# Cabin Crews in Emergency and Abnormal Situations

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## The Challenge

### Emergency and abnormal situations:

- are often time critical, complex, and/or ambiguous
- are high stress, high workload, and a great deal is at stake
- require exceptionally high levels of coordination inside and outside of the airplane

### Emergency and abnormal procedures:

- are generally focused on aircraft systems rather than on the situation as a whole
- are practiced seldom (twice a year or less) and used rarely
- are often highly dependent on fragile cognitive processes
- when needed, are crucial and must be performed correctly







## Industry Contacts and Consultants

Manufacturers: Boeing, Airbus Industries, BAe Systems,

**Bombardier** 

Regulatory and

Governmental Agencies: FAA, CAA (UK), JAA, ICAO, Eurocontrol

Unions and

Trade Groups: ALPA, APA, SWAPA, ATA, ADF

**Accident Investigation** 

Bodies: NTSB, TSB of Canada, ISASI

Airlines: Airborne Express, Air Canada, Alaska,

Aloha, American, Atlantic Southeast,

Cathay Pacific, Continental, Delta, Fed

Ex, Frontier, Hawaiian, Horizon,

JetBlue, Southwest, United, UPS,

US Airways, TWA (prior to merger)



- Broad, Over-arching Issues (3)
- Issues Related to Checklists and Procedures (3)
- Issues Related to Humans (5)
- Issues Related to the Aircraft (2)
- Issues Related to Training (1)
- Selected Emergency Equipment and Evacuation Issues (1)





- Broad, Over-arching Issues
- Issues Related to Checklists and Procedures
- Issues Related to Humans
- Issues Related to the Aircraft
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- Selected Emergency Equipment and Evacuation Issues





## Broad, Over-arching Issues

**Philosophies** 

Economic and Regulatory Pressures

Definitions & Perspectives







Philosophies and Policies of Dealing with Emergencies and Abnormal Situations – Manufacturers, Company, ATC, etc.

Economic and Regulatory Pressures Pertaining to Dealing with and Training for Emergencies

Clarification of terminology (e.g., abnormal vs. emergency) and appropriate usage







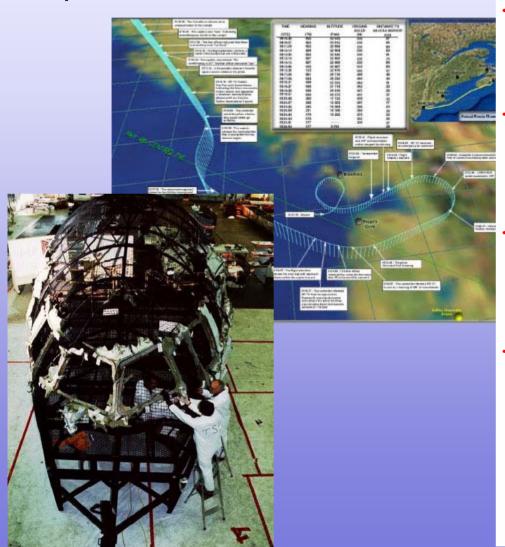
## Philosophy of Response to Emergencies

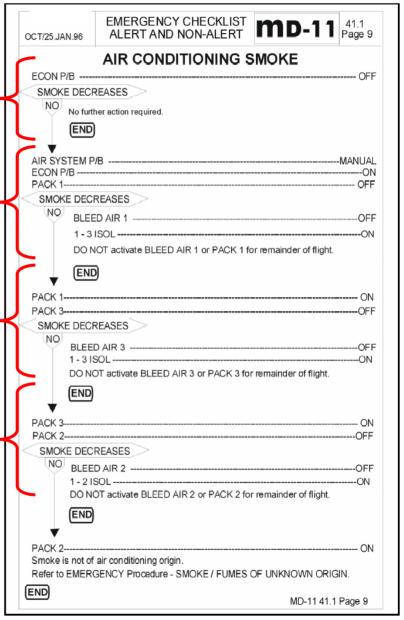
Evident in Checklist Design





# Swissair 111 - In-flight Fire Nova Scotia, Canada September 2, 1998





#### SMOKE / FUMES OF UNKNOWN ORIGIN CAB BUS P/B Pause long enough for cabin crew to evaluate whether smoke or fumes decrease. SMOKE / FUMES DECREASE Continue with cabin bus inoperative. END CAB BUS P/B SMOKE ELEC/AIR Selector -Rotate SMOKE ELEC/AIR Selector clockwise, pausing at each position long enough to evaluate whether smoke or fumes decrease. When a decrease is noted, leave selector in that position for rest of flight Continue with that generator channel and air system inoperative and observe associated consequences. NOTE: - When rotating the SMOKE ELEC/AIR Selector, the autothrottle will disengage and be unusable. The autopilot may disengage but then - Nuisance stick shaker may occur. (Stick: shaker CBs on overhead panel: Captain E-1, F/O E-31) Following essential systems are inoperative or off in accordance with SMOKE ELEC/AIR Selector Pos. SMOKE Selector Pos. 3/1 OFF: only Captains VHF 1 and interphone available. DU 4, 5, 6; MCDU 2; FM3 2; IR3 2 (after 15 min). - Radar 2: All Nav aids 2. - BLEED AIR 1; PACK 1; ECON system; WING anti-ice. - E/O pitot heat. Auto slat extension. - Landing gear aural warning. Autobrakes. FOR APPROACH - Set FLAP LIMIT Selector to OVRD 1. - Go-around mode is not available. SMOKE Selector Pos. 2/3 OFF: -BLEED AIR 3: PACK 3: WING anti-ice. -Aux pitot heat. -Fuel dump low level -HORIZONTAL STABILIZER TRIM Switches on control column. -Engine 2 reverser SMOKE Selector Pos. 1/2 OFF: only VHF 2 and 3 available. - DÚ 1, 2, 3; MGDU 1; FM8 1. - IRS 1 and AUX IRS after 15 min. (AP no longer available). - Radar 1; All Nav aids 1. - BLEED AIR 2: PACK 2: WING and TAIL anti-ice. - Captain pitot heat. - GPWS, GPWS BELOW G/S lights. Auto ground spoilers. Engine reversers 1 and 3. FOR APPROACH: - Set FLAP LIMIT Selector to OVRD 2. - On CAPT SISP push FD P/B to OFF. Go around mode is not available. If smoke/fumes are not eliminated, land at nearest suitable airport END MD-11 41.1 Page 10

# Swissair 111 - In-flight Fire Nova Scotia, Canada September 2, 1998

If smoke/fumes are not eliminated, land at nearest suitable airport

# ValueJet 592 - In-flight Fire, Florida Everglades, May 11, 1996



ELECTRICAL SMOKE OR FIRE	
OXYGEN MASKS AND SMOKE GOGGLES	. ON/100%
RADIO RACK Switch	VENTURI
CABIN PRESSURE Control	MANUAL
EMER PWR Switch	ON
GEN Control and APU Bus Switches	OFF
NOTE: Wait a reasonable time to determine whether or B below.  A If smoke continues:	er to follow step A
AC and DC BUS X TIE Switches	OPEN
R & L GEN or APU BUS Switches	ON
F/O FLT INSTRUMENTS	CHECK

EMER PWR Switch OFF AC EMERG FEED C/B's (K10 & L11) PULL NOTE: If smoke disappears, fault is on AC emergency bus, if smoke

continues: AC EMERG FEED C/B's (K10 & L11) RESET

DC EMERG FEED C/B (M36) PULL 1930, 960 Series A/C ( N37)] NOTE: If smoke disappears, fault is on DC emergency bus. If smoke

continues:

DC EMERG FEED C/B (M36) RESET [930, 960 Series A/C ( N37)]

NOTE: If smoke disappears, fault is on battery bus. If smoke

continues:

**BATT Switch** ON BATT DIRECT BUS C/B's(Overhead) PULL

NOTE: If smoke continues:

BATT DIRECT BUS C/B's(Overhead) RESET DC TRANSFER BUS FEED C/B(M35) PULL

[930, 960 Series A/C (N37)]

[A/C #960 (M36)]

F/O FLT INSTRUMENTS

If smoke stops or decreases, at Captain's discretion:

AC & DC X-TIE Switches OPEN LEFT GEN Switch

NOTE: If smoke reappears, fault is on left gen bus, left AC bus, left DC bus, or AC X-tie is shorted:

L GEN Switch R GEN Switch

**EMGNCY POWER Switch** NOTE: If smoke reappears, fault is on right, gen bus, right AC bus,

right DC bus, ground service AC bus, battery charger, or AC X-tie is shorted:

[END]

OFF

CHECK

ON

OFF

## Philosophy of Response to Emergencies - Checklist Design

In a study of 15 in-flight fires that occurred between January 1967 and September 1998, the TSB of Canada determined that the average amount of time between the detection of an on-board fire and when the aircraft ditched, conducted a forced landing, or crashed was 17 minutes.





- Broad, Over-arching Issues
- Issues Related to Checklists and Procedures
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### Checklist and Procedures Issues

Development of Checklists and Procedures

Checklist Structure and Design

Checklist Type and Availability







Development of Checklists and Procedures – When? By whom? How certified? Are they standardized? Etc.

Checklist Structure and Design – Items, memory items, navigation, locating correct checklist, nomenclature, format, etc.

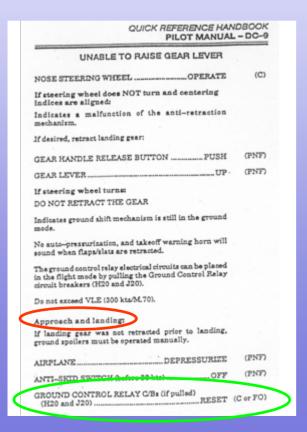
Checklist Type and Availability – Paper, mechanical, electronic (integrated with aircraft and in electronic flight bags), etc.





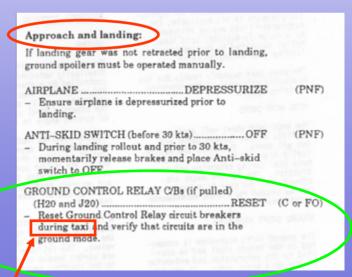
## Valujet 558 - DC-9 Hard Landing – Nashville, Tenn., Jan. 7, 1996

The crew followed QRH procedures that were incomplete. This caused the aircraft to fall from 100 ft agl on final approach. The nosewheel separated from the aircraft.





The missing information was included in the AOM expanded checklists but was never transferred to the QRH checklists.



#### AIR PACK FAULT

If pack not supplied:
If in single pack operation:
REMAINING PACK ON
PACK (Affected) OFF
If pack overheat:
If in single pack operation:
REMAINING PACK ON
PACK (Affected) OFF
PACK MODE SEL (Affected) MAN/COLD
When turb temp below limit:
PACK (Affected) ON
PACK (Affected) MAN CTL
If both packs inoperative:
MAX ALTITUDE 10,000 FT/MEA
WHEN AP BELOW 1 PSI:
RAM AIR ON
PROC: AIR PACK FAULT

If Pack Fault due to low bleed air supply, a bleed leak does not exist, and if WING ANTI-ICE not required:

BLEED VALVE (Affected sided) OFF	
AIR X FEED MAN/IN LINE	
PACK (Affected) ON	
If above FL370:	
ECON FLOW ON	
END OF PROCEDURE	

If Pack Fault due to low bleed air supply, a bleed leak does not exist, and if WING ANTI-ICE not required:

If Pack Fault due to low bleed a bleed leak does not exist. a ANTI-ICE is not required: ply, <u>then</u> NG

If Pack Fault due to low bleed air supply, and if a bleed leak does not exist, and if WING ANTI-ICE is not required:

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### Issues Related to Humans

Crew
Coordination
& Response

Checklist Use Human Performance Personnel Issues

Roles and Behavior of Others











Distribution and prioritization of workload and tasks, distractions, etc.

Errors made when completing checklists, non-compliance, not accessing checklists at all, etc.

Effects of stress, time pressure, and workload on cognitive performance, memory, creative problem solving, etc.

Emotional / affective responses to stress

Influence of crew backgrounds, experience levels, company mergers, etc.

Role of cabin crew, ATC, dispatch, maintenance, ARFF, MedLink, etc. and the degree to which their procedures are consistent / complementary

# ATA 406 B727 Rapid Decompression -Indianapolis, Indiana May 12, 1996

#### PACK REINSTATEMENT **FOLLOWING AUTO PACK TRIP**

#### **ELECTRONIC PRESSURIZATION**

After 1000 Feet AFL:
Both Pack Switches OFF Pack Reset Button PUSH Auto Pack Trip Switch CUT OUT
One Pack SwitchON
Do not reinstate second pack unless flaps are retracted.
When ready to reinstate second pack: Second Pack SwitchON
If in STANDBY mode:
Cabin ALT Selector SET 2000 FEET ABOVE AIRPLANE'S ALTITUDE      Cabin Rate Switch FULL INCREASE     One Pack Switch ON After initial pressure surge and as rate of climb returns to zero:     'abin ALT Selector SET CRUISE     CABIN PRESSURE ALTITUDE     Cabin Rate Knob SET AT INDEX     OR AS REQUIRED     Adjust as required to maintain desired rate of change.
If in MANUAL mode:
- Outflow Valve



tate second pack:

Without referring to a checklist to reinstate a pack that had automatically tripped off, the flight engineer opened the outflow valve by mistake (instead of closing it) and caused the aircraft to rapidly decompress.

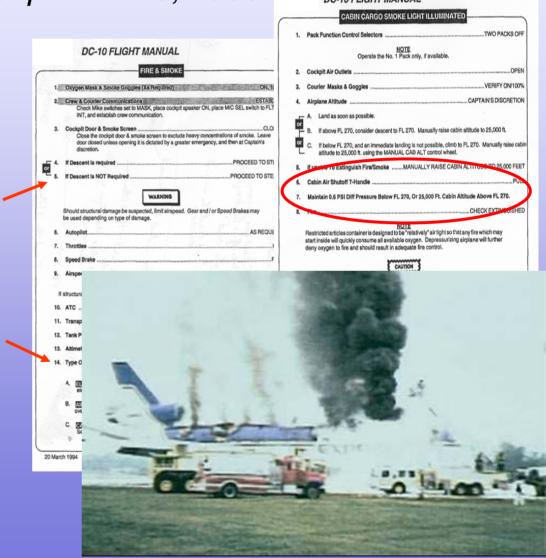
The captain, flight engineer, and a flight attendant, who had been on the flight deck, each lost consciousness during the event.



In a rapidly deteriorating situation under high stress and workload, some checklist steps were missed which resulted in the aircraft being partially pressurized after making an emergency landing.

The crew and two passengers barely escaped the burning aircraft.

FedEx 1406, DC-10 In-flight
Fire – Newburgh, New York
September 5, 1996

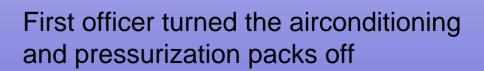


## Air Canada 797 - DC-9 In-flight Fire, Covington, Kentucky June 2,1983

Initial actions taken by cabin crew to assess and deal with fire were inadequate

Captain was told the smoke was lessening – 5 ½ minute delay in starting emergency decent

After poor handoff, ATC identified the wrong radar target as the emergency flight



Toxic fumes and gases built up, a flash fire occurred soon after landing and 23 passengers died.

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### Issues Related to the Aircraft

Critical Aircraft Systems



Automation Issues



Systems within flight protection envelopes, automated systems, etc.

Warnings, warning systems, and "warning overload"

What kinds of automation should be used and under what circumstances and when should automation not be used?

Issues in reverting to manual flying, degradation in hand flying skills, etc.



# SAS 751 - MD-81 Dual Engine Failure – Gottrora, Sweden – December 27, 1991

On takeoff, ice was ingested into the engines which damaged the fan stages and caused the engines to surge – all power was lost 77 seconds later.





During the event engine power was increased automatically by the Automatic Thrust Restoration (ATR) feature, which increased the intensity of the surging and contributed to the failure of the engines.

Neither the crew nor the company knew that the ATR feature existed on the airplane.

## Birgenair ALW 301 - B757 Loss of Control – Puerto Plata, Dominican Republic – February 2, 1996

Erroneous information was sent to the captain's airspeed indicator and center autopilot by the left air data computer because a pitot tube was blocked.

The crew members were tremendously confused by contradictory warnings (overspeed and stall warnings) and conflicting airspeed indications on the three displays.





The center autopilot and autothrottles contributed to their problems. The crew did not attempt to fly the aircraft manually and tried to use automation in a way that did not help them.

The aircraft crashed into the ocean. All onboard perished.

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## Issues Related to Training

**Training** 



Relevant training technologies and approaches

Initial vs. recurrent training in dealing with these situations

Skill acquisition and retention of procedures that are unpracticed or seldom practiced

Training for "textbook" vs. "nonstandard" situations

Training for handling single vs. multiple problems

Joint training of flight and cabin crews





# British Midlands, Loss of Engine Kegworth, Leicestershire, England January 8, 1989

The flight crew mistakenly thought they had problems was with their right engine and

shut it down.

Cabin crew and passengers could see flames coming from the left engine but this information was not given to the flight crew

48 passengers died as a result of the crash landing

Joint emergency training for flight and cabin crews was recommended by the Air Accidents Investigation Branch of the Ministry of Transport (UK)



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## Selected Equipment and Evacuation Issues

Equipment and Evacuation Issues



Equipment that is problematic to use in an emergency (e.g., smoke goggles that do not fit over eyeglasses)

Inadequate training in the use of emergency equipment

Negative transfer (interference) of equipment usage across different aircraft types

Confusion or problems regarding the initiation of evacuations





# Airtran 356 - 717-200 – Flushing, New York – March 26, 2003 NTSB Preliminary Report



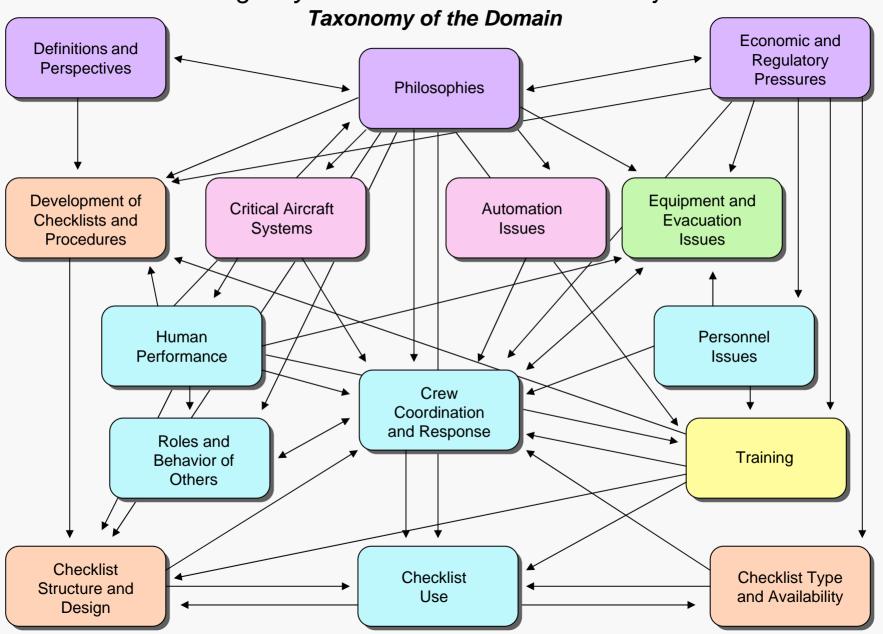
While on final approach the forward flight attendant noticed a burning smell and discovered that the handset to call the cockpit was not working.

After landing she pounded on the cockpit door and yelled to get the flight crew's attention.

The flight crew never heard the flight attendant pounding or yelling.



### Emergency and Abnormal Situations Project



## Overall Goal of the EAS Project

Develop guidance for procedure development and certification, training, crew coordination, and situation management based on knowledge of the operational environment, human performance limitations, and cognitive vulnerabilities in real-world situations.



### Products and Deliverables

## **Intermediate Products:**

Reports, Articles, Papers, Presentations

## **End Products**:

### Field Guides for

- Training Entities and Instructors
- Operators
- Manufacturers
- Regulatory Agencies (Certification, POIs)



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