

Taking Liberties: Fatal Error

What was the name of the airline involved?

What happened in the accident?

What did the commission conclude?

What changes resulted from the investigation?

Do you feel that the interface was flawed (or at fault)? Why or why not?

Was the task appropriate for the operators? Why or why not?

What critical HF concepts were *most* important in the accident? Justify your answer.

How did the operators' mental model of the system help (or hurt) them?

What aspect(s) of the design model supported the operators' mental model?

What suggestions would you make to prevent similar incidents?