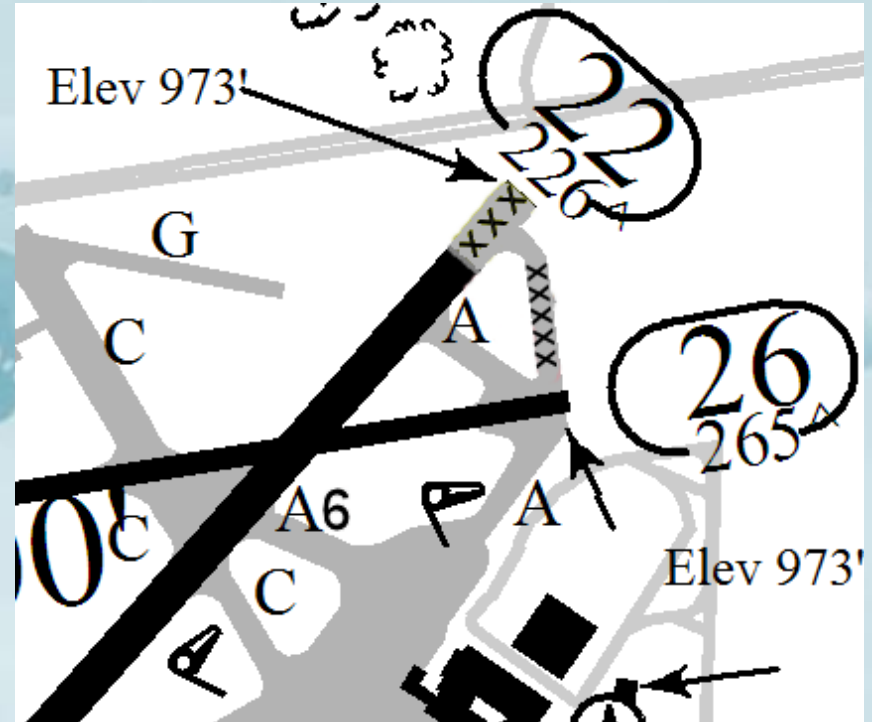
- While holding short of Rwy 26
 - View appeared as holding short Rwy 22
 - View **NOT** as expected if short Rwy 26.
- Appearance match to Rwy 22:
 - Taxiway/Runway angles
 - Lighting/dark areas
 - Pavement width

The Airport Diagram

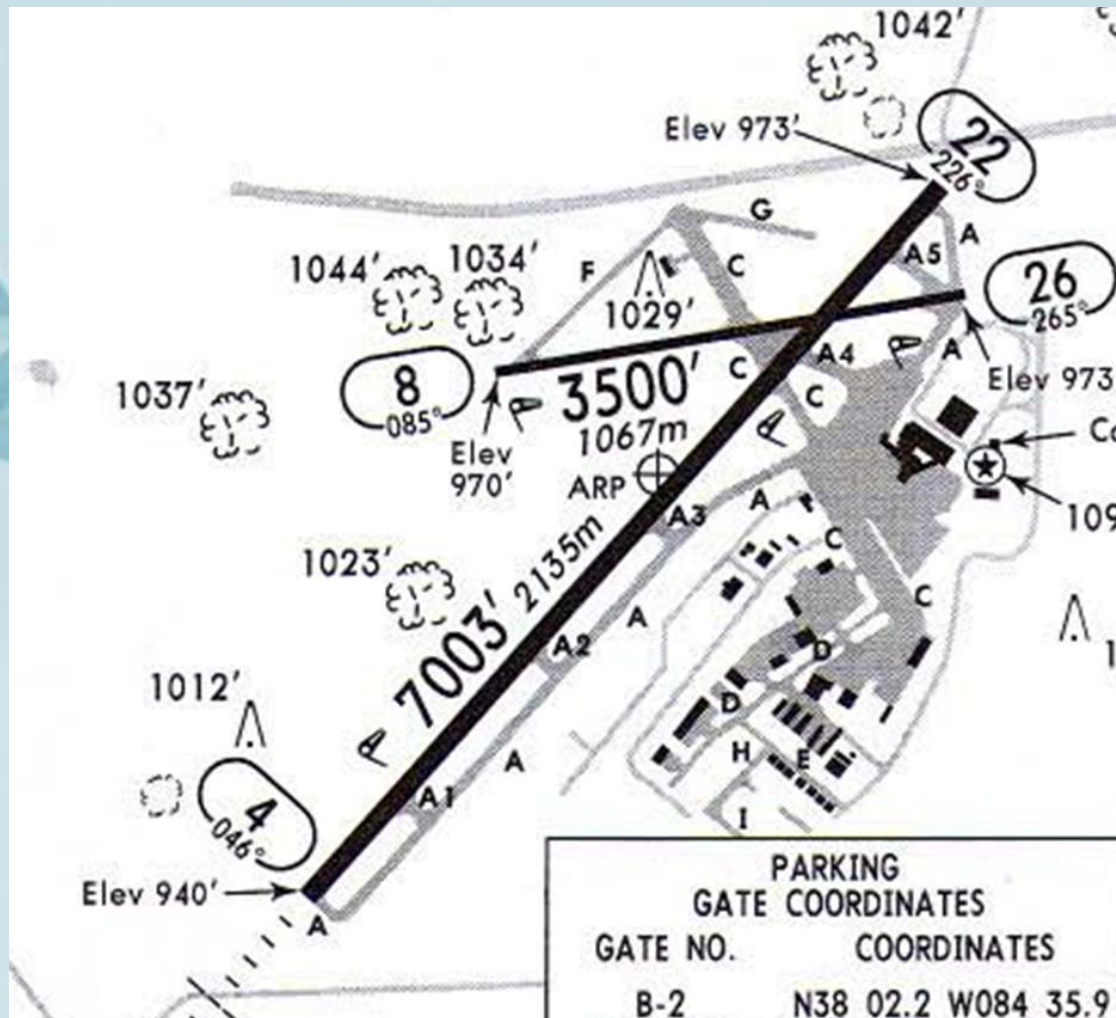
What The Crew had



What the Crew Needed



Controllers Visual Differences



Control Tower View



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LEX ATCT: Why Only 1 Controller?

- LEX Tower Manager: Goal Conflicts, Production Pressure
- Verbal guidance: Staff Tower and Radar functions separately
- Reallocate airspace during night shift
 - Indy Center take Approach/Departure
- 2 yrs trying to:
 - Increase Staffing and/or budget
 - Overtime budget only 35 days

LEX ATC Double Bind

- Email from mid level Management “stay with in budget”
 - “**essential to** the overall **fiscal success** of the hub that **every manager** does their part and **manages responsibly** and **ensures** that the **Hub Manager is informed** immediately **when issues** arise that may **adversely impact the budget**”
- LEX Manager understood—when push comes to shove—protect the budget

Air Traffic Organization: Terminal Services

- Top Management's primary information channel—verbal communication with subordinate management.
- Believed guidance was clear and consistently followed.
- Surprise that LEX was routinely combining Tower and Radar functions with one controller
 - Despite email from LEX manager stating such

Conclusion

- Model used determines what is relevant
- STAMP guides the gathering of “systemic” behavior.
- STAMP frames system behavior so impact of non-linear aspects are validated as relevant.
- STAMP turns “Human error” into the beginning of investigation not the end.

References

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Complete STAMP analysis of 5191

<http://sunnyday.mit.edu/papers/nelson-thesis.pdf>