

The Challenger Launch Decision: Risky Technology, Culture, and Deviance at NASA.

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Vaughan D. Chicago, IL: University of Chicago Press; 1996. ISBN 9780226851754.

<https://psnet.ahrq.gov/issue/challenger-launch-decision-risky-technology-culture-and-deviance-nasa>

A model of [root cause analysis](#) on a system-wide scale, Vaughan's analysis of the Challenger crash looks beyond the widely held belief that pressure from NASA management to meet a launch schedule contributed to the decision to bypass multiple internal warnings. Vaughan identifies two general causes other than pressures related to the timeline: a dispersion of knowledge to silos within the organization, exacerbated by a tendency toward secrecy within silos, and a culture in which unexpected or unwanted test results were minimized, explained away, or out-and-out dismissed. Vaughan refers to this second tendency as the "[normalization of deviance](#)," a phenomenon that shares many features with the "status quo bias" discussed in cognitive psychology. In both cases, potential warnings alerting individuals or groups to the possibility of serious error are cast as consistent with a prevailing belief or strategy, rather than interpreted as grounds for casting it aside. Those who have worked in a health care organization in which a prominent, adverse event has occurred will find the discussion of the aftermath particularly sobering.