

## Abstract

The Schema World Action Research Method (SWARM) has previously been used as a means to explore the underlying decision-making processes involved in retrospective incident reports. The approach has been fruitful in capturing all interacting processes involved in managing incidents. This paper proposes that SWARM may also be used prospectively within the early phases of the design lifecycle for new behavioural-based intervention strategies. Six pilot interviews were conducted to explore pilots' perceptual cycle processing when faced with a suspected engine oil leak. The aim was to explore whether there may be any deficiencies within current practise and explore ways in which pilots may be better supported in dealing with abnormal system parameters such as this. A number of design recommendations are proposed for a new avionic system capable of supporting and guiding pilots through the decision making process.

**Key words:** Aviation; Decision making; perceptual cycle model; schema world action research method

## Introduction

Despite inherent personality differences between pilots (Wang & Zhang, 2020), commercial aviation is a highly regulated and proceduralised environment meaning that, for every predicted eventuality, the flight crew is equipped with standardised procedures to follow (Green, 1990), engrained within extensive training regimes. It can therefore be described as a ‘rule-based’ activity (Sanderson & Harwood, 1988). However, despite this extensive training, Shappell and Wiegmann, (1996) argue that approximately 60-80% of all aviation incidents and accidents could be attributed, at least in part, to human error. Human error on the flight deck is therefore, unsurprisingly, considered to be one of the principle threats to flight safety (Civil Aviation Authority, 2008; Green, 1990; Weigmann & Shappell, 1997). Whilst it is important to acknowledge that overall, people do not deliberately set out to make mistakes (Dekker, 2006; Woods et al. 2010), humans are inherently fallible. Despite the best efforts of designers and safety practitioners, human error remains an unavoidable reality within socio-technical systems including aviation (Fedota & Parasuraman, 2009). Furthermore, the potential for human error appears to be an inevitable by-product of managing complex systems, including an aircraft cockpit (Woods et al. 2010). It is therefore important to understand how pilots make decisions as it provides a means to identify ‘how’ and, potentially more importantly, ‘why’ things go wrong. This gives rise to the possibility of identifying ways in which pilots can be aided in the future, via the potential use of altered training regimes or technological aids.

The processes underpinning decision-making are typically explored in a reactive manner, that is to say research explores why accidents occur or, explore why operators make mistakes, after an event has taken place. However, it can be argued that models of decision making may also be used proactively. Models of decision making can be useful when applied early on in the design and development of new flight deck technology in order to provide a

1 more descriptive and complete account of what pilots actually do, or have done in the past  
2 (Dillon, 1998). There are numerous models of natural decision making (NDM) within the  
3 literature. Considerable debate remains over how decision making processing can be best  
4 conceptualised and presented (Jenkins et al. 2010). Lipshitz (1993) identified nine different  
5 models of NDM. This included the most popular, the Recognition-Primed Decision Model  
6 (RPDM; Klein, 1986). The RPDM model argues that decisions are based upon the  
7 recognition of critical information and utilisation of prior knowledge (Klein 1989; 1998).  
8 When people need to make a decision, they quickly match the situation to previous patterns  
9 that they have learned (Klein, 2008). This process enables the decision maker to recognise  
10 whether the situation is typical or familiar (Klein, 1989). If the situation assessed can be  
11 matched to a prior event (experienced or trained), the decision maker is able to utilise their  
12 previous experiences in dealing with the situation. Kahneman (2011) argues that this  
13 culminates in fast, instinctive and emotional responses. According to Naikar (2010), the  
14 RPDM proposes that decision makers will evaluate each individual option until a satisfactory  
15 option is found. This mental simulation allows the decision maker to evaluate the adequacy  
16 of the proposed action. The exploration of alternatives stops when the operator reaches a  
17 satisfactory option, the action of satisficing (Klein, 1998). Yet, this does not mean it is always  
18 the most suitable option and inexperienced operators may need to reject several options  
19 before selecting an action (Klein et al. 1989; Naikar, 2010). This approach has been useful in  
20 understanding decision making across a variety of domains including Rail (Stanton &  
21 Walker, 2011) and Truck drivers (Salmon et al, 2013).

22 Yet, critique of the RPDM states that interactions to the decision making are solely  
23 within the individuals cognitive processing and the model does not capture the moderating  
24 effect of the environmental interactions (Plant & Stanton, 2014). Furthermore, RPDM does  
25 not fully capture the connection between the decision and the external environment, which is

1 vital in order to understand why a decision was made at the time (Dekker, 2006). Excessive  
2 focus is placed on the decision as processed in the mind of the individual (Plant & Stanton,  
3 2014; 2016). In this respect, the Perceptual Cycle Model (PCM; Neisser, 1976) is thought to  
4 give a better account of how decisions are made relative to the psychological processing of  
5 the individual and the environmental context surrounding it (Plant & Stanton, 2014; 2016).  
6 For this research, the aspects of the environment that influence the decision making were  
7 crucial in understanding how the pilot may be better supported by their surroundings to make  
8 enhanced decisions.

9         A schema is an organised pattern of thoughts and/or behaviours that help organise our  
10 knowledge of the world (Neisser, 1976). Schemas therefore provide a template in which we  
11 formulate mental representations of the world that can be used to guide future behaviour  
12 (Chalmers, 2003; Plant & Stanton, 2012). According to the literature, there are five defining  
13 features of a schema; meaningful organisation, embedded with other schema, change  
14 dynamically as information is received, reorganised based upon incoming data and they are  
15 gestalt mental representations (Anderson, 1977; Norman, 1981). Schema Theory provides a  
16 valuable explanation for how we interact with the world (Stanton & Walker, 2011). The PCM  
17 (Neisser, 1976) offers a visual representation of how ‘schema’ is embedded in a reciprocal,  
18 cyclical relationship between an individual and their environment. In this manner, it identifies  
19 that the schema that are based on the training and experience of the individual determine the  
20 actions that the individual will perform in a set scenario. Yet, it also dictates that present  
21 information in the world can assist in constructing the schema. This is in agreement with  
22 others who support the notion of sensemaking, whereby situation specific beliefs are thought  
23 to be activated by contextual factors that guide behaviour when generic belief networks  
24 require additional support (Baber et al, 2015; Attfield & Baber, 2017). Therefore the PCM  
25 suggests a way to understand how environmental sampling, combined with pre-existing

1 biases can influence and guide behaviour; but also how subsequent information within the  
2 environemnt determines how an individual perceives and gains understanding within specific  
3 situations,. The PCM process is represented in Figure 1.

4

5 ISERT FIGURE 1 HERE

6

7 The PCM places emphasis on understanding the processes involved in decision  
8 making, rather than focussing entirely upon decision output. Rather than focusing solely on  
9 the decision making within the head of an individual, it places the individual and their  
10 schema within the wider decision-making environment. It therefore supports the notion that  
11 congition is distributed across the wider system within which it is occurring (Hutchins, 1995;  
12 2000; Stanton et al, 2009) To that end, it does not fall victim to criticism of other approaches  
13 that are deemed reductionist in their account of only the individual level of analysis (Reason,  
14 2000). Incorporating the role of the wider system surrounding the decision-making process  
15 allows for a greater understanding in how decision making can be supported within the  
16 environment that it is conducted (Stanton et al, 2009; Plant & Stanton, 2012). This is  
17 important to this area of study because it enables us to see where and how pilots may be  
18 better supported throughout the decision making process. This paper was interested in  
19 understanding airline pilot decision making in relation to suspected engine oil leak in order to  
20 see if any further information may be able to assist the pilot in managing the event. The PCM  
21 was proposed as an effective tool for gaining a full representation of all factors impacting on  
22 the decision from the training that pilots receive, the information that they are presented  
23 within in the cockpit as well as the actions that they take.

1           Understanding perceptual cycle processing can however be extremely complex (Plant  
2   & Stanton, 2013). One approach to reducing this inherent difficulty is to use the Schema  
3   World Action Research Method (SWARM; Plant & Stanton, 2016). SWARM is an  
4   interview-based method designed specifically for aeronautical decision making, originally  
5   developed to elicit information about perceptual cycle processes. Its development aimed to  
6   capture the interaction between internal schemata and external world information in order to  
7   fully inform the development of the perceptual cycle process (Plant & Stanton, 2016). The  
8   method was developed and validated through interview data from airline pilots (Plant &  
9   Stanton, 2016).

10           SWARM facilitates the collection of data from Subject Matter Experts in relation to  
11   the three categories of the PCM; schema, action and world. Each of these has sub-types.  
12   Schema is comprised of six sub-types (direct past experience, trained past experience,  
13   vicarious past experience, declarative schema, analogical schema, insufficient schema.  
14   Action has 11 sub-types (Aviate, navigate, communicate, system interaction, system  
15   monitoring, environment monitoring, concurrent diagnostics, decision action, situation  
16   assessment, non-action, standard operating procedures). The world subtype also has 11 sub-  
17   types (Natural environmental conditions, technological conditions, communicated  
18   information, location, artefacts, display indications, operational context, aircraft status,  
19   severity of problem, physical cues, absent information). Within each of these sub-types are  
20   further interview prompts that draw out wide reaching information from subjects to capture  
21   the complete processing surrounding the decision making. The full repository of 95 prompts  
22   can be found in Plant and Stanton (2016), although the authors recommend not using all of  
23   these prompts but reviewing them to determine those relevant to the analysis required.  
24   SWARM was the first attempt to develop a methodology that could facilitate the collection of  
25   data and practically apply it to the PCM (Neisser, 1976). Previously, the PCM has been used

1 to explore systemic decision-making processes in retrospective analysis of incidents or  
2 accidents (Banks et al. 2018; Plant & Stanton, 2012; Stanton & Walker, 2011). However, the  
3 authors propose that by using SWARM, the PCM may also be used prospectively during the  
4 early phases of the design lifecycle, meaning it may be used to generate data that can inform  
5 design requirements for future flight deck technologies.

6         Displays within commercial airline cockpits have remained largely unchanged for a  
7 number of decades (Harris, 2011). This stagnation remains despite it being universally  
8 recognised that new sensor-based technology could be used to provide flight crews with more  
9 information about aircraft status, potentially offering flight crew more information which  
10 could be used to inform safety critical decisions (Salas et al., 2010; Harris & Stanton, 2010).  
11 Green (1990) stated that aircraft equipment can be more closely tailored to human  
12 requirements and so it makes sense to explore and highlight possible deficiencies in current  
13 procedures and displays on the flight deck. This is because it has long been established that  
14 there is a connection between the information that is available to an operator and the  
15 subsequent quality of their decisions (Jenkins et al. 2010; 2016). Thus, within this paper, we  
16 seek to explore the underlying mechanisms of pilot decision making in abnormal operating  
17 scenarios using the PCM (Neisser, 1976) and SWARM (Plant & Stanton, 2016) to provide  
18 insight into the possible deficiencies within current flight deck architecture and propose how  
19 pilots may be better supported through access to timely, accurate information from new  
20 avionic systems.

21

22

## **Method**

23 *Participants*

1           Six commercial airline pilots were recruited to take part in this study (2 female, 4  
2 male), aged between 26 and 35 years ( $M = 30.17$ ,  $SD = 3.02$ ). All participants were qualified  
3 fixed wing ATPL or CPL pilots with an average 3692 hours flight experience ( $SD = 570.39$ )  
4 and had held their licences for an average 8.08 years ( $SD = 1.59$ ). Interviews lasted for  
5 approximately 1.5 hours and participants were reimbursed for travel and time spent  
6 participating in the study. The study was ethically approved by the university Ethical  
7 Research Governance Office (ERGO).

### 8 ***Procedure***

9           Participants were first introduced to the aims of the research before being asked to  
10 give informed consent to take part. The participants were then presented with a hypothetical  
11 scenario relating to a suspected aircraft engine oil leak. This stated the following:

12 *An incomplete maintenance action has resulted in an oil leak in the aircraft engine. You are*  
13 *in cruise.*

14           The rationale behind focusing on an engine oil leak scenario is that despite being rare,  
15 they can have serious repercussions on flight operators, maintenance teams and passengers  
16 when handled inappropriately (Australian Transport Safety Bureau; ATSB, 2012; 2017;  
17 Parnell et al. in press). In addition, the presentation of engine system parameters has  
18 remained largely unchanged for a number of decades with analogue displays simply being  
19 replaced by digital equivalents (Harris, 2011). This means that in current practise, pilots only  
20 become aware of abnormal system parameters when threshold limits have been met via their  
21 on-board alerting systems. At the point of notification, pilots have few options available to  
22 them and they must either throttle back, or shut down the engine completely, in order to  
23 prevent the engines from reaching oil starvation (ATSB, 2012; 2017). Engine shutdowns in  
24 particular have significant implications for the flight operator both in terms of economics and



1 safety so there is great value, both from operations and economic perspectives, in exploring  
2 how such situations can be prevented (Parnell et al. in press). The limited options available to  
3 pilots within this scenario was also ideal for the explorative nature of the current work.

#### 4 ***Schema World Action Research Method***

5 Following the presentation of the scenario, participants were invited to take part in a  
6 semi-structured interview using exemplar prompts from the SWARM repository. To get their  
7 initial thoughts on the scenario and their response they were asked to give a brief initial  
8 overview of their thoughts in relation towards the scenario, prompted by two questions:

9 1. Currently, how would you be informed of an oil leak in an engine?

10 2. How would you respond to it?

11 While these questions were not part of the SWARM interview prompts, they allowed the  
12 participants to speak openly about their perception of the scenario as well as ask any further  
13 details from the researchers. After this the SWARM prompts began.

14 A down selected set of SWARM prompts were selected from the original 95 as  
15 suggested by Plant and Stanton (2016), not all are relevant to all events so down selection  
16 allows the interview to be more efficient. Plant & Stanton, (2016) state that preferably this  
17 would use the top five subtypes for each PCM category. The SWARM prompts were  
18 reviewed by Human Factors experts to determine which would be relevant to the scenarios  
19 presented in the study which is in line with the guidance. A total of 37 of the SWARM  
20 prompts were selected for the interview. Example relevant prompts included “What would  
21 you be looking at on the technological system during the scenario?”; “Would you require  
22 information from others?” and “What information would you use to assess the severity of the  
23 problem?”. Participants were asked to speak open and honestly and in as much depth as  
24 possible. This enabled a full account of their anticipated response to the scenario, capturing

1 their schema representations, information they would access from the world and the actions  
2 they would be taking.

### 3 ***Data Analysis***

4 All interviews were audio recorded and subsequently transcribed by the researchers.  
5 Transcripts were then reviewed by the researchers. The comments from the interviews were  
6 coded to the Schema, Action or World feature of the PCM. As the method utilised the  
7 SWARM methodology the application of the reports to the PCM model was straightforward, as  
8 the relevant prompts related to the relevant PCM category, see Plant & Stanton (2013; 2016)  
9 for further details on this process. The process of mapping the interview reports on to the  
10 PCMs was conducted in an iterative manner until the researchers were satisfied that the  
11 mapped decision making process accurately reflected the interview data. The data was used  
12 to develop an amalgamated representation of the pilots' PCM for the given scenarios. As the  
13 pilots are highly trained and the procedures that they conduct on the flight deck are heavily  
14 standardised and regulated, the reports were largely similar. The generated PCM containing  
15 the combined responses of the pilots was then reviewed by an independent subject matter  
16 expert, with over 10 years flight experience and a strong background within the Human  
17 Factors discipline to ensure accuracy.

### 18 **Generating Design requirements**

19 The second part of the interview asked participants to consider how a future engine  
20 monitoring assistant (EMA) system may influence their responses to the previous scenario.  
21 Here the updated scenario stated the following:

22 *“An incomplete maintenance action has resulted in an oil leak. An automated system*  
23 *detects a non-normal change in system parameters and notifies you of a non-critical oil leak*  
24 *i.e. sufficient levels to complete flight to intended destination safely”*

1 Participants were again asked key SWARM prompts of relevance to generate data that  
2 could also be used to inform the development of a PCM that could inform how participants  
3 thought a future system could assist them. From the PCMs and the transcriptions the  
4 researchers reviewed how the pilots could be further supported with their decision making to  
5 inform design recommendations. Importantly, participants were not given specific details of  
6 how this system may work, rather they were asked to determine how they may want it to  
7 work and what utility it may have.

8

9

## **Results and Discussion**

10 The interviews generated extensive accounts of how trained and experienced airline  
11 pilots would respond to the hypothetical scenario of an engine oil leak. Pilots undergo  
12 stringent training on a regular basis and they have a set of standard operating procedures that  
13 dictates how they respond to engine events such as the engine oil leak. The reports that pilots  
14 gave therefore followed similar decision making processes and could be aggregated in one  
15 PCM. This was also the approach used by Plant & Stanton (2014) who aggregated data from  
16 20 pilots into one composite PCM, demonstrating that the model can account for all decision  
17 making data. Due to applying the SWARM, the accounts were comprised of information that  
18 detailed the components that inform the PCM. This included the comprising element of the  
19 participants schema, including any previous experience of an event, their trained experience  
20 and knowledge of oil leakage. The world information captured all available information in  
21 the environment, including the visual presentation of information in the cockpit and  
22 communicated information from relevant others. They also detailed all relevant actions that  
23 they would take in their response to this event. Through application of the SWARM

1 interviews to the PCM the information could be easily categorised into the three PCM  
2 components.

### 3 *PCM of current processing in response to an aircraft engine oil leak*

4           The final amalgamated PCM of current practise is presented in Figure 2 and outlines  
5 the perceptual cycle processes of a pilot when they are subjected to dealing with a suspected  
6 engine oil leak. Information available in the ‘world’ acts as the impetus for diagnosis and  
7 option generation. In order to first diagnose and understand the problem presented to them,  
8 pilots would attend to any warning messages on the Electronic centralised aircraft monitor  
9 (ECAM) system, also sometimes referred to by some manufacturers as the Engine Indicating  
10 and Crew Alerting System (EICAS). This system provides data to pilots on the status of a  
11 variety of aircraft systems, as well as providing warnings and alerts when parameters reach  
12 unusual levels. These warnings are colour-coded to differentiate their urgency for attention  
13 and action by the pilot. Participants reported that when receiving an ECAM/EICAS message  
14 in this scenario they would seek to validate it by checking the most appropriate system  
15 parameters, in this case oil pressure, oil quantity and oil temperature. All of these artefacts are  
16 available in the ‘world’ via the Engine Display. Appraisal of these dials would enable the  
17 pilots to determine whether the warning is genuine or spurious. Particularly on older aircraft,  
18 sensors are vulnerable to exhibiting false indications and therefore the presence of a single  
19 abnormal reading may not be a valid indication of failure (Flight Safety Foundation, 2001).  
20 Thus, in order to confirm a genuine failure, flight crews must inspect multiple sources of  
21 information. Five participants suggested they might also seek assistance from the cabin crew  
22 in terms of performing a visual inspection of the engines. This would provide an opportunity  
23 to gather more ‘world’ based information that would be used to trigger relevant ‘schema’,  
24 previous experience in dealing with available information. This process shows how  
25 information in the ‘world’, that is the presence of a master warning, can go on to trigger

1 relevant 'schema'. For example the presence of the master warning suggests something is  
2 seriously wrong, leading to subsequent 'action' which includes checking affected engine  
3 system parameters. Further detail is given in Figure 2.

4           When it came to making a decision, all six pilots spoke about the utilisation of the  
5 'DODAR' decision aid (Diagnose, Options, Decision, Assign task, Review) or variations of  
6 such, for example, T-DODAR (Time, Diagnose, Options, Decision, Assign task, Review) in  
7 order to help them systematically reach a decision (Walters, 2002). The variation in the  
8 DODAR come about due to airline specific guidelines, yet each uses a similar tool to guide  
9 the pilots decision making. Each element of the tool details key requirements and the order  
10 dictates the order the requirements should be fulfilled. 'Diagnosis' is the requirement to  
11 gather as much information as possible to determine and confirm the problem. 'Options'  
12 required the pilot(s) to consider all possible alternatives relating to all possible actions.  
13 'Decide' requires the pilot(s) to come to the most appropriate selection of action(s). Once the  
14 decision is made, they must then 'Assign tasks' to allocate tasks between the pilot flying and  
15 pilot monitoring. The 'Review' aspect then denotes that the resulting consequences and  
16 emerging situation should be continuously reviewed to ensure the desired outcome is  
17 achieved. It was evident from the interviews that the DODAR aid was central to the decision  
18 making process. The detail they gave regarding the DODAR decision aid linked into the  
19 SWARM interviews to allow participants to discuss the factors that guided their decisions  
20 and the resulting actions.

21

22 INSERT FIGURE 2 HERE

23

24 *PCM of future proposed processing in response to an aircraft engine oil leak*

1           In scenario 2, all six pilots recognised that an early warning from an EMA system  
2 would indicate that minimum thresholds had not yet been met. For example, one pilot stated,  
3 *“Time is everything in an aircraft, with failures, with everything. It buys you time so you can*  
4 *sit, think, discuss with the company, come up with a plan and have a bit more time before it is*  
5 *critical.” (Participant 2).* Participants stated that they would still utilise the DODAR decision  
6 making tool. This is an airline regulated decision tool that pilots must use to guide their  
7 decision making and therefore it would still be applied when the EMA is present. In this  
8 scenario, the flight crew would begin monitoring and trending oil in order to rule out the  
9 potential for spurious sensor readings as soon as the assistant system alerted them to a  
10 possible issue. With engine parameters continuing to show an abnormal downward trend, the  
11 flight crew would use their prior experience (both through operational activities and training)  
12 to determine that an oil leak was indeed occurring. In terms of a pilots PCM, Figure 3  
13 demonstrates that information in the world (i.e., the system triggers alert in relation to the oil  
14 system) can trigger underlying schemata (i.e., EMA provides an advisory warning that may  
15 be wrong and therefore requires further investigation), which then goes on to influence action  
16 (i.e., monitor and trend oil system parameters to confirm what the problem may be).  
17 Importantly, the majority of the PCM remains similar to that presented in Figure 1 (i.e., pilots  
18 would utilise the same information in the world which would go on to trigger the same  
19 underlying schema). As one pilot stated; *“I would do the same checks. I would have a look*  
20 *for myself...” (Participant 4).* However, this is likely to be a product of the strict training a  
21 pilot goes through. For example; *“...I think that is something that pilots always do. We have*  
22 *to check, check and double check” (Participant 1).* With this in mind, it is mainly the  
23 ‘Action’ phase of the PCM that changes as a result of EMA implementation which is what we  
24 would expect.

25

1 INSERT FIGURE 3 HERE

2 Whilst in the first scenario (current practise), pilots would choose to shut down the  
3 engine, the general consensus amongst the pilots for the second scenario (with the EMA)  
4 would be to accept the information provided by the pilot decision aid and therefore execute  
5 the operational limitation. Pilots would then re-evaluate whether they would still be able to  
6 reach their destination, based upon their monitoring and trending of oil quantities. A key  
7 difference between the current processes in Figure 2 and anticipated processes in Figure 3 are  
8 that pilots are better informed with the future system on the remaining level of oil and if they  
9 can reach their destination. Pilots suggested that if they could receive more up-to-date  
10 information regarding the oil level in the case of a leak then there would be less ambiguity  
11 and therefore, they could make more informed decisions about shutting the engine down.  
12 Importantly, pilots did not think that the addition of an EMA would slow down a pilots  
13 response to an incident. Instead, the provision of an early warning would enable pilot  
14 responses to be more considered. The process of diagnosis, the options that are available, the  
15 allocation of tasks and key decision points remain very similar.

### 16 *Design Recommendations*

17 Once an understanding of pilots actions had been collected using the SWARM technique and  
18 subsequently mapped using PCM, it was possible to use this information to generate design  
19 concepts that would enable easier access to appropriate information, and therefore reduce the  
20 likelihood of the suspected oil leak having a significant impact on flight operations. Table 1  
21 lists a number of possible design recommendations that could be implemented on the flight  
22 deck that may reduce the requirement for, and number of, in-flight engine shutdowns as a  
23 result of abnormal engine system parameters. These recommendations are based upon

1 providing the flight crew with reliable and accurate data relating to the on-going status of  
2 engine system parameters using the EMA.

3 **INSERT TABLE 1 ABOUT HERE**

4 As suggested in Table 1, an additional potential benefit relating to the diagnosis of oil  
5 leaks is supporting pilots in choosing an appropriate route diversion and an appropriate  
6 airfield for landing. Diversions are typically less of a problem for short haul operators,  
7 operating in heavily populated and serviced locations, such as Europe and the United States,  
8 whereby maintenance bases are easily accessible. Yet, it is important to remember that  
9 choosing an appropriate, non-maintenance landing site is based upon multiple factors. These  
10 include environmental factors, for example local terrain and topography, local weather,  
11 runway length, type of approach and air traffic, aircraft status, including remaining fuel,  
12 weight of aircraft and type of aircraft, and commercial factors such as location of  
13 maintenance, costs associated with displaced passengers and crew, availability of alternative  
14 accommodation and transport options for passengers. Thus, deciding where to divert is not  
15 always an easy and straightforward decision. Novel flight deck technology may be of value  
16 within this circumstance to assist pilots in determining the best diversion alternative. For  
17 instance, Table 1 suggests that appropriate diversion airports, be this due to aircraft type and  
18 weight or company preference, could be automatically highlighted on a new display and  
19 updated in real time based upon specific contextual requirements and location, reducing  
20 pilots workload when dealing with an abnormal flight scenario.

21 **Future Avionic Systems**

22 In current practise, flight crews typically only become aware of abnormal engine oil  
23 system parameters once thresholds for triggering the alerting systems have been met. This is  
24 because although instructed to monitor oil level, pilots struggle to interpret abnormal oil



1 behaviour. Technological developments have led to new sensor based technologies within  
2 aircraft engines that may be able to provide more accurate and timely information to pilots.  
3 This Engine Monitoring Assistant would allow for a more complete understanding of both  
4 the current status of the engine as well as projected status. By identifying oil leaks earlier  
5 than currently possible and pre-empting potential oil leaks based on trending data, it may be  
6 possible to prevent the need to perform in-flight engine shutdowns. This is advantageous for  
7 airlines as it would increase the likelihood the aircraft would be able to reach a maintenance  
8 base and thus reducing the subsequent disruption caused by the leak. Earlier warning systems  
9 would allow pilots to make better, more informed decision, or at minimum less disruptive  
10 decisions. This is because they would have greater time in which to consider appropriate  
11 actions. In this paper, a number of possible design recommendations that serve to support the  
12 pilots in the decision making process have been identified, all compiled following interviews  
13 using the SWARM technique. The theoretical underpinnings of the PCM, upon which  
14 SWARM is based, provides a contemporary approach to generate novel design ideas for  
15 future technology.

16         Given the severity of the scenario under discussion (i.e. master warning rather than  
17 master caution), all participants reported that the current appropriate action following the  
18 warning notification would be to shut down the affected engine and land as soon as possible,  
19 including completing any necessary diversion. The decision to perform an engine shut down  
20 utilises previous knowledge of mandatory training and guidance available within the  
21 aircraft's Quick Reference Handbook (QRH). The primary aim of an engine shutdown would  
22 be to protect the engine from entering a state that could lead to catastrophic failure, as a  
23 consequence of oil starvation, which could cause irreparable damage to the engine and may  
24 risk damage to the rest of the aircraft. However, it is known from previous incidents and  
25 accidents that flight crews are not always able to elicit the correct information from their

1 instruments or state cues provided from the airframe itself, for example the presence of  
2 significant vibration. A key example of pilots' inability to elicit complete and correct  
3 understanding within recent years was the Kegworth air disaster. On January 8, 1989, a  
4 Boeing 737-400 bound for Belfast experienced a detached fan blade in No.1 engine (left) (Air  
5 Accident Investigation Branch, 1990). This led to the significant airframe vibration and  
6 fluctuations on No.1 engine parameters. Smoke and fumes also entered the cabin. A decision  
7 was made to divert to East Midlands Airport. However, the crew mistakenly believed No.2  
8 engine (right), and not No1. engine (left), was the damaged engine and proceeded to throttle  
9 it back. Airframe vibration reduced which reinforced the crew that their action had been  
10 appropriate to deal with the current emergency, as such they proceeded further to shut down  
11 the engine (Plant & Stanton, 2012). No.1 engine, which was significantly damaged, appeared  
12 to operate normally following the reduction in vibration and the crew's shut down of No2.  
13 engine. However, during the flights descent to East Midlands Airport, the damaged No.1  
14 engine suffered complete failure causing the aircraft to crash approximately 2nm from the  
15 runway, and onto the busy M1 motorway. Out of 118 passengers, 47 died and 74 suffered  
16 serious injury.

17           Furthermore, a recommendation to provide pilots with real time and accurate  
18 information regarding engine status was made by the National Transportation Safety Board  
19 (NTSB; 2010) following the 2009, "Miracle on the Hudson" whereby US Airways Flight  
20 1549 that was forced to land on the Hudson River following a dual engine bird strike which  
21 caused a loss of thrust in both engines (Marra et al. 2009). Whilst oil leaks are considered to  
22 be less safety critical than catastrophic Foreign Object Debris (FOD) strikes, such as in the  
23 case of flight 1549, oil leaks and the potential for oil starvation represents a scenario in which  
24 additional data relating to the status of the engine would be particularly beneficial. Using the

1 two PCMs detailed up, the design insights in Table 1 provide options for how such a system  
2 may be implemented.

### 3 *Evaluation*

4 SWARM can be seen as a similar methodological approach to the Critical Decision  
5 Method (CDM) (Klein, Calderwood & MacGregor, 1989), in that it relies on verbal reports to  
6 elicit understanding. As a consequence, similar to CDM, one of the main limitations of  
7 SWARM is the reliance on verbal reports (Klein et al. 1989; Stanton et al. 2005) to represent  
8 the cognitive processing of the decision maker. There are known issues with memory  
9 alteration and decay when data is collected this way (Klein & Armstrong, 2005; Plant &  
10 Stanton, 2016). The interviews were conducted in a class-room type environment where there  
11 were no cues to the cockpit. If the studies were conducted within the cockpit it is true that the  
12 pilots may have had more cues to assist them in reporting their decision making process. This  
13 should be reviewed in future work. The interviews were based on a hypothetical scenario that  
14 the pilots may not have directly experienced in the real world. They did, however, report  
15 experience in the simulator of similar events that would trigger the same standardised  
16 responses that they reported in response to the oil leak scenario. It is often the case that pilots  
17 are trained not to respond to the cause of an engine failure, but the resulting impact that it has  
18 on the aircraft functionality. This was why the pilots were able to give detailed accounts of  
19 the procedures they would conduct to diagnose and contain the scenario. The standardised  
20 procedures facilitated the amalgamated PCM representation from SWARM interviews. The  
21 validation of the models by an independent subject matter expert also credits the robustness  
22 of the PCMs.

23

24

### **Conclusion**

1           The main purpose of this paper was to explore the potential utility of using the  
2 SWARM interview technique to elicit value within the product development lifecycle. Using  
3 an engine oil leak as an exemplar scenario, the interviews sought to provide insight into the  
4 current procedures pilots must undertake, their thought processes and the sources of  
5 information that pilots access when dealing with such a scenario. Not only did SWARM  
6 enable the production of a perceptual cycle model for this process but the SWARM technique  
7 also enabled researchers to generate insight into how pilot decision making can be better  
8 supported in such events. In addition to this the same approach was used to determine how  
9 pilots may want to be assisted in the future and from this key design recommendations were  
10 generated. This represents a much more proactive approach to technology, and specifically  
11 cockpit display, design that engages end-users in the design process at a much earlier stage of  
12 the design lifecycle than is typical. Such engagement can lead to designs which are more  
13 suitable for implementation and installation within a cockpit environment and can more  
14 directly address end user needs. While the focus within this work was on aviation, it is  
15 possible that similar approaches can be taken in other domains to facilitate early engagement of  
16 users in the design process. This includes areas such as rail and road where the PCM has  
17 already been shown to be effective.

18

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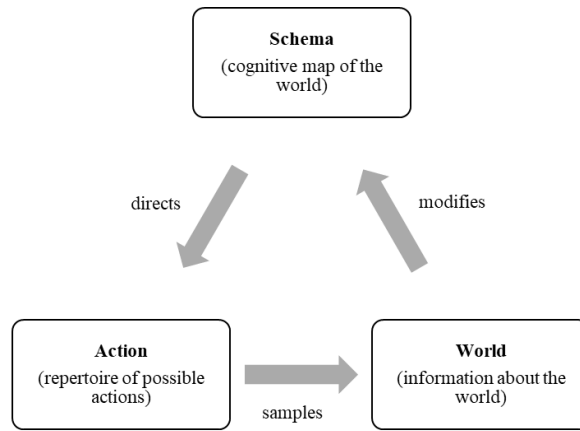
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1 **Figures and Captions**

2



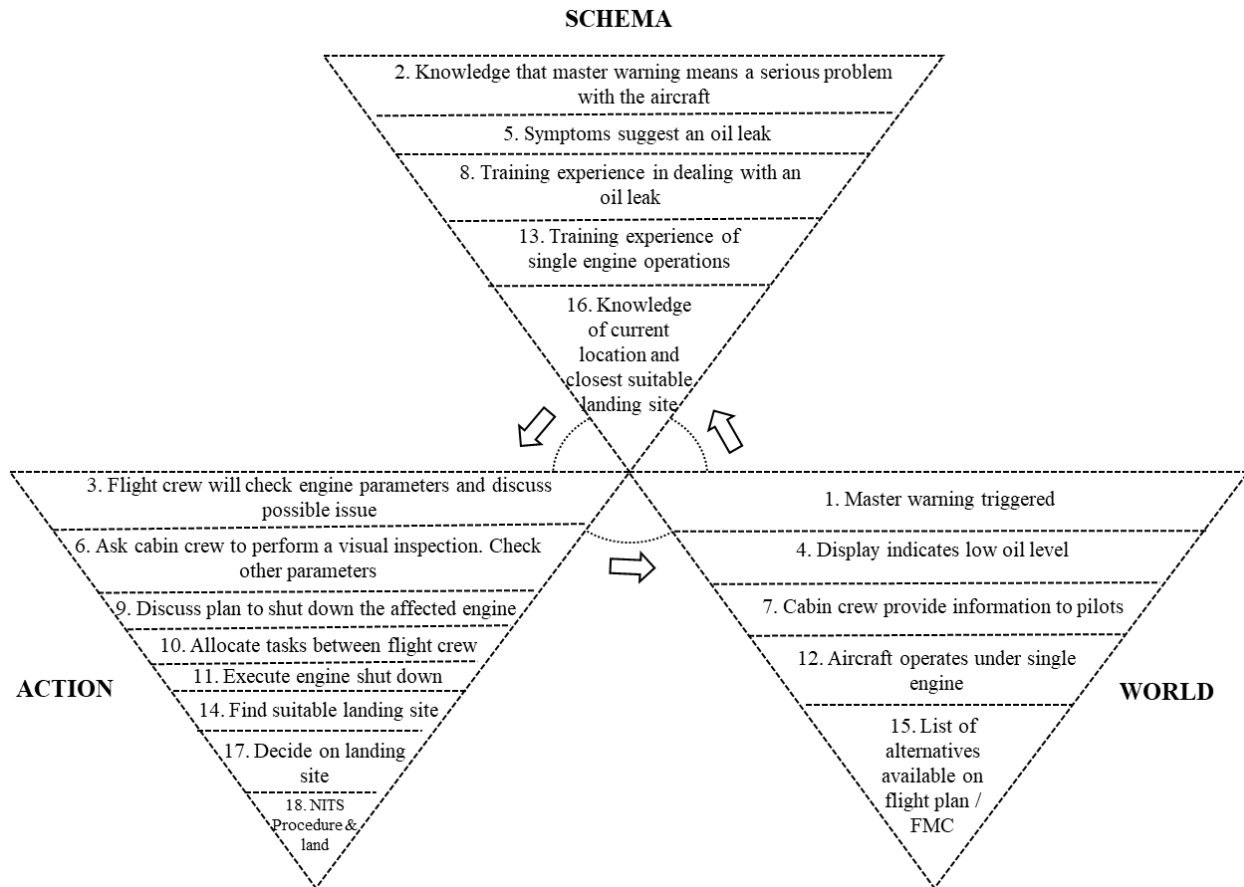
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5 Figure 1. Perceptual Cycle Model (adapted from Neisser, 1976).

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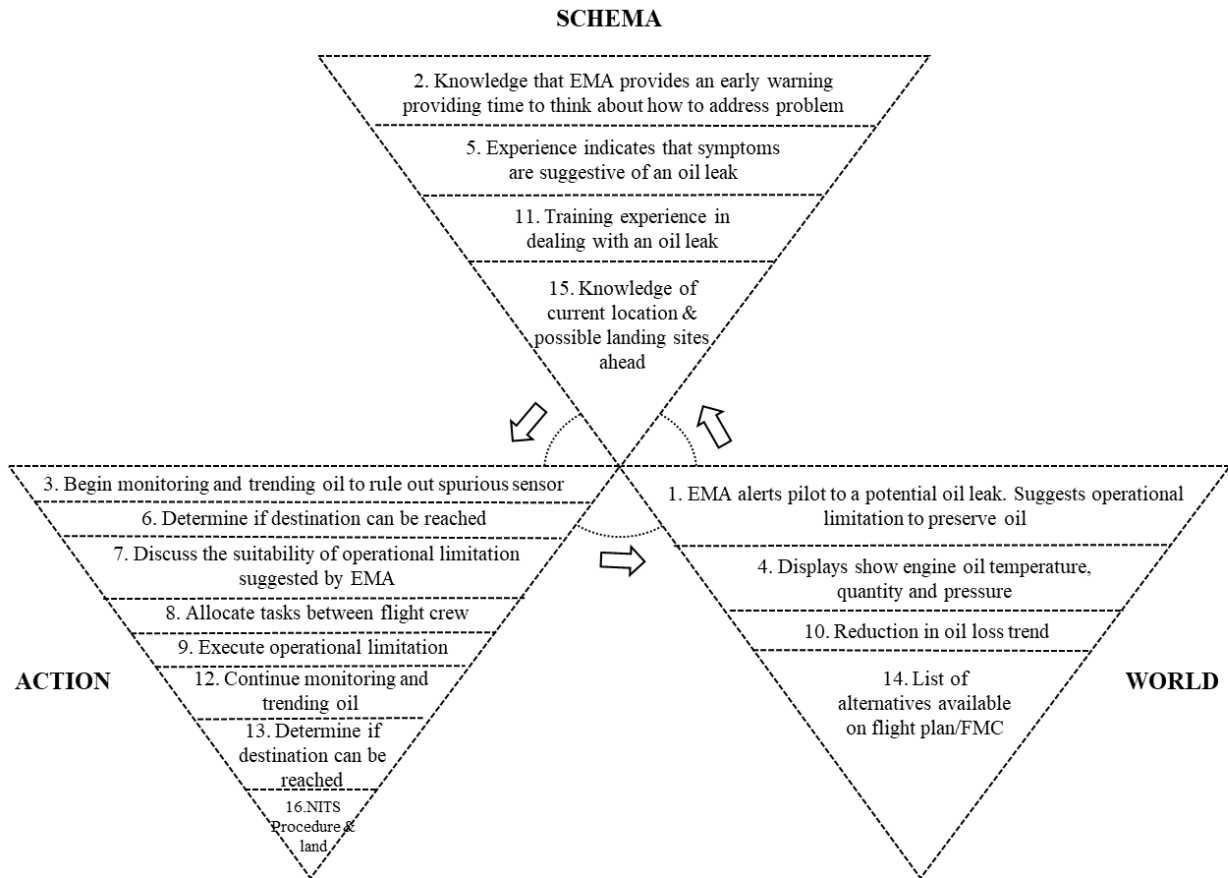
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2 Figure 2. Amalgamated PCM of pilots' current approach to dealing with an engine oil leak

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Figure 3. Amalgamated PCM of pilots' future proposed approach to dealing with an engine oil leak with an automated system assistance

1 **Table and Caption**

2 Table 1. Design recommendations for the flight deck instrumentation

<i>Current practise</i>	<i>Possible deficiencies in performance</i>	<i>Design recommendations</i>
Pilots to deliberately check system displays and begin trending oil	Subtle leaks difficult to detect using current displays	Provide a graphical representation of oil trend data over time. Enables subtle abnormalities to be highlighted earlier.
Determine how much time is left before engine reaches starvation by trending oil	Requires potentially complex estimations to be carried out by pilots in addition to standard flight tasks.	Automatically present estimated time left to reach starvation based on flight parameters.
Determine most appropriate strategy based on available information	Pilots may select sub-optimal strategy as they lack all available information or find it difficult to access information due to increase in workload as a consequence of the leak.	Provide indication of preferred action but present various options
Follow relevant checklist from Quick Reference Handbook	Time lag associated with finding relevant checklist within Quick Reference Handbook	Automatically present relevant checklist for chosen action
Review information and check that any action has yielded the desired response	Difficult to maintain a detailed and accurate understanding of oil trend levels, especially when considering standard oil dynamics.	Enable flight crew to review historic data and provide them with a projection of future engine state

	Pilots may neglect monitoring of healthy engine to focus on defective engine.	Present data on healthy engine so that regular monitoring can be performed
Check diversion airports on the flight plan	Cost-benefit analysis of alternative airports based on commercial pressures may result in suboptimal choice.	Automatically display most appropriate diversion airports based on aircraft type and other situational requirements

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