

CALLBACK

From NASA's Aviation Safety Reporting System



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Some "Thoughts" on Safety

An ASRS report that appears in CALLBACK is meant to stimulate thinking about aviation safety. The following reports offer a few thoughts that might prompt us to think twice when that 'little voice' says, "Something's not right"

"He Thought I Said..."

A misunderstanding leads to an unexpected reconfiguration, a look of consternation, an unplanned deceleration, an embarrassing interrogation, and a resolve to improve communication.



■ We were assigned FL 240 with clearance to cross INTXN at 10,000 feet and 250 knots. At approximately 78 DME, Center asked if we were going to be able to get down by INTXN. The First Officer had started the descent [checklist] and was responding to an ATC query. I stated (to the First Officer), "We're down," as I had already started the descent. The First Officer extended the landing gear at 23,000 feet and 300+ knots. He thought I said, "Gear down." We attempted to raise the gear, but were unsuccessful until we slowed below 250 knots. The First Officer informed ATC that we were temporarily unable to maintain the assigned speed of 310 knots. ATC asked if there was a problem...then vectored us off track and then back to the Arrival. During the vector, the gear retracted normally and we resumed [our] assigned speed.

From the First Officer's report:

While I was starting to run the descent checklist, I noticed that we were a little high for our descent to INTXN... Because we were high, ATC had told us to expedite our descent, and I heard the Captain say, "Gear down." I quickly lowered the gear handle. After I had put the handle down I realized that could not have been what the Captain had asked for - and the look on his face confirmed it... Upon reflection...I realize that I should not react so fast to an order that is not a normal procedure. If I had questioned the order first, then the Captain could have cleared up my misunderstanding. CRM works if you use it.

"I Thought He Said..."

A B757 pilot shows that even when we think we are paying attention, the thinking process can be short-circuited by a preconceived notion.

■ Approach said, "Expect Runway 18R." On short final I thought I heard, "Cleared to land Runway 18R." I asked [Tower to] confirm clearance to land. Again, I thought he said, "Cleared to land Runway 18R." After landing, Tower

said both transmissions were, "Cleared to land Runway 18L." [I] don't know what to say. I just kept thinking Runway 18R

In another "I thought he said" incident, a Tower controller might have helped the involved pilot avoid a wrong runway landing by mentioning a change of runway assignments in the clearance.

■ At ten miles out, I [gave] my position...[and] was told to enter a right pattern to Runway 28. I was also told to report the river, which is about three miles out. I reported the river where I was told to continue to Runway 28 and enter a right downwind. When I got abeam Runway 20, I was cleared to land Runway 20. I didn't catch the difference in the two runways. I was told twice to report Runway 28 and when told Runway 20, I thought he said Runway 28. I landed on Runway 28... The controller asked why I landed on Runway 28 instead of Runway 20. I responded that I didn't realize that I had made that mistake.

"You are where your thoughts have brought you." – James Allen

The pilot in our next report makes three references to "thinking" about where he is going, but doesn't appear to be "hearing" any directions until the First Officer says, "Stop!"

■ Tower told us to hold short of Runway 19L. The First Officer acknowledged the call from Tower and confirmed the "Hold short of Runway 19L" [clearance]. I, however, was thinking Runway 19R. We proceeded on Taxiway L toward Runway 19L, but since I was thinking Runway 19R, I crossed the hold short line for Runway 19L. The First Officer rightly called for the "hold short," and I was still thinking (erroneously) to hold short of Runway 19R. The First Officer, recognizing that we weren't actually stopping, said, "Stop!" At that point, I quickly applied the brakes and stopped the aircraft about 20 feet beyond the hold short line. A light aircraft (a C172, I think) on final went around, seeing that we had crossed the hold short line. Tower then cleared us into "position and hold" on Runway 19R. Lessons learned: 1) Confirm with the First Officer the actual taxi/hold short instructions. 2) Check final approach corridor for traffic. 3) Call out simple commands like, "Stop now" that don't require further thought. ▲

ASRS Recently Issued Alerts On...

BE55 landing gear incident
B777 main battery overheat
A fuel contamination incident
An approach frequency charting error
Oceanic Area Control Center clearance lead time incident

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August-September 2002 Report Intake

Air Carrier / Air Taxi Pilots	4209
General Aviation Pilots	1499
Controllers	116
Cabin/Mechanics/Military/Other	286
TOTAL	6110

"I Never Thought It Would Happen to Me"

With sophisticated aircraft systems, extensive training, comprehensive checklists, and CRM, it is hard to imagine some of the "classic" flying errors happening today. The pilot who submitted this report probably felt the same way, until...

■ *Departure called an early turn for traffic at approximately 800 feet AGL. This momentary distraction made me forget to call for "Flaps up, VNAV" which is the standard procedure. My First Officer also forgot to back me up.... At 3000 feet MSL, I called for the After Takeoff checklist. The First Officer ran the checklist, but during the "Flaps and slats up" challenge, he didn't realize the flaps were still at the takeoff position. After accelerating at 10,000 feet, I felt a buffeting similar to light chop and checked the flap gauge. Airspeed at this point was 270 knots, a 40 knot flap over-speed. After slowing to 225 knots, I called for flaps up, and then proceeded to call company maintenance for further guidance.*

In retrospect, it's very hard to believe I allowed this major oversight. I never thought it would happen to me... I discussed with my First Officer my technique in running the after takeoff checklist which is to check the gauge (flaps) and then look up to check the leading edge devices annunciator panel... He was quite confident that he checked the gauge, but feels he must have "looked right through it."

It Was a Dark and Foggy Night...

Factors such as weather and fatigue have contributed to many aviation incidents and accidents. In the following ASRS report, a corporate pilot cites several common factors that contributed to a mistake he thought would "never happen to me."

■ *I departed from a parallel taxiway instead of the runway. I never thought I could ever do such a stupid, unsafe maneuver. Leading factor: fatigue; Second: "That will never happen to me" attitude; Third: complacency; Fourth: weather; Fifth: I was in a hurry to get home. We had already been up more than 24 hours even though, technically, we were legal... After being cleared for takeoff by the tower, I lined up on a long, wide parallel taxiway and took off, rushing the poor copilot and myself. I realized my error just as we lifted off. Tower said nothing. Commuter aircraft were behind me and must have seen it - in disbelief. Nothing was said. It was dark and foggy. Tower may not have been able to see either. Tower and ground may have been the same person that early in the morning. Maybe he was busy.*

This event has cautioned me about two things: 1) fatigue is insidious, and 2) I'm not as good as I thought I was, but I'll get better - for sure. ▲

The Maintenance Desk



Several recent ASRS maintenance reports have indicated a recurring oil filler cap problem. These incidents should be of particular interest to operators of PW JT-8

engines. Our thanks to the maintenance technicians who shared their findings and recommendations.

■ *The Pratt & Whitney JT-8 engine oil filler cap locking mechanism can visually appear to be seated in the full down and locked detent when actually it is not! The handle is too small to effectively be leveraged to the locked position with thumb and forefinger only, especially in cold weather. Such was the case, I believe, when I properly serviced the left and right engine oil, then secured both engine oil fill caps. Upon departure, the crew noticed a decrease in right engine oil level and safely diverted to ZZZ where the right engine oil filler cap was found slightly dislodged. This cap needs either a redesign or modification to prevent a much more serious emergency in the future... ▲*

The Controller's Corner



An Air Traffic Controller's report to ASRS shows how pilots' use of vague terminology can cause concern in an atmosphere of increased security.

■ *We recently experienced two incidents in which pilots have used vague terms when describing conditions affecting their aircraft. In one case, the pilot was on the ground and reported [that] he had "issues" before leaving the frequency for an extended period of time while on a taxiway. In the second instance, the pilot made reference to "a situation" while airborne. The pilot wanted to circle the airport for an unspecified period of time, but was not specific regarding why he needed to circle. In both cases, the controllers and supervisors-in-charge had concerns about the safety of the flight crew and passengers... Fortunately, neither case involved unlawful interference. However, the words used by the pilots certainly raised suspicions and concerns among ATC personnel...*

Pilots should be aware that vague references might be misinterpreted as a pilot attempting to covertly alert ATC to an instance of unlawful interference. Now, more than ever...communication is key to ensuring that ATC does not overreact to a minor problem or, even worse, under-react to a life threatening condition. ▲