

# CALLBACK



From NASA's Aviation Safety Reporting System

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To make a long story short: a review of ASRS database reports reveals that the word “short” is a staple of many aviation incident narratives (“short” appears in more than 17,000 ASRS narratives). Just as the film world has its “short takes” (brief but memorable movie moments), ASRS reporters frequently employ the word “short” to describe a variety of situations, from operational restrictions to time-critical decision-making.

Pilots describe short takeoffs or landings, short approaches, short finals, hold-short incidents, cockpit short-cuts, short announcements, and landings short of destination. Aircraft technology reportedly has its shortcomings – especially when it short-circuits. And then there are commentaries from air carrier pilots, flight attendants, maintenance technicians, and air traffic controllers about short layovers, short rest, short breaks, short staffing, and short-sighted management policies.

This month we offer a sampling of “short takes” submitted to the ASRS.

## “Hold Short”

Weather factors complicated a flight crew’s taxi to the runway in a “hold short” incident typical of many reported to the ASRS.

■ *During our taxi to Runway 15R we were instructed by Ground to taxi via Taxiway C and P to Runway 15R. It was raining slightly at dawn making the pavement glossy and markings difficult to see. Our aircraft was lined up with Taxiway C so we taxied straight to P and ended up on Runway 4/22, which was inactive. At the time we immediately recognized the mistake and notified Ground. Ground instructed us to taxi via Taxiway P1 and Taxiway P to Runway 15R, which was complied with, and there was no further incident. There are no hold short lights or bars at the intersection of Taxiway C or Runway 4/22. With the glossy pavement, we never noticed crossing a hold short line...Despite briefing the First Officer on the taxi routing, this mistake occurred, so I also feel that extra caution is needed when there are wet surfaces that may impair your ability to see pavement markings.*

## “Short Temper”

A short temper and short rest contributed to a Captain’s misinterpretation of a vector heading as an altitude assignment.

■ *The problem was, as Pilot Flying, I misinterpreted an assignment to a heading of 200 degrees as an assignment to descend to 2,000 feet. The problem arose due to the*

*First Officer bickering with the Approach Controller who would not provide a visual approach clearance after we advised the field in sight twice. I [attribute] both my misinterpretation of the issued clearance and the First Officer’s short temper to both crew members flying up to the legal maximum flight hours with the legal minimum rest....*

## “Short Final”

A Bonanza 36 pilot on short final, with an open door, had a short time to make a decision when informed by ATC that he was at the wrong airport.

■ *Approximately 6 minutes after takeoff...and just prior to opening my flight plan with the FSS, I experienced the main cabin door unlatching and becoming open to the air stream. This necessitated an immediate landing to secure the door. While circling over a large lake I examined the Terminal Area Chart as well as looked for closest available airport from the air. Seeing an airport about 8 miles to my northeast, which in general layout and approximate location appeared to be ZZZ, I contacted their Tower, stated the nature of my emergency, and was cleared to immediately land. As I approached the airport, ZZZ Tower contacted me and asked my location, to which I replied that I was on a very short final. They then asked me the runway number that was visible, and I replied that it was numbered ‘34.’ They then informed me that the runway I was approaching was located at ZZZ3. Being at a low altitude, approximately over the threshold and with an unsecured door, and not having enough time to contact the ZZZ3 Tower, I continued my landing and turned off at the first available taxiway. I then contacted the Tower [and] stated...why I had made an unannounced incursion into their airspace and landing at their airport...It should be noted that both ZZZ and ZZZ3 have very similar airport layouts, ramp locations, runway alignments and are both a similar distance north from the lake....*

An Airbus air carrier flight crew reported that they had a “very exciting three minutes” on short final.

■ *Turning base to final to runway approximately 7 miles from the runway we experienced multiple failures. I’ll list the failures in order of receiving them. Our first failure was an RA [Radar Altimeter] 1, ILS 1 and loss of Captain’s PFD [Primary Flight Display] and ND [Navigational Display] immediately followed by a blue hydraulic electric pump failure. I handed off the airplane to the First Officer to fly visually to the airport and land. After running the ECAM [Electronic Centralized Aircraft Monitor] for the hydraulic fault, we received an engine 1 generator fault. By this time we were on short final and completed the landing checklist. At about 500 feet we received a BSCU 2 [Brake Steering Control Unit] fault and landed uneventfully. Taxied to the gate and informed maintenance of our problems. Once maintenance got on board and saw all the faults that were generated, they proceeded to troubleshoot the problems. All the failures were real and not just false warnings...It was a very exciting three minutes, much more complicated than a simulator ride. We really had no time to call for the*

ASRS Alerts Issued in June 2008	
Subject of Alert	No. of Alerts
Aircraft or aircraft equipment	21
Airport facility or procedure	13
ATC procedure or equipment	2
Company policy	2
<b>Total</b>	<b>38</b>

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June 2008 Report Intake	
Air Carrier/Air Taxi Pilots	2973
General Aviation Pilots	830
Controllers	117
Cabin/Mechanics/Military/Other	343
<b>TOTAL</b>	<b>4263</b>

checklist as this would have taken us 30 minutes...Since we were on approximately a 5-mile final, I felt that landing the airplane was more prudent than breaking off the approach and trying to troubleshoot our problems.

An ASRS callback to this reporter revealed that an Integrated Drive Generator malfunction was the cause of the multiple fault indications.

## “Short Lake”

A short lake and a windy day were a treacherous combination for a C172 float plane pilot.

■ While taking off from a lake I was forced back in the water after takeoff by wind (downdraft). I aborted my takeoff, shut down the airplane and hit the bank at the opposite end of the lake. Nobody was hurt. The shore of the lake is rocky and I put a tear in the bottom of my right float and a dent in my spreader bar. After several attempts to reach some help on radios, I temporarily repaired the float and flew the plane back to ZZZ alone. I had no ferry permit to do this. [Contributing Factors:] 1) Taking off from a short lake on a windy day. 2) Not having a way to contact someone from a remote location. 3) Not filing a flight plan. 4) After being there several days I wanted to get home. 5) Being new to this lake I misjudged the effects of mountain winds.

## “Short Runway”

A late runway change to a short runway distracted a DC8-71 flight crew on their approach.

■ While performing a high-speed descent, because of being kept above a normal descent profile, we were given an unplanned runway assignment for landing...This new runway was short and as pilot monitoring, I worked with the engineer to confirm the available runway length. I noticed that the First Officer was in the descent mode on the autopilot, ensuring an auto slow down to 250 knots at 10,000 feet and began to set myself up for the new approach. I felt a sharp pull-up on the aircraft and looked up to see 330 knots at 9,000 feet.. The First Officer had gone to speed mode while my head was down and not slowed down at 10,000 feet. We subsequently slowed and landed normally... The approach was very rushed...If my First Officer had announced his change from descent mode to speed mode on the autopilot, I would have been cued to be more observant at 10,000 feet. Still, as a Captain I need to ensure that the 10,000 feet /250 knots requirement is met no matter the cockpit congestion and resolve to be more aware, especially because of the emphasis this particular issue has received.

## “Short of Impact”

ASRS is receiving an ever-increasing number of air carrier ramp incident reports. In this incident, a pushback ‘snake dance’ almost resulted in a ramp collision.

■ We were cleared to push and began our pushback. Both pilots noted that the tug driver drifted the aircraft 4 feet left of centerline and then made an aggressive cut back to centerline. This correction was never really taken out

and the aircraft ended up well right of centerline (my estimate was 18 feet). We both made comments on how far the aircraft was off the centerline. The Captain then set the parking brake and I went heads down to start the #2 engine. [The aircraft at] gate XX called for and received clearance to push...The Captain noted their movement and told me to call ramp and stop their push. I did so, stating that ‘aircraft at gate XY is well right of centerline and we need you to stop the push.’ Ramp made that call, but the B737 at XX did not respond. I was now getting very concerned so began making directive calls on ramp frequency. ‘Aircraft at gate XX stop your push!’ I made that call at least two times but they were still moving back (on centerline at least). In desperation, I gave the emergency stop signal to our wing walker...He began running to the XX tug and stopped their push. When they stopped, the leading edge of their #1 engine was abeam my seat, so I estimate that they were just 15 feet short of impact...I am submitting this for two reasons...It is not at all unusual for pushes...to ‘snake dance’ plus or minus 10 feet of the centerline. On many occasions I have seen pushes like this one where a small deviation results in larger deviations that rapidly become unsafe...This leads me to the second point, We had a wing walker. I never saw one at [gate] XX. Our wing walker was key to averting an unsafe situation....

## “Short Field Takeoff and Landing”

This very short report describes a standard flight procedure went awry for a PA28 pilot landing at a private grass strip.

■ Because of recent heavy rains our landing strip had a wet area in the middle of the strip. This necessitated short field landing and takeoff procedures. My approach was a few feet to the left. My left wingtip caught some cornfield plants causing my plane to turn to the left and skid to a stop.

## “A Short Announcement”

For a GA pilot taking off from a non-Tower field, climb-out over an obstruction led to afterthoughts about use of the CTAF.

■ My preflight briefing stated that the east taxiway was closed, no reason given. After run-up, I was ready to depart Runway XX, the calm wind runway that is about 5,100 feet long. A light twin had just landed on Runway XY. There was some activity on the south half of the east taxiway, too far away to identify and of no obvious interest since I knew the east taxiway was closed. The runway was clear and I announced my departure and my intended turn to the north. During the takeoff roll, I discovered that vehicles (or a disabled aircraft) had moved onto the runway, apparently to cross to the west side of the field. Since I could lift off several thousand feet before the obstruction and clear it by several hundred, I considered a takeoff safer than a high-speed abort and continued my takeoff. No announcement of any kind had been made on the CTAF. It is certain that my radio was working properly since I listened to the ASOS before switching frequencies and I confirmed the correct frequency was set...A short but clear announcement by the obstructing party would have been helpful.