

CALLBACK



From NASA's Aviation Safety Reporting System

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Hurry-Up

Incidents in ASRS Reporting

Prior ASRS research into the "Hurry-Up Syndrome" (the perceived or actual need to hurry or rush tasks or duties for any reason) has revealed that most time-pressure errors reported to ASRS occur during the preflight and taxi-out phases. The results of rushing and hurrying often do not manifest themselves until later flight phases, especially takeoff and departure.

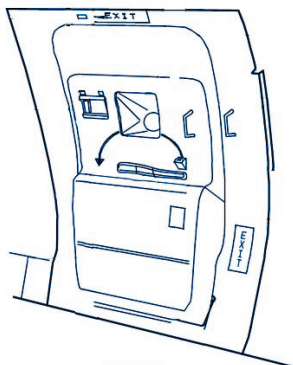
As we will see in this month's selection of **CALLBACK** reports, hurry-up pressures affect every segment of the aviation community – flight attendants, air carrier flight crews, general aviation pilots, maintenance personnel, and ATC. When the urge to hurry strikes, taking time to prioritize tasks and adhering to strict checklist discipline will often catch a time-pressure error before it occurs.

A summary of ASRS research into the Hurry-Up Syndrome is provided in *ASRS Directline* Issue Number 5, and is available on the ASRS web site at the following link: http://asrs.arc.nasa.gov/directline_issues/dl5_hurry.htm.

Hurry-Up in the Cabin

A flight attendant rushing to set up the galley overlooked a key duty – causing the aircraft to return to the departure airport.

■ ...I felt rushed to get the galley in First Class set up. When it was near time for the entry door [to be] closed, I was rushing to put everything away and securing the galley for takeoff. I didn't hear the command to arm the doors for departure...When we reached a certain altitude, the Captain called the purser to notify her that a warning light indicated that door 1R was not closed properly. We looked at the door and then realized that the door was not armed. We tried arming the door but couldn't. The Captain then descended and proceeded to burn fuel for landing...When we got to a lower altitude, the purser got a call from the Captain saying that the warning light had gone out and we tried arming the door again. This time we were able to do so. We landed...safely and the mechanics I spoke to determined that the door was not closed properly. They inspected the door, we refueled and left.



Hurry-Up in the Cockpit

A B757 Captain suffered embarrassing consequences from a hung start – and acknowledged that rushing may have contributed to the incident.

■ ...The First Officer mentioned that he had a tight connection...to catch the last flight to his home. I normally do not let myself become rushed, but this may have been a contributing factor. We completed the preflight and pushed back from the gate. After receiving clearance, I asked the First Officer to start both engines. The left engine was started normally, and he asked if I wanted to start the right. I said yes, that it would be a short taxi. As he was in the process of starting the right engine, I was communicating with the pushback crew. With everything done, I received a salute and release from guidance. Then, and I don't know why, I glanced at the engine instruments and believing the right engine was stable, shut down the APU. The engine was not fully started and we got a hung start. The First Officer took out the QRC and we agreed that the engine should be shut down. Maximum temperature was about 350 degrees, way below max start-up temperature. Up to now, no harm, no foul. As the engine was spooling down, the First Officer asked if we should motor the engine to keep the temperature coming down. The right answer was, 'What does the QRC say?' My answer was 'OK.' The First Officer opens the bleed valve and it did not take us long to realize we sheared the starter shaft. My heart just sank. Never done something that dumb in 35 years of flying big airplanes.

Shutting down the APU...was a recoverable error. All we needed to do was complete the 'abnormal engine start' QRC!...
Lessons learned: always, always, always use the checklist.

Rushing to get airborne on a mercy mission tripped up this BE100 pilot.

■ It was an early morning departure to pick up human organs. In a rush to get airborne, I overlooked the correct altimeter setting...The correct altimeter setting was 30.73 inches. The previous crew brought the aircraft in when the altimeter setting was 29.71 inches. In my pre-dawn haste, I simply adjusted the altimeter up .02 inches thinking I had set 30.73 inches. The altimeter was set at 29.73 inches. Leveling at 15,000 feet, [the] Center controller asked me to verify altitude. I replied 'level 15,000 feet, confirm 29.73 inches.' He replied with 30.73 inches and indicated my altitude was 15,800 feet. I immediately reset the altimeter and leveled at 15,000 feet...

This event was influenced by my very early and short notice departure...I simply allowed myself to be rushed and have the mistake to prove it. This event goes against the very grain of a basic verification of flight instruments prior to departure. In the future, I will not allow myself to be rushed. It is a great example of how getting away from the basics causes bigger problems in the short term. I will also remember that no one can rush you but yourself!

ASRS Alerts Issued in May 2007	
Subject of Alert	No. of Alerts
Aircraft or aircraft equipment	9
Airport facility or procedure	4
ATC procedure or equipment	9
Chart, Publication, or Nav Database	3
Company policy	6
Maintenance procedure	2
Other	1
Total	34

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May 2007 Report Intake	
Air Carrier/Air Taxi Pilots	2338
General Aviation Pilots	876
Controllers	148
Cabin/Mechanics/Military/Other	229
TOTAL	3591

Hurry-Up in the Cockpit (continued)

Attempting to save time, a B737 Captain elected to depart with the aircraft depressurized.

■ *We needed to do a bleeds off takeoff for performance reasons. As we taxied out, I forgot and shut the APU down. As Tower cleared us for takeoff, we remembered about the bleeds off takeoff. Since our APU was shut down, I thought I would be clever and do an unpressurized takeoff to still get the performance we needed and not waste any more time. In our haste we did not get the pressurization panel configured correctly. This caused us to get an auto fail light about 2 minutes after takeoff. We applied the QRH and put the pressurization controller in standby, which extinguished the auto fail light and returned the panel to a workable configuration... Upon review of the Operations Manual, I don't think I had the option of an unpressurized takeoff since my APU was operable. In any case, I used bad judgement by making a split-second decision that caused us to rush our checklist and preparation leading to our wrong configuration of the pressurization panel... The few minutes I saved [were] not worth the problems caused. Slow down, refer to reference materials if necessary, admit your mistake, stop and do it correctly.*

Hurry-Up in the Maintenance Hangar

Maintenance technicians must often work at night, on multiple aircraft, under tight deadlines, and sometimes with limited staffing. The constant pressure to turn aircraft around quickly can lead to hurry-up errors:

■ *During an operations check of the passenger service unit oxygen masks (drop test) we discovered left-hand #1 passenger service unit mask was not dropping. After troubleshooting, we discovered the cannon plug was damaged. Since we did not have the part in stock and the aircraft was already late, my manager instructed me to remove a passenger service unit from another CRJ200 that was in the hangar and install it on the aircraft in question. I questioned his instructions, but he told me to complete the tasks and to hurry. I completed switching the passenger service units and did an operations check. Sometime later and upon further review it has come to my attention that the passenger service unit removed from the other aircraft was not applicable to the aircraft in question. The result was the aircraft had to be removed from service as soon as the discrepancy was discovered, and a new part brought in to replace the incorrect passenger service unit.*

“No One Should Be in That Big of a Hurry”

And finally, we hear from an ATC Departure controller frustrated by a pilot in a big hurry.

■ *Aircraft called Low Altitude / Clearance Delivery for IFR clearance as Tower was not yet open. Aircraft was told,*

#2, issued clearance with hold for release. Aircraft responded that he was in a hurry and would depart VFR. Controller acknowledged, issued instructions to remain outside of Class B and call airborne. Aircraft acknowledged. Aircraft departed, was again told to remain outside Class B and ident. After radar identification, issued clearance, maintain 3,000 feet and fly heading 320 degrees... Aircraft was at 3,500 feet climbing. Controller coordinated with Departure to go to 4,000 feet (Departure's airspace), aircraft climbed to 4,000 feet, next frequency (mine). Aircraft instructed to climb to 8,000 feet and heading 360 degrees, acknowledged, aircraft turned, did not climb. Reissued climb to 12,000 feet. Aircraft acknowledged and climbed. Handed off to Center. Aircraft was observed out of 13,000 feet climbing... Supervisor asked Center to issue pilot deviation advisory... Pilot calls later, apologized, won't happen again, never happened before, in a hurry, thought VFR would help, did not know floor of Class B was 3,000 feet where he was...

[The problem is] aircraft violated Class B, violated clearance at 3,000 feet, missed climb from 4,000 feet, violated altitude at 12,000 feet. Three pilot deviations, one missed clearance in 10 minutes. No one should be in that big of a hurry.



New Database Export Capabilities Are Here!



In the May 2007 issue of CALLBACK (#329), we announced a pending enhancement of the ASRS Database Online (<http://asrs.arc.nasa.gov>) – the capability to export incident record downloads to Microsoft Excel (.xls) or Comma Separated Value (.csv) formats. This enhancement was implemented on schedule in June. ASRS Online Database users now have the choice of several convenient formats for analyzing and sorting incident records.

To access the new export capabilities, users should perform a database search query using online search parameters. Clicking on the “Run Search” button will bring up the Search Results Page and the options, “Export to Excel” and “Export to Comma Separated Values.” If the incident record output is desired in a Microsoft Word format, selecting the “View Reports”/ “Open in MS Word” options will result in a Word output file.

Exports in the .xls, .csv, and Word formats will be limited to 10,000 incident records per download, due to speed and time considerations. The new export capabilities are intended to serve a wide community of data users.

As always, we would appreciate your feedback about the latest ASRS Database Online enhancement.