

# Cognitive Biases and Other Challenges in Going Beyond Human Error in Safety Investigations

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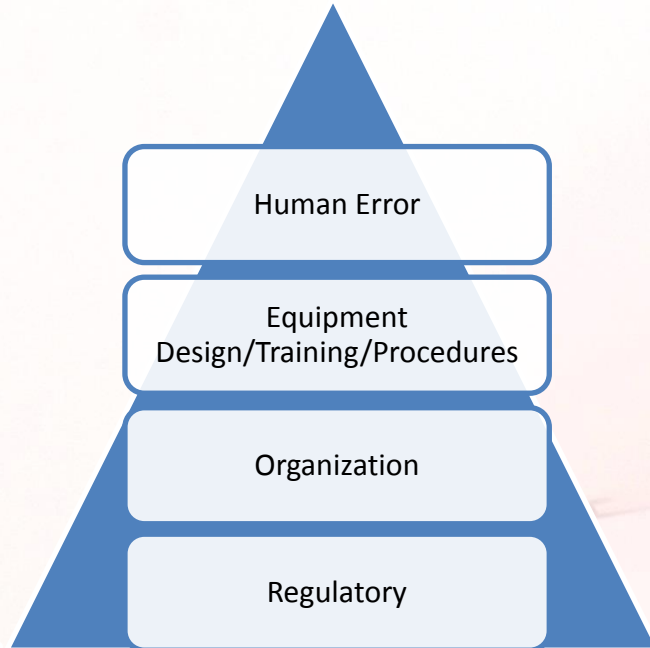
# Disclaimer:



The views presented are those of the authors and do not necessarily represent the views of the U.S. National Transportation Safety Board or the U.S. Federal Aviation Administration

# Prevention is the Goal of Investigation

- Still an emphasis on error
- Effective investigations go beyond the actions of individuals and examine underlying factors



# Target Audience: Safety Investigators and their Organizations



- Governmental organizations
- Manufacturers
- Airlines
- Air traffic service organizations
- Maintenance organizations

# What is **Cognitive Bias**?

A systematic error in thinking that affects the decisions and judgments of people

**Hindsight  
Bias**

**Fundamental  
Attribution  
Error**

**Confirmation  
Bias**

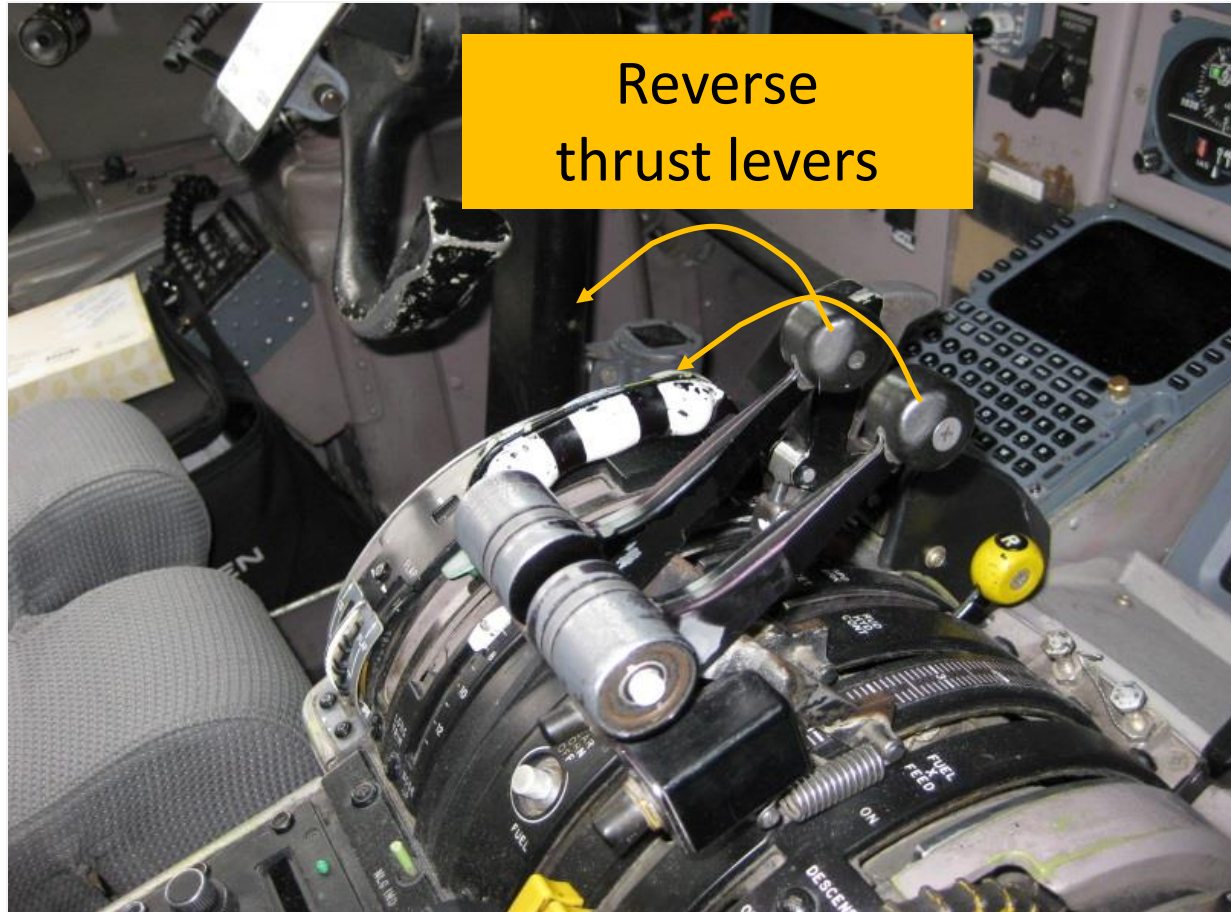
**Outcome  
Bias**



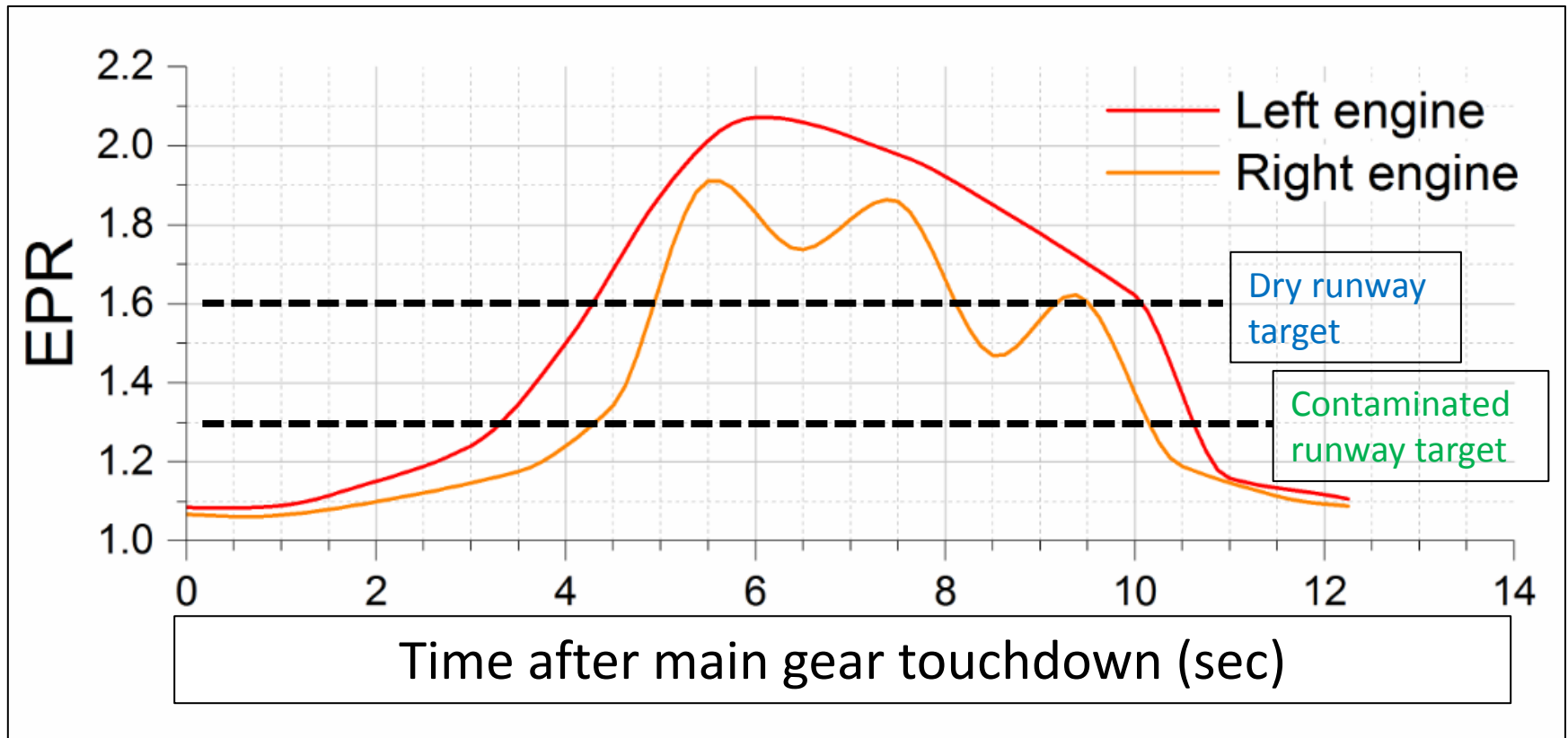
# Example 1: Accident Involving Delta Flight 1086 at LaGuardia International Airport



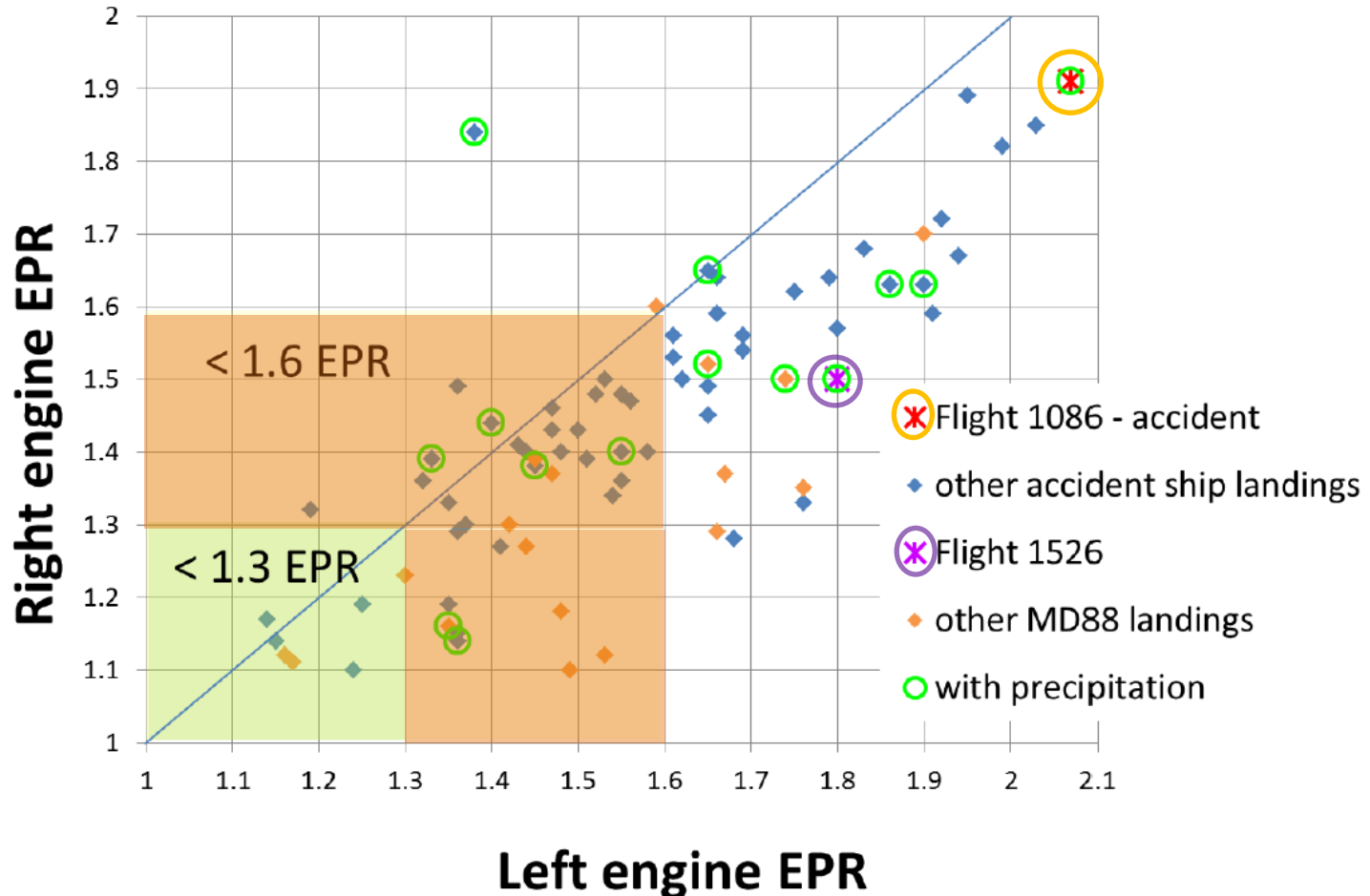
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# Outcome Bias

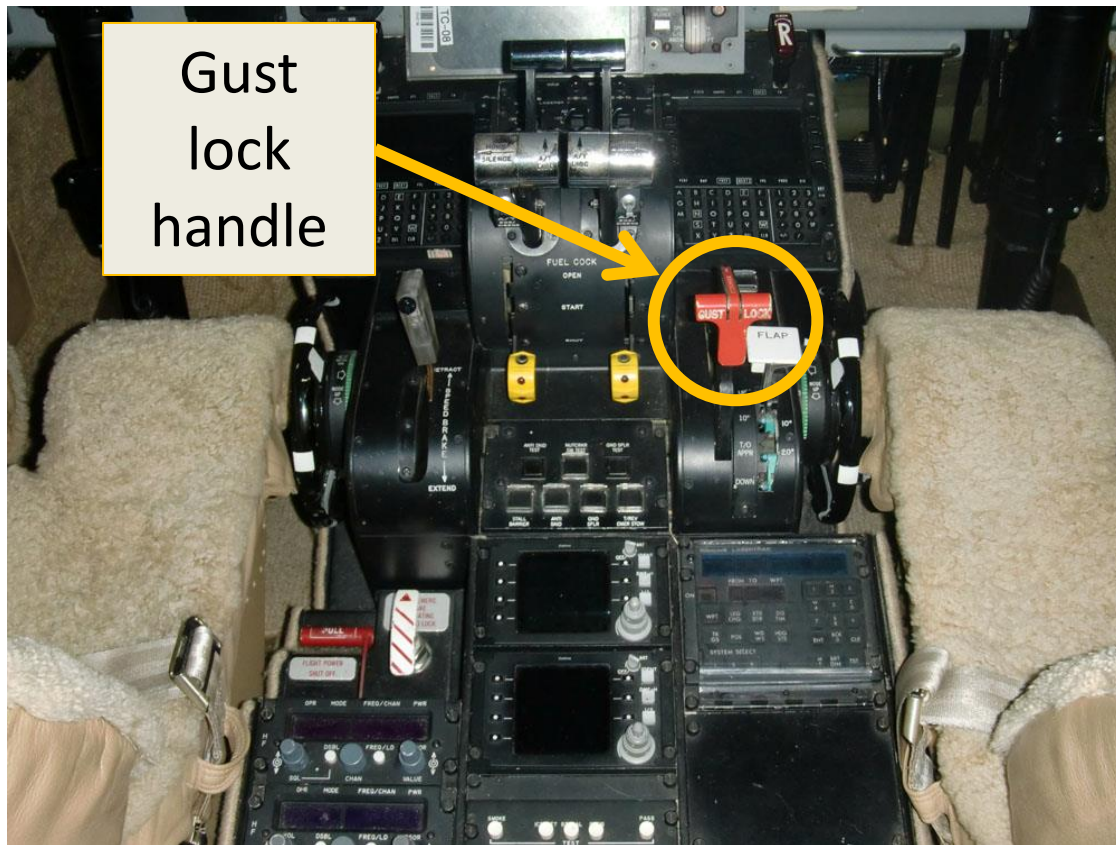
Our evaluations of others' decisions are disproportionately influenced by outcome

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

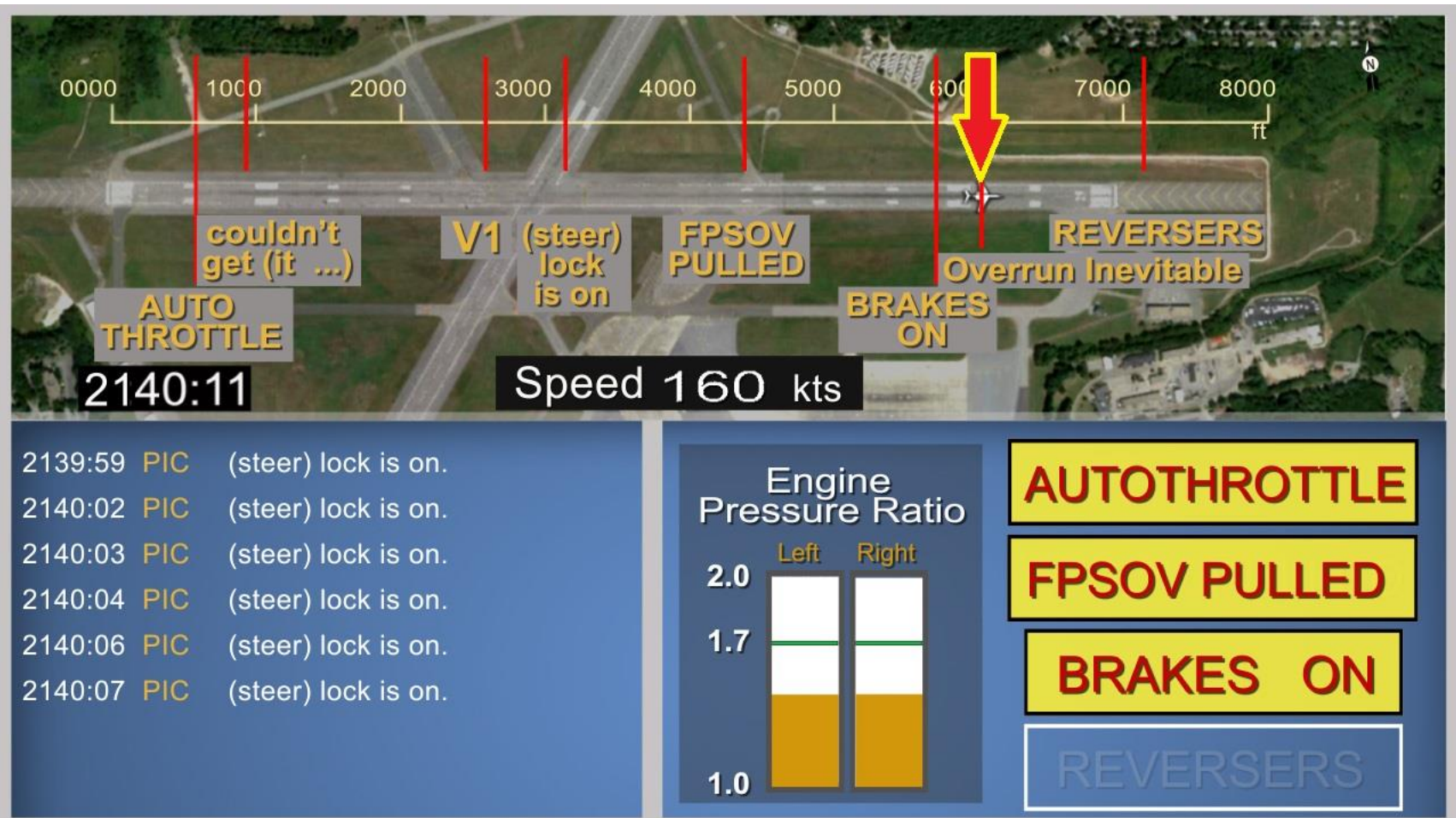
# Example 2: Accident Involving Gulfstream G-IV at Hanscom Field (Massachusetts)



# Example 2: Accident Involving Gulfstream G-IV at Hanscom Field (Massachusetts)



# Example 2: Accident Involving Gulfstream G-IV at Hanscom Field (Massachusetts)



# Hindsight Bias

- Hindsight  $\neq$  Foresight
- Minimizes the uncertainty faced by those involved in an event
- Difficult to overcome, even when we are aware of it

# Example 3: Accident Involving Continental Airlines Flight 1404 at Denver International





WIND

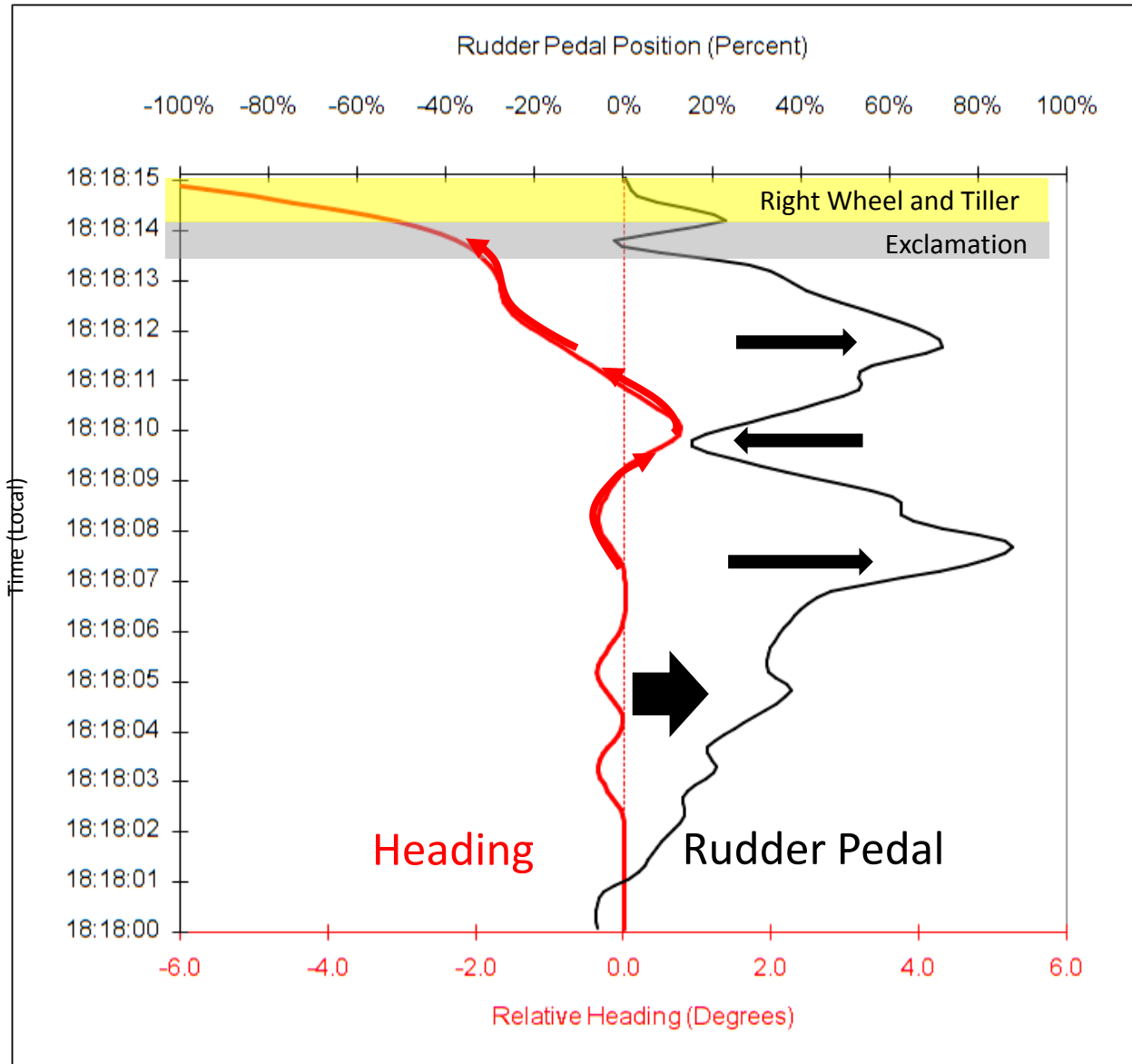
# Confirmation Bias:

Judgment  
disproportionately  
influenced by  
initial ideas

WINGLETS!

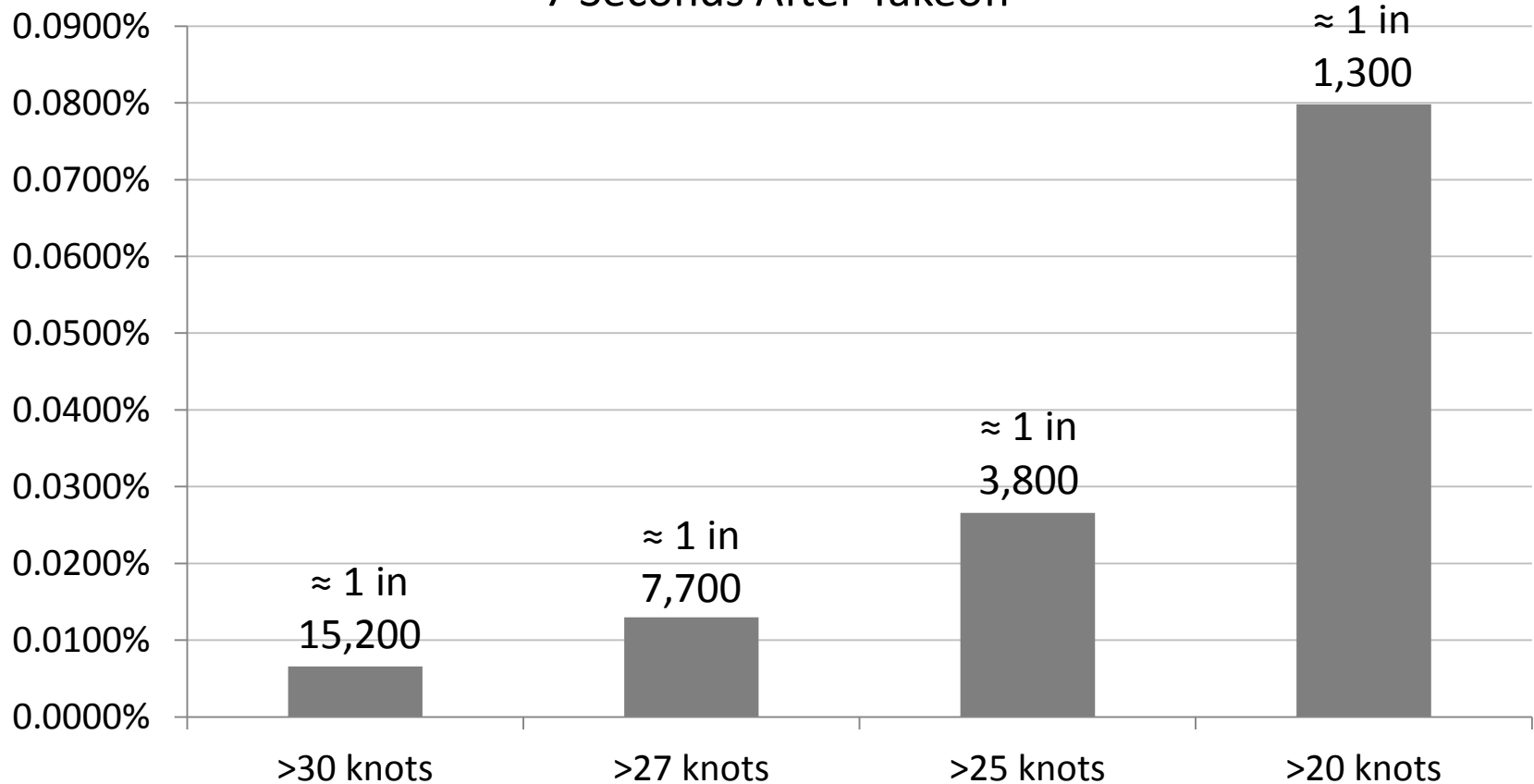


# Example 3: Accident Involving Continental Airlines Flight 1404 at Denver International



# Example 3: Accident Involving Continental Airlines Flight 1404 at Denver International

940,000 Major Airline Flights Encountered a Crosswind Component Greater than the Specified Value  
7 Seconds After Takeoff

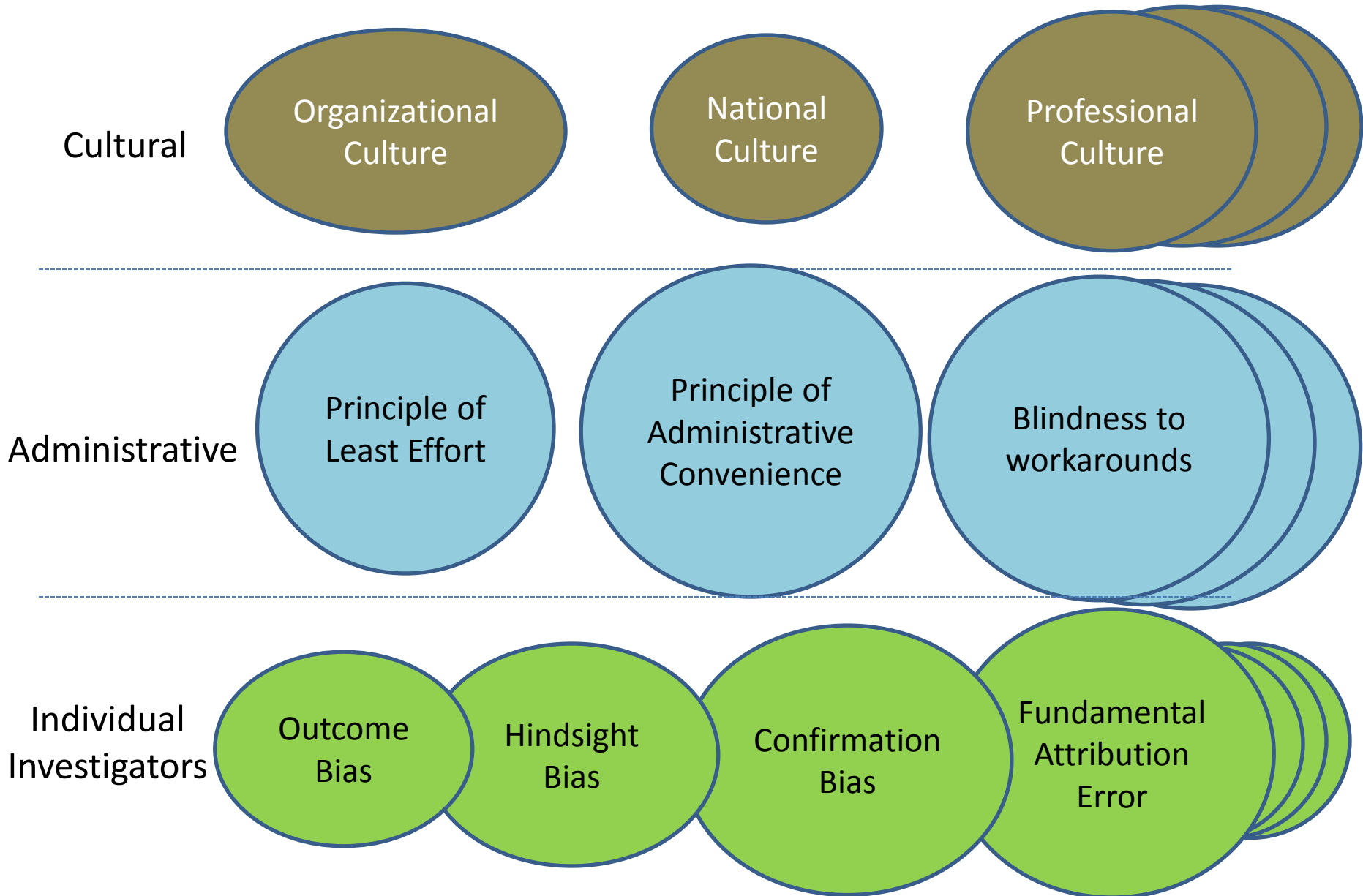


# Fundamental Attribution Error:

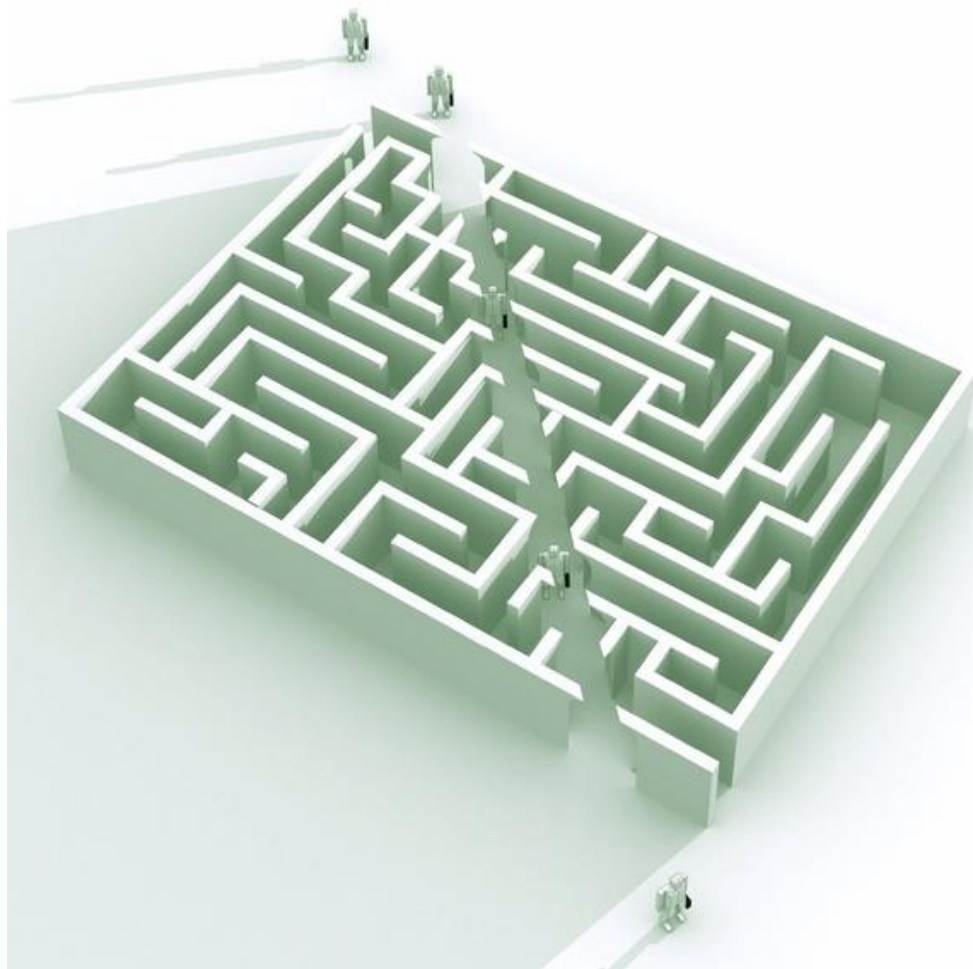
Estimating the Influence of Situations on Behavior

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

# Potential Biases



# Principle of Least Effort



# Blindness to workarounds

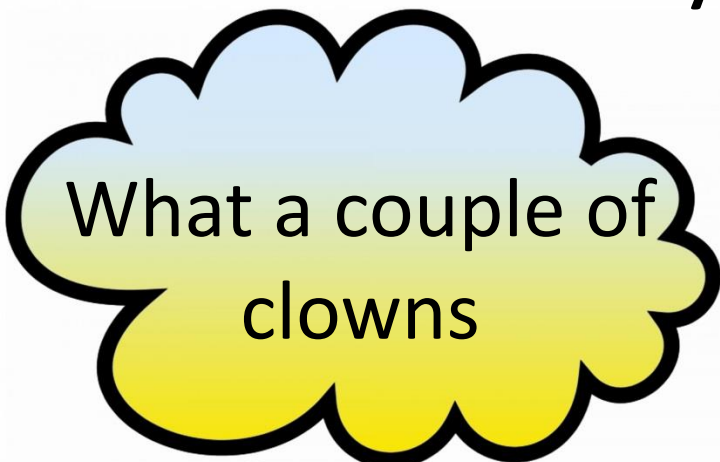


# Professional Culture

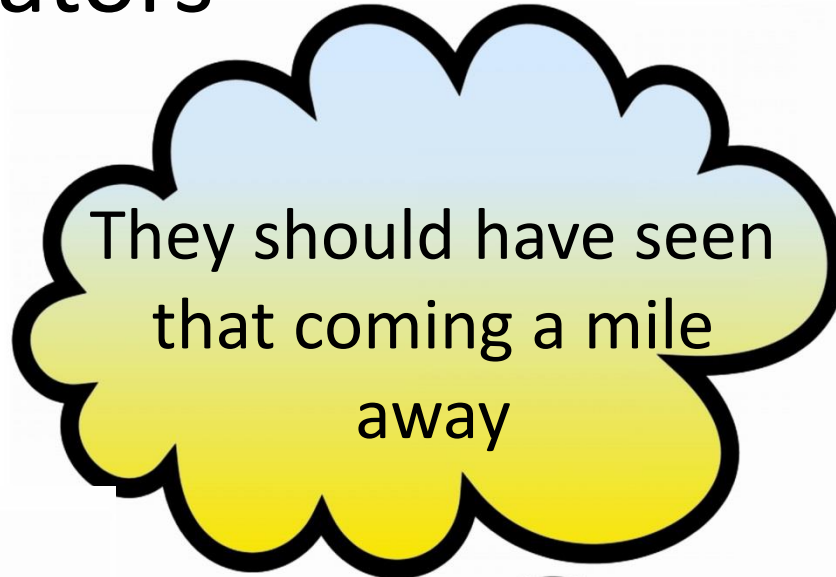
- **Attitudes about responsibility and accountability - “trade indignation”**
- **Counterfactual thinking – “if only”**



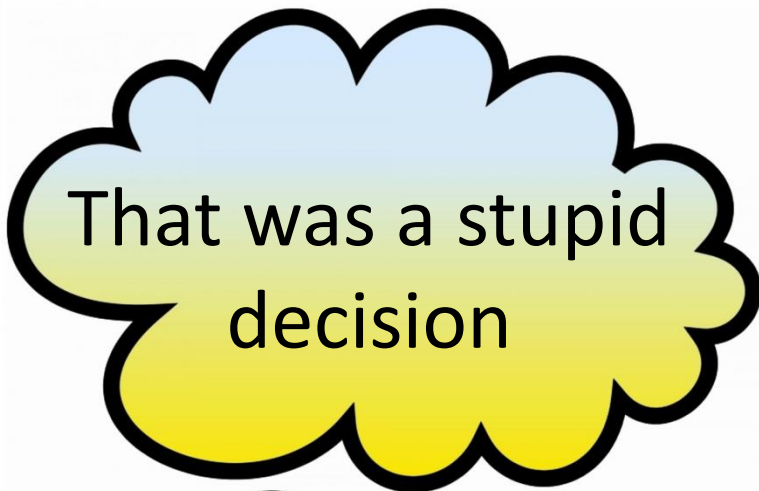
# Signs of Potentially Biased Thinking by Investigators

A thought bubble with a yellow-to-white gradient and a black outline, containing the text "What a couple of clowns".

What a couple of  
clowns

A thought bubble with a yellow-to-white gradient and a black outline, containing the text "They should have seen that coming a mile away".

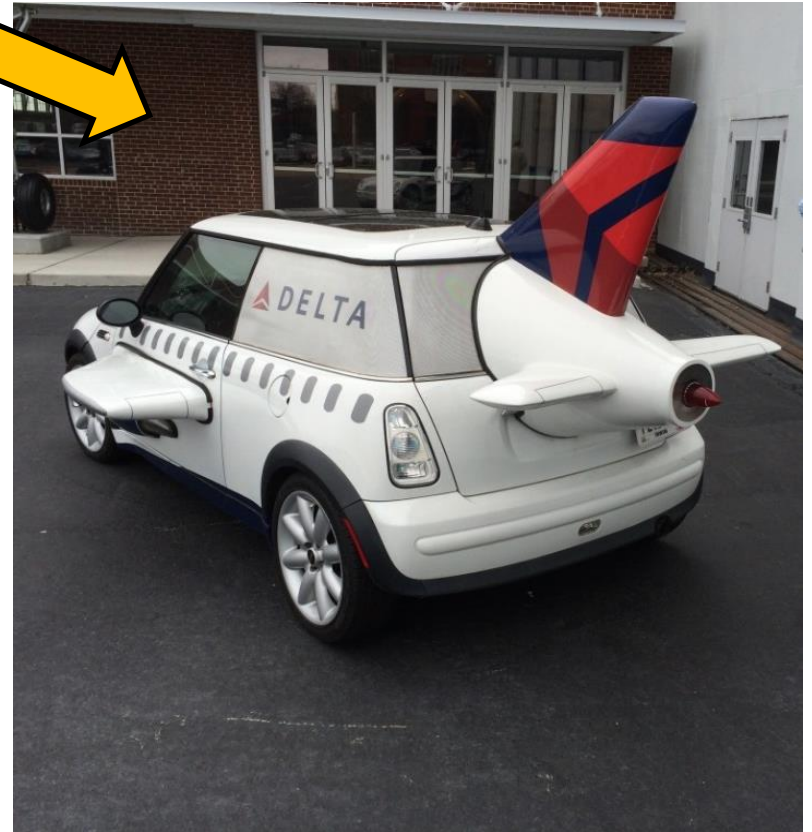
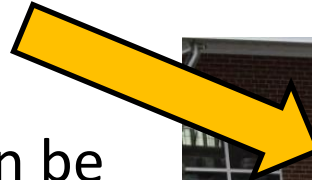
They should have seen  
that coming a mile  
away

A thought bubble with a yellow-to-white gradient and a black outline, containing the text "That was a stupid decision".

That was a stupid  
decision

# More Signs of Potentially Biased Thinking by Investigators and Organizations

- “Safety investigations will be just as effective if we compress investigative timelines.”
- “That accident (incident) can be easily explained...The crew didn’t do X, Y, and Z.”
- “Recommendations will be just as effective if we avoid controversy.”
- “We can eliminate accidents through total compliance.”



# What Do We Do About It?

- Educate investigators and their organizations about biases
- Be alert to signs of potentially biased thinking
- Be aware of tradeoffs between resources expended and investigative depth/breadth
- Identify/develop recommended investigative processes for addressing underlying factors in safety events
- Identify opportunities for peer review

# Concluding Remarks

- Get beyond human error in investigations
- Avoid or mitigate biases by accident and incident investigators
- Awareness and education are the first steps