HUMAN ERROR ASSESSMENT AND REDUCTION TECHNIQUE (HEART) AND HUMAN FACTORS ANALYSIS AND CLASSIFICATION SYSTEM (HFACS)

Presenter: Tiffaney Miller Alexander, PhD
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Presentation Overview

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Introduction

How can we eliminate Human Error?
Introduction

- **Human Error** - “An action which fails to produce the expected results and therefore, leads to an unwanted consequence” (Hollnagel, 1993).
- **Person approach**
- **Systems approach**

“The pursuit of greater safety is seriously impeded by an approach that does not seek out and remove the error proving properties within the system at large” (Reason, 2000).
• Research results have shown that more than half of aviation, aerospace and aeronautics mishaps/incidents are attributed to human error. As a part of Quality within space exploration ground processing operations, the identification and/or classification of underlying contributors and causes of human error must be identified, in order to manage human error.

• Most incident reports are not designed around a theoretical framework of human error (Wiegmann and Shappell, 2001).

• Report systems have been beneficial for identifying engineering and mechanical failures, but often fail to address the core issues and causes of the failure due to human error (Wiegmann and Shappell, 2001).

• This makes the intervention and integration of a strategy to reduce the human error become difficult (Wiegmann and Shappell, 2001).
Dynamics of the Generic Error Model System (GEMS) used for relating Reasons’ three basic error types to Rasmussen’s three performances levels (Reason, 1990).

<table>
<thead>
<tr>
<th>Performance Level</th>
<th>Error Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skill-based level</td>
<td>Slips and lapses</td>
<td>Automated non-cognizant errors of automatic processing (attention/memory) during regular routine actions that are identified quickly (Reason, 1990).</td>
</tr>
<tr>
<td>Rule-based level</td>
<td>Rule-based mistakes</td>
<td>Errors of rule-based behavior. For example: applying the wrong rule for a give situation (often with a tendency to keep repeating the same wrong actions “strong but wrong”).</td>
</tr>
<tr>
<td>Knowledge-based level</td>
<td>Knowledge-based mistakes</td>
<td>Errors of cognitive (knowledge-based) processing whereby a problem is not analyzed correctly (or not at all) and this results in an error (e.g. wrong response to a multitude of alarms based on an incomplete understanding of the actual problem).</td>
</tr>
</tbody>
</table>
GEMS is an effort to provide an integrated framework of the error types operating at all three levels of performance: Skill based, Rule based and Knowledge based. This is a hybrid of two sets of error theories proposed by Norman (1981) and Reason and Mycielska (1982) (Reason, 1987).
Research Objective

• Provide a framework and methodology using the Human Error Assessment and Reduction Technique (HEART) and Human Factor Analysis and Classification System (HFACS), as an analysis tool to identify contributing factors, their impact on human error events, and predict the Human Error probabilities (HEPs) of future occurrences.

• This research methodology was applied (retrospectively) to six (6) NASA ground processing operations scenarios and thirty (30) years of Launch Vehicle related mishap data. This modifiable framework can be used and followed by other space and similar complex operations.
Research Question

• What are the identified leading human error causes and contributors to historical Launch Vehicle Ground Processing Operations mishaps and findings based on past mishaps, near mishaps, and close calls?

Hypothesis 1

• Contributing factors: unsafe acts of operators, preconditions for unsafe acts, unsafe supervision, and/or organizational influences (multiple causes) do not have an impact on human error events (i.e. mishaps, close calls, incident or accidents) in NASA ground processing operations.

Hypothesis 2

• The HFACS framework conceptual model can be proven to be a viable analysis and classification system to help classify latent and active failures, underlying contributors and causes of human error in NASA ground processing operations.
Hypothesis 3

• The development of a model using the HEART assessment can be used as a tool to help determine the probability of human error occurrence, in order to help minimize human error in NASA ground processing operations.

• **Independent variable**: Contributing Factors (identified by the SMEs for specific Scenarios of tasks performed for NASA KSC Ground Processing Operations).

• **Dependent Variable**: Probability of a Human error event (i.e. mishaps, close calls, incident or accidents).
Preliminary Analysis

- Conducted informal Subject Matter Expert (SME) discussions (3 SMEs with 34, 31 and 30 years KSC GPO experience).
- HEART Generic Tasks - SMEs identified and categorized examples of historical shuttle specific ground processing operations.
- HEART Surveys - SMEs identified general tasks and error producing conditions associated with three (3) NASA KSC Ground Processing Area Scenarios used in research.
- HFACS – SMEs modified HFACS’ four (4) Levels of Human Error examples with the specific KSC examples for categorization.
KSC Human Error Framework

HFACS 4 Levels of Human Error

Unsafe Acts

Preconditions of Unsafe Acts

Unsafe Supervision

Organizational Influences

HFACS Sublevels/HEART Error Producing Conditions

Common Errors
Specific "Unsafe Acts of Operators"
EPC 1, EPC 2, EPC 3, etc.

Common Errors
Specific "Preconditions of Unsafe Acts of Operators"
EPC 1, EPC 2, EPC 3, etc.

Common Errors
Specific "Unsafe Supervision"
EPC 1, EPC 2, EPC 3, etc.

Common Errors
Specific "Organizational Influences"
EPC 1, EPC 2, EPC 3, etc.

GPO Tasks (e.g. HEART Generic Tasks)

Task A
Task B
Task C
Task D
Task E
Task F
Task G
Task H

Scenarios/Locations

VAB OPFs Pads A/B

NASA KSC Ground Processing Operations Human Error Framework (Alexander, 2016)
Methodology Overview

- **Literature Review**
  - Existing Gap
  - Experiment Overview
    - Assesment approach
  - Data Collection
    - Mishap and Survey Participant data
- **Qualitative Study**
  - HEART, SME Preliminary Analysis & HFACS Method
  - Surveys
  - Quantitative Study
    - HEART HEP Calculation & Binary Logistics Regression
- **Data Analysis - Validation**
  - Triangulation

- Research Objective Achieved?
  - No
  - Yes

End
Mishap data from October 1984 – May 2014 was categorized and sorted into HFACS Four Levels of Human Error categories.
Data categorized into 8 HFACS Sublevels: Skilled Based, Routine violations, Crew Resource Management, Perceptual Errors, Exceptional Violations, Decision Based, Physical Environment and Supervisory Violation.
Binary Logistics Regression Analysis

- Occurrence of a Mishap identified as “response/event” and represented by and “0” or “1”.

- The Regression Analysis generated a regression model in which the predicted probability of each occurrence was calculated.

- Binary Logistic Regression Expression for this Model is:

\[ P(1) = \frac{e^{Y}}{1 + e^{Y}} \]

<table>
<thead>
<tr>
<th>HFACS Human Error Factor</th>
<th>Fitted Probability</th>
<th>P value</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Based</td>
<td>27%</td>
<td>0.070</td>
<td>10.15</td>
</tr>
<tr>
<td>Decision Based</td>
<td>41%</td>
<td>0.037</td>
<td>18.72</td>
</tr>
<tr>
<td>Perceptual Errors</td>
<td>47%</td>
<td>0.009</td>
<td>24.25</td>
</tr>
<tr>
<td>Routine Violation</td>
<td>9%</td>
<td>0.444</td>
<td>2.67</td>
</tr>
<tr>
<td>Exceptional Violation</td>
<td>36%</td>
<td>0.052</td>
<td>15.67</td>
</tr>
<tr>
<td>Crew Resource Management</td>
<td>14%</td>
<td>0.283</td>
<td>4.38</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>33%</td>
<td>0.138</td>
<td>13.72</td>
</tr>
<tr>
<td>Supervisory Violation</td>
<td>24%</td>
<td>0.226</td>
<td>8.61</td>
</tr>
</tbody>
</table>
Results - HFACS

Binary Logistics Regression Analysis with Stepwise Backward Elimination

• Binary Logistic Regression Expression for this Model is:
  \[ P(1) = \frac{e^{Y'}}{1 + e^{Y'}} \]

<table>
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<th>HFACS Human Error Factor</th>
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<th>P value</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Based</td>
<td>27%</td>
<td>0.000</td>
<td>3.54</td>
</tr>
<tr>
<td>Decision Based</td>
<td>41%</td>
<td>0.005</td>
<td>6.60</td>
</tr>
<tr>
<td>Perceptual Error</td>
<td>52%</td>
<td>0.000</td>
<td>10.33</td>
</tr>
<tr>
<td>Exceptional Violation</td>
<td>36%</td>
<td>0.013</td>
<td>5.38</td>
</tr>
</tbody>
</table>
Human Error Assessment and Reduction Technique (HEART)

- Participation Goal: At least 18 subjects for all Scenario assessments based on Power Curve test with a Variance: 0.707, Std Dev: 0.5, Power: 0.80, $\alpha$: 0.05
- Total Participants: 41
- Participants’ average years working at KSC: 23.9875 years (Range 10 to 37 years).
- Participants’ average years working at KSC supporting Ground Processing Operations: 19.8125 years (Range 3 to 33 years).
Subjects were asked to answer a total of 21 questions.

- 3 job related questions for statistical purposes
- 18 evaluation questions involving 3 NASA KSC GPO Scenarios (VAB, OPFs and Pads A/B).
- Assessment based on the level of affect an Error Producing Condition (EPC) may have on a specific GPO task (very low, low, moderate, high, and very high).
• Of the calculated Human Error Probability (HEP) values, three (3) values had the highest probability (22%, 22% and 26%).

• The three highest HEP values were from survey questions 5, 19, and 20, which all had an EPC commonality.
  – Accessibility Limitations, Physical Stress and Tiredness.
  – Poor lighting deals with the Physical environment.

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>EPC(s)</th>
<th>Max. Effect #1</th>
<th>Max. Effect #2</th>
<th>Max. Effect #3</th>
<th>Assessed Proportion of Affect (average)</th>
<th>Assessed Factor – Calc. #1</th>
<th>Assessed Factor – Calc. #2</th>
<th>Assessed Factor – Calc. #3</th>
<th>Generic Task, HEART Nominal Human Error Prob. Value (HEPs) (Table 20)</th>
<th>Generic Task, HEART Nominal Human Error Prob. Value (HEPs) (Table 20)</th>
<th>HEP %</th>
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<tr>
<td>4</td>
<td>35</td>
<td>1.1</td>
<td></td>
<td></td>
<td>0.556410</td>
<td>1.055641</td>
<td>C</td>
<td>0.16</td>
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<td></td>
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<tr>
<td>5</td>
<td>22</td>
<td>1.8</td>
<td></td>
<td></td>
<td>0.495</td>
<td>1.396</td>
<td>C</td>
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<td>22%</td>
<td></td>
<td></td>
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<tr>
<td>6</td>
<td>33</td>
<td>1.15</td>
<td></td>
<td></td>
<td>0.529672</td>
<td>1.079481</td>
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<td>17%</td>
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<tr>
<td>7</td>
<td>27</td>
<td>1.4</td>
<td></td>
<td></td>
<td>0.421711</td>
<td>1.168684</td>
<td>C</td>
<td>0.16</td>
<td>19%</td>
<td></td>
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<td>8</td>
<td>27</td>
<td>1.4</td>
<td></td>
<td></td>
<td>0.397179</td>
<td>1.158872</td>
<td>C</td>
<td>0.16</td>
<td>19%</td>
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<td>9</td>
<td>33</td>
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<td>0.463077</td>
<td>1.069462</td>
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<tr>
<td>10</td>
<td>22, 27</td>
<td>1.8</td>
<td>1.4</td>
<td></td>
<td>0.62561</td>
<td>1.500488</td>
<td>E</td>
<td>0.02</td>
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<td>11</td>
<td>27</td>
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<td>0.538902</td>
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<td>12</td>
<td>5, 22</td>
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<td></td>
<td>0.597195</td>
<td>5.77756</td>
<td>E</td>
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<td>12%</td>
<td></td>
<td></td>
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<tr>
<td>13</td>
<td>27</td>
<td>1.4</td>
<td></td>
<td></td>
<td>0.603125</td>
<td>1.24125</td>
<td>F</td>
<td>0.003</td>
<td>0%</td>
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<tr>
<td>14</td>
<td>27</td>
<td>1.4</td>
<td></td>
<td></td>
<td>0.529</td>
<td>1.2116</td>
<td>F</td>
<td>0.003</td>
<td>0%</td>
<td></td>
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</tr>
<tr>
<td>15</td>
<td>5, 22</td>
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<td></td>
<td></td>
<td>0.58475</td>
<td>5.678</td>
<td>1.4678</td>
<td>F</td>
<td>0.003</td>
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<tr>
<td>16</td>
<td>5, 22</td>
<td>1.8</td>
<td>1.4</td>
<td></td>
<td>0.529146</td>
<td>5.233168</td>
<td>1.423317</td>
<td>F</td>
<td>0.003</td>
<td>3%</td>
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<tr>
<td>17</td>
<td>3</td>
<td>1.0</td>
<td></td>
<td></td>
<td>0.412683</td>
<td>4.714147</td>
<td>F</td>
<td>0.003</td>
<td>1%</td>
<td></td>
<td></td>
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<tr>
<td>18</td>
<td>13, 27</td>
<td>4</td>
<td>1.4</td>
<td>1.15</td>
<td>0.552439</td>
<td>2.657317</td>
<td>1.220976</td>
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<td>0.003</td>
<td>1%</td>
<td></td>
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<tr>
<td>19</td>
<td>22</td>
<td>1.8</td>
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<td></td>
<td>0.47622</td>
<td>1.380976</td>
<td>C</td>
<td>0.16</td>
<td>22%</td>
<td></td>
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<tr>
<td>20</td>
<td>22, 27</td>
<td>1.8</td>
<td>1.4</td>
<td></td>
<td>0.448205</td>
<td>1.358564</td>
<td>1.179282</td>
<td>C</td>
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<td>26%</td>
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<tr>
<td>21</td>
<td>35</td>
<td>1.1</td>
<td></td>
<td></td>
<td>0.573415</td>
<td>1.057342</td>
<td>C</td>
<td>0.16</td>
<td>17%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Binary Logistic Regression model with Stepwise Backward Elimination

- All factors’ p values are < 0.05, thus statistically significant.
- All three Goodness-to-Fit tests’ p values were greater than 0.05, indicating we want to reject the first null hypotheses (H₀).

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<tr>
<td>Exceptional Violation</td>
<td>0.013</td>
<td>5.38</td>
</tr>
<tr>
<td>Skilled Based</td>
<td>0.000</td>
<td>3.54</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goodness-of-Fit tests</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deviance</td>
<td>0.725</td>
</tr>
<tr>
<td>Pearson</td>
<td>0.458</td>
</tr>
<tr>
<td>Hosmer-Lemeshow</td>
<td>0.795</td>
</tr>
</tbody>
</table>
The HFACS model was verified by consistency and comparison to other research conducted with the HFACS Classification system and data in the aeronautics field.

Remotely Piloted Aircraft (RPA) Operations (Tvaryanas, 2006)
- Prior HFACS RPA mishap studies, 3 of the 5 studies’ largest percentage of mishaps fell under the “Unsafe Acts.”

Remotely Piloted Aircraft Mishaps HFACS analysis on recurrent error pathways on 95 Remotely Piloted Aircraft Mishaps (Tvaryanas, 2008).
- “Perceptional” and “Skilled” Based Error pathways (under HFACS “Unsafe Acts”) and had common associated latent failures.
- Together accountable for the majority of crewmember related mishaps.
• Republic of China (ROC) Air Force study
  – Ten (10) highest ranking frequencies of occurrence fell within the “Unsafe Acts (Level 1)” and “Preconditions for unsafe acts (Level 2)” HFACS Categories.
Research Question

- What are the identified leading human error causes and contributors to historical Launch Vehicle Ground Processing Operations mishaps and findings based on past mishaps, near mishaps, and close calls? Quantifying this data and identifying the leading cause will be essential in the research analysis.

Results

- The Binary Logistics Regression Equation with Stepwise Backward Elimination (simplified) Equation identified the significant causes and contributors as:
  - Skilled Based Errors
  - Decision Based Errors
  - Perceptual Errors
  - Exceptional Violations
Hypotheses Results

Hypothesis 1

• Contributing factors: unsafe acts of operators, preconditions for unsafe acts, unsafe supervision, and/or organizational influences (multiple causes) do not have an impact on human error events (i.e. mishaps, close calls, incident or accidents) in KSC ground processing operations.

Results

• Binary Logistics Regression Model results support that mishaps categorized using the modified NASA KSC HFACS Model, show significant contributing factors to KSC Ground Processing Operations (GPO) Human Error.

• Ability for KSC’s GPO related Mishaps to be sorted into the HFACS Levels and sub-categories support that the HFACS tool could be used for complex operations such as KSC GPOs.
  – Of the HFACS 4 Levels, the only level that did not have any KSC GPO mishaps was “Organizational Influences.”

• Therefore, the H₀ null Hypothesis is REJECTED. Contributing HFACS factors DO have an impact on human error events.
Hypothesis 2
- The HFACS framework conceptual model *can* be proven to be a viable analysis and classification system to help classify both latent and active underlying contributors and causes of human error in KSC ground processing operations.

Results
- The HFACS framework conceptual model used in this research revealed both active and latent failures. The majority of the significant contributing factors were from HFACS Levels 1 and 2, which encompass both active and latent failures.

- This research revealed human error underlying contributors and causes based on the HFACS framework and identified with the Binary Logistics Regression Equations.

- In the Model Validation of this research, the HFACS model was verified by consistency and comparison to other research conducted with the HFACS Classification system and data in the aeronautics field.

- Therefore, the H₀ null Hypothesis is **ACCEPTED**. The HFACS framework conceptual model **CAN** be proven to be a viable analysis and classification system.
Hypothesis 3

• The development of a model using the HEART assessment can be used as a tool to help determine the probability of human error occurrence, in order to help minimize human error in KSC ground processing operations.

Results

• Comparing the 3 highest HEART HEP survey values (22% - 26%) related to physical limitations, there is a correlation with the HFACS Physical Environment Fitted Probability of 33% data (before Stepwise Backward Elimination).

• All of the SME generated HEART survey scenarios, tasks, subtasks and EPCs all fell under the HFACS Level 2 Preconditions of Unsafe Acts Levels.

• After gathering survey data and calculating the HEART HEPs, the HEART tool was successful in determining the probability of human error occurrence from the generated Scenarios.

• Therefore the $H_0$ null hypothesis is ACCEPTED due to consistency with related HFACS aerospace studies classifying the majority of human error occurrences falling within the HFACS Level 1 and 2 categories. The development of a model using the HEART assessment CAN be used as a tool to help determine the probability of human error occurrence.
Conclusion

• Based on the HFACS and HEART results and validation, the KSC Ground Processing Operations Framework is confirmed as a valid approach for human error analysis.

• The framework is flexible in that it allows modification.
  
  • HEART’s “Generic Tasks” can be modified to specific tasks performed in the Operation.
  
  • This research can be modified and used for complex operations, such as other Space Operations and Space Programs on an International Level.
  
  • This research can be modified for use in recorded or documented Quality surveillance data over a period of time, as it relates to Operations and failure occurrences.

• All of the error producing conditions in the final stage of the KSC GPO framework, cover contributing factors for both models.
The following set of steps is a research Methodology approach that Space Operations and other complex organizations may use to modify and apply to their unique processes.
References


