To get an idea of the scope of what we are talking about, I will begin with review of 5 different emergency or abnormal situations
• Dallas Text to Toronto, Ontario, Canada – 5 crew members and 41 passengers – in cruise at FL330

• CA reset cbs twice – thought the flush motor was overheated

• CA did not appear to refer to procedure for resetting cbs in abnormal section of AOM – no reference to this procedure on CVR

• FO and FA didn’t clearly communicate that they could not see the source of the fire

• FA’s discharge of CO2 completely ineffective – fire was behind the lavatory wall

• Lost left AC and DC left electrical systems so CA made report to Indy Center

• NTSB estimated that fire had been burning up to 15 minutes before detected by passenger and flight attendants
Air Canada 797 - DC-9 In-flight Fire, Covington, Kentucky
June 2, 1983

- 1907:41 Emergency AC and DC busses lost power; CA & FO attitude indicators tumbled
- ATC offered landing at Cincinnati-Covington Airport
- CA accepted; heading 060° and 20 miles
- Declared emergency, squawked 7700 but transponder inoperative due to power loss
- 1909:33 Handoff from Indy Center to TRACON
- TRACON unaware of /9/’s electrical problems identified the wrong target on radar scope
- ATC planned for landing rwy 36; aircraft not positioned well for rwy 36 when identified as correct target; eventually landed rwy 27L

- ATC asked for “fuel and souls” twice, FO declined
- Though not required by procedure, FO turned off the air conditioning & pressurization packs “because the smoke was getting bad at that point and my reasoning was I have to do something…”
- Toxic fumes and gases built up, a flash fire occurred soon after landing and opening doors for evacuation; 23 passengers died.
Illustration of range of situations – a pack trip is generally pretty benign and easily handled – not much increase in stress or workload – some pack trip checklists may have more than 4 items
ValuJet 558 - DC-9 Ground Spoiler Activation In-flight, Nashville, TN
January 7, 1996

- CA performed preflight walk around, all looked normal
- Ice and snow on taxiways, concern about contamination
- FO was PF; on Take off called “positive rate, gear up”
- CA unable able to move gear lever to retract position
- CA consulted UNABLE TO RAISE GEAR LEVER checklist in QRH
  
  ![Checklist Image]

- CA determined malfunction of the anti-retraction mechanism & completed appropriate checklist steps
- CA took over as PF; FO confirmed checklist complete
- CA advanced throttle to climb power, TO warning horn sounded, cabin not pressurizing
- Decided that ground shift mechanism must have also malfunctioned
- To place ground control electrical relay circuits in flight mode, FO pulled the Ground Control Circuit cb’s as per checklist.

- Atlanta, GA to Nashville, TN – 5 crew members and 88 passengers
ValuJet 558 - DC-9 Ground Spoiler Activation In-flight, Nashville, TN
January 7, 1996

- Crew did not contact dispatch as per SOPs because they thought the problem was resolved.
- During landing brief, consulted QRH, decided to depressurize aircraft on approach.
- Around 100' AGL, CA verified zero psi differential and the reset obs as per QRH checklist.
- Aircraft went into ground mode and ground spoilers deployed.
- Aircraft hit hard in approach light area short of runway 2R, lost nose wheel and radios, bounced, went around and landed on runway 31.
- Information about when to reset ground control circuit breakers missing from QRH but included in AOM.

| Approach and landing: | The ground control relay electrical circuits can be placed in the flight mode by pulling the Ground Control Relay circuit breakers (H and J20).
<table>
<thead>
<tr>
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<tr>
<td>Do not exceed VLE (350 kts/470).</td>
<td>Ensure the airplane is depressurized, anti-skid switch is located on the ground.</td>
</tr>
<tr>
<td><strong>Approach and landing:</strong></td>
<td><strong>AOM</strong></td>
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<tr>
<td>If landing gear not retracted prior to landing, ground spoilers must be operated manually.</td>
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<tr>
<td>AIRPLANE ....................... DEPRESSURIZE (PNF)</td>
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<td>ANTI-SKID SWITCH (before 35 kts) .......... OFF (PNF)</td>
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<td>GROUND CONTROL RELAY CIRCUIT BREAKERS (C, J20) ............... REMOVED (C or PN)</td>
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Example where checklist is inappropriate for the situation – designers did not consider variety of situations in which the checklist would be needed.

Hydraulic caution light illuminated while taxiing...I completed the QRH checklist...We rolled to a stop in the grass...A very poorly written QRH emergency checklist. CALLBACK: ...The checklist is for use in-flight, not on the ground.

(ASRS Report, Accession #437817)
Hilo to Honolulu, HI – 5 crew members and 41 passengers – leveling off at 24,000 ft. when decompression occurred

FO reached for oxygen mask and it wasn’t there – had been pulled out of storage compartment by decompression and was flopping in the wind behind her seat, still attached by its tubing to the oxygen system

CA, FO, and Jumpseat rider don oxygen masks

CA takes over a PF and begins emergency descent, FO dials in 7700 on transponder

Attempt to contact FAs is unsuccessful

FO attempts multiple radio calls to Honolulu Center, Maui Approach, and Maui Tower

1345:43: As aircraft is leveling off at cruise altitude of FL240, sound of increased wind noise is heard on Cockpit Area Microphone

1348:34: FO hears Maui Tower ATC respond and declares emergency

Initial ATC confusion about aircraft flight number – multiple radio calls, FO requests ambulance

Left engine was lost, CA could not transmit over radios, no nose gear down indication

FO attempts two manual gear extensions, advises ATC they have no nose gear

ATC: “OK, if you need assistance keep me advised” FO: “We’ll need all the equipment you got.”

CA lands flaps 5, 170 kts. on runway 2 Maui, aircraft visibly bows up and down on rollout

FO estimates all or parts of 17 different checklists completed in 13 min. almost all from memory. QRH consulted only for flaps 5 landing speed and passenger evacuation

Hilo to Honolulu, HI – 5 crew members and 41 passengers – leveling off at 24,000 ft. when decompression occurred

FO reached for oxygen mask and it wasn’t there – had been pulled out of storage compartment by decompression and was flopping in the wind behind her seat, still attached by its tubing to the oxygen system

FO and CA could see blue sky and tail of the aircraft through the open cockpit door

One flight attendant lost, one knocked unconscious, the third was crawling up and down the isle on hands and knees assisting passengers put on life vests

Multiple serious injuries for passengers

FO and CA helped passengers evacuate, some were so bloody that they slipped through hands of FO, CA and ARFF when trying to help them up
Situational and Operational Demands of Emergencies

✦ Wide range of conditions:
  • Straight forward and clear cut – ambiguous, misleading cues
  • Common, highly trained – uncommon, never trained or anticipated
  • Relatively benign, minimal time pressure – potentially catastrophic, highly time critical
  • Characteristic: static – dynamic and/or cascading failures
  • Checklists: exist for exact situation – don’t exist at all, not pertinent, no time to access and consult

✦ Communication and coordination is a challenge
  • Between / among / with: flight crew, flight attendants, ATC, dispatch, maintenance, passengers, ARFF
Situational and Operational Demands of Emergencies

**Workload:**
- Manage increased workload
- Distribute workload effectively
- Ask for assistance as appropriate
- Handle interruptions, distractions
- Interleave concurrent task demands appropriately
- Accomplish normal flying tasks
- Shed tasks appropriately
- Make accurate diagnosis, determine appropriate response, estimate time available accurately
- Maintain “big picture” and update mental model as situation unfolds
Operational and Situational Demands → Response to an Emergency Situation
**Contextual Factors**

- **Environmental** – night, day, angle of sunlight, weather and precipitation, winds, haze (visibility), ice, amount of other aviation traffic

- **Geographic** – altitude, terrain, water, mountains, plains, roads/highways, city/suburban/rural, familiarity with area

- **Aviation infrastructure, external** – numbers and kinds of nav aids, location of airports, location of maintenance bases/dispatch support, availability of ARFF and hospitals

- **Aviation infrastructure, internal** – types and kinds of automation, aircraft equipage, types and kinds of checklists and procedures, single-pilot, crew ops

- **Historical** – other recent similar emergencies/accidents, issues emphasized during training, known historical problems for type of aircraft

- **Personal and Interpersonal** – exposure to/experience with similar situations in the past, crew pairing history (first day, last day, previous trip), personality, fatigue, health status, knowledge, skill, single-pilot vs. crew background, culture
Human Performance Capabilities under Stress

Well-learned motor skills
• remain robust and relatively unaffected by stress

Our simulator training really paid off. This was my first engine shutdown in 20 years of flying and it felt like I had done it a thousand times before!

(ASRS Report, Accession #466167)
**Human Performance Capabilities under Stress**

**Cognitive Performance**

- Reduced Cognitive Processing Speed

- Tunneling
  - narrowing of human attention
  - restricts scanning of environmental cues
  - narrow focus on most salient or threatening cues (positive and negative aspects)
  - yields poor differential diagnosis of situation

- Working Memory
  - capacity and length of time information can be held decreases
  - when exceeded – difficulty performing mental calculations, problem solving, making sense of disparate pieces of information, shifting mental sets

- Tendency to Rush

- Altered Sense of Time

- When overwhelmed, tend to be reactive, cannot see the "big picture"
Human Performance Capabilities under Stress

We did find communication difficult and the use of oxygen masks, intercom, trying to talk to ATC was a handful.

At night made it that much harder to read/accomplish checklist items. Turning cockpit lights on sooner would have helped.

(ASRS Report. Accession #472755)
Crew Performance under Stress*

- Effective teams tend to shift strategies from explicit to implicit coordination
  - this only works if roles are well understood and all share the same mental model of situation and needed response
- Telegraphic speech, incomplete communication, greater reliance on body language is common
- Level of cooperation tends to increase
- Lower status crew members are more likely to rely on leader’s decisions and defer, less likely to speak up or confront
- Under high stress, leaders tend to be more open to input from lower status crew members

* Findings primarily from laboratory studies with subjects from Western Cultures
Checklists are essential tools that crews use to help them respond appropriately to emergency and abnormal situations. Two examples of checklists – B777 ECL and a paper checklist (paper checklists can look very different from this one – this is just one example and I used it because it is already in the public domain (included in an NTSB accident report).
### 14 Checklist Design and Content Factors (Paper, Electronic, EFB)

| Physical Properties, Interface, & Integration | - size, weight, materials, integration w/displays & alerts |
| Typography, Symbology, Color, Graphics, and Display Characteristics | - font, font size, boldface, intuitive symbology, flashing text, font and paper/display background colors |
| Layout, Format, & Display | - look, arrangement, philosophy of response/use |
| Organization, Access, & Prioritization | - finding correct checklist, prime real estate pg. |
| Purpose | - fix, troubleshoot, stabilize/safe, disable/isolate |
| Objective (of checklist item) | - direct action, inform, assess, make decision |
| Length and Workload | - physical length, timing length, workload |
| Nomenclature, Abbreviations & Numerical Information | - terms, labels, abbreviations, numerical information |
| Language, Grammar, & Wordin | - English?, verb tense, reading difficulty, clarity, orientation/perspective, directiveness |
| Level of Detail | - amount of information provided |
| Comprehensive & Correct | - all necessary steps included, appropriate for situation |
| Engineering Coherence | - order of steps/timing makes "sense" to aircraft |
| Logical Coherence | - order of actions makes sense to the pilot and make "sense" operationally |
| Progression & Jumping | - movement within & between checklists/manuals |

List of checklist design and content areas
Of course, much more complicated picture – a number of interactions
US Airways 1549 - A320 Dual Engine Failure, Hudson River, NY
January 15, 2009

- During climb out from LGA the aircraft hit a flock of geese and lost the thrust in both engines
- CA took over as PF and called for the ENG DUAL FAILURE checklist
- This is a paper checklist (ECAM Exception)
- FO tries several time to start the engines - unsuccessful
- Approx. 3 min. after hitting the birds, CA performs a forced landing into the Hudson River

Analysis:
- Daylight, good visibility, crew saw the birds right before hitting them
- Assessment: Knew immediately what their problem was and why, amount of time
- Division of workload clear – CA took over as PF and called for checklist
- FO recently completed training, recognized the checklist as an ECAM exception and knew to go to QRH for the checklist
Analysis, continued:

- **ENG DUAL FAILURE** checklist is three pages long
- Divided into three parts:
  - No fuel remaining vs. fuel remaining
  - 3 steps if restart is successful vs. unsuccessful
  - Forced landing or ditching anticipated
- Organized for dual engine failure at altitude
- Items expected to be completed in order presented
- Flap configuration item at bottom of page 2 (For landing...Use FLAPS 3)
- Expectation that configuration for ditching will occur above 3,000 ft.
- “Ditching pb......ON” item near the end of the checklist
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List of checklist design and content areas pertinent to this accident
Saudi Arabian 163 - L1011 Cargo Fire, Riyadh, Saudi Arabia
August 19, 1980

- 7 minutes after takeoff, climbing through 15,000 ft, crew given visual and aural alerts of smoke in aft cargo compartment
- 4 minutes spent trying to confirm warning & locate procedure in QRH never found
- CA attempted to fly aircraft, assess situation, and remedy problem himself
- FO inexperienced, did not assist with radio communication or monitoring systems, SO spent most of event looking through AOM repeating “No Problem” to himself; FAs not informed
- No. 2 engine thrust level became stuck during return to airport, engine shut down
- Aircraft stopped on taxiway 2 min. 40 sec. after touchdown, 3 min. 15 seconds later engines shut down, evacuation never initiated, doors remained closed, all 301 on board perished

**Analysis:**

- Night flight, crew unsure if alerts were accurate or false alarms
- Very poor CRM and distribution of workload, CA attempted to do it all
- Crew were looking for checklist in “Abnormal” section of QRH, it was located in the “Emergency” section
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List of checklist design and content areas pertinent to this accident
· 0535:23, Flight was in cruise, FL330, cabin cargo smoke light illuminated
· CA and FE donned smoke goggles, FE removed them after noting no smoke, CA removed them prior to landing so he could put his glasses back on
· CA spent a few minutes determining that alert was real
· '3 min. 44 sec. after first light illuminated, CA called for emergency descent, emergency descent checklist items completed from memory
· FO continue as PF, CA handle radios and work with FE in completing checklists – “Fire and Smoke” and “Cabin Cargo Smoke Light Illuminated”
· FO slowed to 250 kts CA told him to keep his speed up
· CA broadcast internal cockpit communication over the ATC frequency
· FE asked for and was told identifier for diversion airport three times – he never got it
· FE confused by one step and missed two checklist items by mistake; the evacuation checklist was never called for or completed
· Aircraft was still partially pressurized upon landing.
Analysis:

- Some delay in descent; focus on monitoring progression of smoke and fire
- High level of stress and workload for all three crew members
- FE knew that first checklist to complete was “Smoke and Fire” checklist (gateway)
- CA engaged in multiple tasks, did not monitor FE workload closely
- Multiple checklists not completed; FE made errors during checklist completion

- Section of Cabin Cargo Smoke Light Illuminated Checklist
- Multiple items make reference to cabin altitude and FL270 – logical coherence issues
- Inconsistencies in amount of information provided re: identical actions
- “MANUAL CAB ALT” control wheel – FE “cranked it open a couple of times” – NTSB determined it would have needed 16 cranks to fully open – difference between simulator and real life
List of checklist design and content areas pertinent to this accident

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14 Checklist Design and Content Factors
(Paper, Electronic, EFB)
**Events:**

- During the takeoff roll, the CA indicated that his airspeed indicator was not working.
- It appeared to start working properly once the aircraft began to climb but significant discrepancies existed between the CA’s, FO’s, and alternate airspeed indicators.
- A few seconds later two advisory messages appeared on the EICAS display: RUDDER RATIO and MACH/SPD TRIM.
- The overspeed warning clacker sounded.
- The center autopilot commanded an 18 degree nose up attitude, the autothrottles went to a very low power setting due to high airspeed on the CA's PFD.
- The FO selected Alt Hold in an attempt to level off but throttles at too low a setting to maintain altitude.

**Analysis:**

- Daylight, good visibility.
- Crew highly confused, agreed that alternate airspeed indicator was correct but continued to try use (and be confused by) airspeed information on PFDs.
- Crew didn’t attempt to fly the aircraft manually; automation contributed to problems.
- Did not try to access CLs for RUDDER RATIO or MACH/SPD TRIM but unlikely they would have helped – was no specific “airspeed discrepancy warning” on B757.

**Findings:**

- Investigators determined that a pitot tube that provided information to the left Air Data Computer (ADC) was most likely completely blocked. The left ADC provided information to the CA’s airspeed indicator and the center autopilot.
- There was no specific airspeed discrepancy warning on the B757.
- The crew did not attempt to clarify the RUDDER RATIO or MACH/SPD TRIM advisories but it is unlikely that any related checklists would have proved useful.
- Although the crew agreed that the alternate airspeed indicator was correct they continued to try to use (and be confused by) airspeed information on the PFDs.
- The contradictory warnings and indicators were confusing and the center autopilot and autothrottles contributed greatly to their problems at least initially.
- The crew did not attempt to fly the aircraft manually and continued to try use automation that did not help them (i.e., Altitude Hold).
List of checklist design and content areas pertinent to this accident

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Upcoming Publication

Barbara Burian, Ph.D.
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Emergency and Abnormal Situations Study
http://human-factors.arc.nasa.gov/eas