ASRS Database Report Set

Maintenance Reports

Report Set Description.....A sampling of reports from aircraft maintenance personnel.

Update Number.....34

Date of Update.....May 7, 2024

Number of Records in Report Set.....50

Records within this Report Set have been screened to assure their relevance to the topic.

National Aeronautics and
Space Administration

Ames Research Center
Moffett Field, CA 94035-1000

TH: 262-7

MEMORANDUM FOR: Recipients of Aviation Safety Reporting System Data

SUBJECT: Data Derived from ASRS Reports

The attached material is furnished pursuant to a request for data from the NASA Aviation Safety Reporting System (ASRS). Recipients of this material are reminded when evaluating these data of the following points.

ASRS reports are submitted voluntarily. Such incidents are independently submitted and are not corroborated by NASA, the FAA or NTSB. The existence in the ASRS database of reports concerning a specific topic cannot, therefore, be used to infer the prevalence of that problem within the National Airspace System.

Information contained in reports submitted to ASRS may be clarified by further contact with the individual who submitted them, but the information provided by the reporter is not investigated further. Such information represents the perspective of the specific individual who is describing their experience and perception of a safety related event.

After preliminary processing, all ASRS reports are de-identified and the identity of the individual who submitted the report is permanently eliminated. All ASRS report processing systems are designed to protect identifying information submitted by reporters; including names, company affiliations, and specific times of incident occurrence. After a report has been de-identified, any verification of information submitted to ASRS would be limited.

The National Aeronautics and Space Administration and its ASRS current contractor, Booz Allen Hamilton, specifically disclaim any responsibility for any interpretation which may be made by others of any material or data furnished by NASA in response to queries of the ASRS database and related materials.

B Hooey

Becky L. Hooey, Director
NASA Aviation Safety Reporting System

CAVEAT REGARDING USE OF ASRS DATA

Certain caveats apply to the use of ASRS data. All ASRS reports are voluntarily submitted, and thus cannot be considered a measured random sample of the full population of like events. For example, we receive several thousand altitude deviation reports each year. This number may comprise over half of all the altitude deviations that occur, or it may be just a small fraction of total occurrences.

Moreover, not all pilots, controllers, mechanics, flight attendants, dispatchers or other participants in the aviation system are equally aware of the ASRS or may be equally willing to report. Thus, the data can reflect **reporting biases**. These biases, which are not fully known or measurable, may influence ASRS information. A safety problem such as near midair collisions (NMACs) may appear to be more highly concentrated in area "A" than area "B" simply because the airmen who operate in area "A" are more aware of the ASRS program and more inclined to report should an NMAC occur. Any type of subjective, voluntary reporting will have these limitations related to quantitative statistical analysis.

One thing that can be known from ASRS data is that the number of reports received concerning specific event types represents the **lower measure** of the true number of such events that are occurring. For example, if ASRS receives 881 reports of track deviations in 2010 (this number is purely hypothetical), then it can be known with some certainty that at least 881 such events have occurred in 2010. With these statistical limitations in mind, we believe that the **real power** of ASRS data is the **qualitative information** contained in **report narratives**. The pilots, controllers, and others who report tell us about aviation safety incidents and situations in detail – explaining what happened, and more importantly, **why** it happened. Using report narratives effectively requires an extra measure of study, but the knowledge derived is well worth the added effort.

Report Synopses

ACN: 2069879 *(1 of 50)*

Synopsis

Aircraft Technician reported lack of key information in A321 aircraft maintenance manual when removing a fuel pump lead to fuel spill.

ACN: 2062965 *(2 of 50)*

Synopsis

Maintenance technicians reported that while they were working on an aircraft with a flap issue the company management was not supportive of AMT's working to find root cause of the problem.

ACN: 2061958 *(3 of 50)*

Synopsis

Maintenance Technician reported an aircraft with extensive damage to nose was approved for flight before repair.

ACN: 2061955 *(4 of 50)*

Synopsis

Air carrier maintenance personnel reported the improper shipping and handling of fire extinguisher bottles. Reporter suggests additional training of shipping and handling personnel is needed.

ACN: 2061581 *(5 of 50)*

Synopsis

Helicopter maintenance technicians reported that after scheduled maintenance they learned a pilot discovered during preflight inspection the tail rotor gearbox oil cap was not installed.

ACN: 2060780 *(6 of 50)*

Synopsis

Air carrier Maintenance Lead Technician reported accepting a late arriving important parcel. The late parcel caused a departure delay in order to load in the cargo compartment and to issue a revised final load plan.

ACN: 2059864 *(7 of 50)*

Synopsis

Air carrier Stores Personnel reported the failure to include the AWB with the Hazmat parcel which is required to close the final DG summary. Reporter stated the lack of experience in shipping hazardous material contributed to the document mishandling.

ACN: 2059860 *(8 of 50)*

Synopsis

Air carrier Storekeeper reported the improper packaging and shipment of Hazmat tools by a fellow Storekeeper.

ACN: 2058249 *(9 of 50)*

Synopsis

B737 MAX 8 Technician reported the MEL procedure on testing the fire detection loop was vague and needs to provide more information and direction.

ACN: 2058245 *(10 of 50)*

Synopsis

A319 Mechanic reported heavy corrosion was found on components of the fuel tank.

ACN: 2058239 *(11 of 50)*

Synopsis

Maintenance Inspector reported a connector was mistakenly removed during the replacement of an engine harness. Reporter stated time pressure was a contributing factor.

ACN: 2054307 *(12 of 50)*

Synopsis

Maintenance Technician reported a near miss while towing an aircraft when it almost made contact with another aircraft due to tow lines in the hangar not labeled.

ACN: 2053650 *(13 of 50)*

Synopsis

Aircraft Maintenance Technician reported multiple brake rotor drive clips cracked on 737 MAX aircraft.

ACN: 2053162 *(14 of 50)*

Synopsis

Maintenance Lead Technician reported finding opened aircraft engine oil cans on the oxygen service cart near the oxygen bottle service valves during a routine inspection.

ACN: 2053161 *(15 of 50)*

Synopsis

Aircraft Maintenance Technician reported that the IDG drain plug on B737 aircraft has been found to be cracked due to possible over-torquing.

ACN: 2051190 *(16 of 50)*

Synopsis

Maintenance Technician reversed hydraulic flex lines when reassembling brake valve causing brakes to lock up on landing.

ACN: 2050590 *(17 of 50)*

Synopsis

B737 Aircraft Maintenance Technician reported not performing a required bird strike inspection as the reporter did not see evidence of the bird strike on the engine intake during a walkaround inspection of the fuselage.

ACN: 2050589 *(18 of 50)*

Synopsis

Aircraft Technician found missing panel on engine thrust reverser during pre-departure walk around.

ACN: 2050585 *(19 of 50)*

Synopsis

Maintenance Technician reported finding corroded batteries in a B787 portable oxygen bottle.

ACN: 2047663 *(20 of 50)*

Synopsis

Maintenance technician found un-installed engine bolt during maintenance troubleshooting due to jamb of engine twist grip.

ACN: 2040780 *(21 of 50)*

Synopsis

Maintenance Technician reported missing insulation in the cargo pit causing high temperatures due to the pneumatic duct.

ACN: 2040479 *(22 of 50)*

Synopsis

Maintenance technicians working on an A320 aircraft reported inadvertent gear retraction causing minor injury to another technician.

ACN: 2039328 *(23 of 50)*

Synopsis

Aircraft technicians reported fuel spill when removing wing tank fuel pump.

ACN: 2038548 *(24 of 50)*

Synopsis

Maintenance technicians serviced aircraft IDG with possible contaminated fluid.

ACN: 2036377 *(25 of 50)*

Synopsis

Maintenance Technician incorrectly closed an MEL on a B767 item due to not reading all of the logbook updates.

ACN: 2033529 *(26 of 50)*

Synopsis

Two onboard air carrier Mechanics and one Ground Marshaller reported a ground encounter with a parked aircraft during aircraft repositioning to a hangar. Marshaller stated he misjudged the lack of winglet clearance.

ACN: 2033522 *(27 of 50)*

Synopsis

Aircraft Maintenance Technician reported a suspected design issue regarding the lack of safety wire on the main landing gear valve stem assembly.

ACN: 2032488 *(28 of 50)*

Synopsis

Aircraft Maintenance Technician reported aircraft had hydraulic system failure due to non-accomplishment of aircraft modification.

ACN: 2032484 *(29 of 50)*

Synopsis

Aircraft Maintenance Technician towing an aircraft into the hangar struck the wing of another aircraft with the radome of the aircraft under tow.

ACN: 2030501 *(30 of 50)*

Synopsis

Aircraft Maintenance Technician reported wing access panels departed the aircraft inflight due to possible missing or damaged part.

ACN: 2030003 *(31 of 50)*

Synopsis

Aircraft Maintenance Inspector and Technician reported incorrect sign-off of cabin door assist actuator during previous maintenance visit.

ACN: 2028354 *(32 of 50)*

Synopsis

B787 Technician reported being marshaled into the gate when a service vehicle entered the safety area passing close by the Technician and Marshaller.

ACN: 2028082 *(33 of 50)*

Synopsis

Maintenance Supervisor reported only a nose wheel chock was used for an aircraft parked in the hangar and it was improperly positioned resulting in the aircraft rolling into a scissor lift.

ACN: 2028067 *(34 of 50)*

Synopsis

Maintenance Technician reported that during preflight the flight crew found the aircraft flight crew escape ropes were not installed properly.

ACN: 2027475 *(35 of 50)*

Synopsis

Air carrier Safety Representative reported inconsistencies of aircraft hazmat components tagging during ground processing. Reporter suggested more training for stores clerks.

ACN: 2026576 *(36 of 50)*

Synopsis

Aircraft Maintenance Technicians reported improper removal of 737-900 aircraft wing structure protective coatings and material.

ACN: 2024817 *(37 of 50)*

Synopsis

Aircraft Maintenance Technician reported incorrectly installing landing gear uplock brackets and had mistakenly installed them upside-down.

ACN: 2024499 *(38 of 50)*

Synopsis

Aircraft Technician reported PSU units with O2 generators were not being processed as a HAZMAT part and were being improperly tagged without the proper shelf life information.

ACN: 2023499 *(39 of 50)*

Synopsis

Helicopter owner/pilot reported performing own maintenance due to experimental exhibition category. The helicopter experienced a loss of power during a flight and was damaged upon landing.

ACN: 2023427 *(40 of 50)*

Synopsis

Aircraft Technician reported missing step in maintenance procedure to restore circuit breakers for VOR antenna.

ACN: 2022066 *(41 of 50)*

Synopsis

A320 Maintenance Technician reported that the incorrect part was listed in the Illustrated Parts Catalog (IPC) and needs to be corrected and updated. The installation of the incorrect part as instructed in the current IPC could lead to possible malfunction of the aircraft's thrust reverser system.

ACN: 2021140 *(42 of 50)*

Synopsis

A320 technicians reported the Aircraft Maintenance Manual (AMM) did not clearly provide defuel instructions for a fuel pump removal procedure. After removing the pump, fuel began to leak, spilling all over on the ramp.

ACN: 2020865 *(43 of 50)*

Synopsis

Maintenance Stores Personnel reported he mistakenly advanced a hazmat parcel as a "No hazmat on board NOTOC". This mistake resulted in the undocumented air transport of hazmat.

ACN: 2017583 *(44 of 50)*

Synopsis

Air carrier Ground Personnel reported being notified of a box containing two Dangerous Goods (DG) components combined in one box. Reporter stated he was not aware of any DG in the box.

ACN: 2017070 *(45 of 50)*

Synopsis

B737 Technician reported that an EA (Engineering Authorization) does not have a sufficient fuel nozzle leak check process after fuel nozzle post-replacement work is completed. If the leak test is not performed and a potential problem goes undetected, the reporter states that it can lead to in-service engine fires.

ACN: 2010947 *(46 of 50)*

Synopsis

Aircraft Maintenance Technician reported pressure from Maintenance Control department to install incorrect part onto airplane.

ACN: 2008358 *(47 of 50)*

Synopsis

Aircraft Maintenance Technician reported an inadvertent discharge of the cargo pit fire extinguisher bottle during a maintenance check.

ACN: 2008352 *(48 of 50)*

Synopsis

Maintenance Technicians reported missing a procedural step when deferring a thrust reverser while the aircraft was at the gate prior to departure.

ACN: 2005229 *(49 of 50)*

Synopsis

Maintenance Manager reported non compliance with MEL procedure and incorrect maintenance practices led to water leaking into the Lower avionics compartment, causing system failures on a B747 aircraft.

ACN: 2000321 *(50 of 50)*

Synopsis

Technician reported concerns over trouble shooting and the correct application of an MEL while working in a B777-200.

Report Narratives

ACN: 2069879 *(1 of 50)*

Time / Day

Date : 202401
Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : A321
Operating Under FAR Part : Part 121
Flight Phase : Parked
Maintenance Status.Maintenance Type : Unscheduled Maintenance
Maintenance Status.Maintenance Items Involved : Repair

Component

Aircraft Component : Fuel Booster Pump
Aircraft Reference : X
Problem : Design

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Lead Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2069879
Human Factors : Troubleshooting

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Ground Event / Encounter : Fuel Issue
Anomaly.No Specific Anomaly Occurred : Unwanted Situation
Detector.Person : Maintenance
When Detected : Routine Inspection
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Chart Or Publication
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Manuals
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

Aircraft X had an open discrepancy for the RH wing INBD fuel pump fuel leak. As the crew chief assigned with the aircraft, I requested a defuel of the aircraft because it had 22,000lbs total fuel. The Aircraft Maintenance Manual (AMM) does not call for a defuel but I decided it was best as a precaution. The aircraft was eventually defueled to 13,000 lbs total fuel but was imbalanced with fuel in the right wing tank. I instructed the mechanic to pump all of the fuel into the center tank which resulted in roughly 8000lbs of fuel in the center tank and the remaining fuel in the left wing. Once the fuel was moved, the mechanic began the removal procedure of the fuel pump in accordance with the AMM. All precautions and steps were followed. During the removal of the pump, the slide valve remained on the pump and was pulled from the wing tank as one unit. The slide valve was tightly sealed with O-rings on the fuel pump which prevented it from separating from the pump as it should have per the AMM. This caused a fuel leak from the wing. The mechanic immediately tried to stop the leak but was unable to successfully put the fuel pump back in place. He then contacted me by phone. I immediately went to the aircraft. I contacted management and was told that the fire department was already notified. Many mechanics, crew chiefs, and supervisors immediately got spill kits and attempted to contain the fuel. Mechanics were able to then separate the slide valve from the fuel pump on the ground and slide it into place on the wing to stop the leak. We then cleaned the spill. The slide valve is supposed to be locked in place by a flange. The flange is very small and easily worn, about the size of half a 3/16 washer. The pump was very sealed into the slide valve, so when it was removed, it came out as one assembly past the flange. In addition, the center fuel tank gravity fed fuel into the right wing which caused the large spill even after taking extra precautions to defuel the wing tank. Suggestions: There needs to be more details in the AMM as precautions to take when removing a fuel pump. The Aircraft Maintenance Manual does not suggest defueling the tank before removal of the pump. The Aircraft Maintenance Manual also does not caution in the removal procedures that on A321 aircraft the center fuel tank will gravity feed into the wing tanks if the center tank has less fuel. This spill could have been easily avoided if that precaution was present in the removal of the fuel pump reference.

Synopsis

Aircraft Technician reported lack of key information in A321 aircraft maintenance manual when removing a fuel pump lead to fuel spill.

ACN: 2062965 *(2 of 50)*

Time / Day

Date : 202311
Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : Commercial Fixed Wing
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Mission : Passenger
Flight Phase : Parked
Maintenance Status.Maintenance Type : Unscheduled Maintenance
Maintenance Status.Maintenance Items Involved : Inspection

Component

Aircraft Component : Flap Control (Trailing & Leading Edge)
Aircraft Reference : X
Problem : Malfunctioning

Person : 1

Location Of Person : Repair Facility
Reporter Organization : Air Carrier
Function.Maintenance : Technician
Qualification.Maintenance : Powerplant
Qualification.Maintenance : Airframe
ASRS Report Number.Accession Number : 2062965
Human Factors : Time Pressure

Person : 2

Location Of Person : Repair Facility
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2065814
Human Factors : Time Pressure

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Maintenance
When Detected.Other
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Staffing
Primary Problem : Company Policy

Narrative: 1

On the night of Day 0 going into Day 1, a few of us were assigned to work the OTS (Out of Service) aircraft for a flap lock issue. The report generated from the aircraft stated the warning message (F/CTL FLAPS LOCKED, SFCS). Failure messages included: (FLP 1 CHK LH MECH DRIVE, AND FLP 2 CHK LH MECH DRIVE). We failed to receive any kind of turnover due to the fact that morning shift was the last to touch the aircraft, and swing shift was waiting on parts, so by the time the midnight crew arrived, we had no direction on where to start besides searching through scattered paperwork in search of where to begin maintenance. We concluded that a previous shift found damage to the track 3 system and based off our manual instructions for the associated faults, we proceeded as such to inspect for more damage. By the end of the shift, we discovered more underlying damage of the flap system which included track 3 and track 4 (the outboard flap), and potential damage to the inboard flap system (track 1 and 2). Us AMTs created a copious amount of non-routine items for tracks 3 and 4, and nothing for track 1 and 2. We were told by a crew chief to hold off on writing up a potentially worn attaching link of the track 2 inboard flap, due to the fact that since track 3 was removed, it could have caused play in the inboard flap system. We were told that the next shift will check out track 1 and 2 when track 3 was reassembled. This is a failure on our behalf to write this particular item up. When the aircraft left ZZZ, we proceeded to check documentation, and did not find anything regarding inspection of the LH track 1 and 2 system, but rather a GVI (General Visual Inspection) of the LH flap system, in which we are unsure if that was included. The following night after we were assigned to the aircraft, management decided that the crew chief from the day before will no longer be able to have that aircraft, and they wanted a whole new crew to be assigned to it. Our opinion was that due to the immense amount of write ups the day prior, management felt as if it caused an operational delay in production. Mind you, this is suspected by us AMTs. As techs searching for a flap failure, we felt as if there was an unjust pressure and judgement against us by scrupulously following the approved maintenance manual references. This feeling of a "push" in order to have forward progress in regard to aircraft repair seemed to become overwhelming as the night progressed. This type of operational pressure and feelings of being wanted to "look the other way" is a dangerous work practice when attempting to make possibly consequential airworthiness decisions, especially regarding an emergency landing flight control issue with our innocent passengers onboard. Cause: Saturation of write ups for damage found, and pressure for forward progress regarding work production in order to get the aircraft out as soon as possible for revenue service. Contributing factors regarding why this happened also includes preemptive decision making by our crew chief without reference material regarding our track 2 inboard flap concern. Solution: "Judgement free" expectation for writing up suspected damage or confirmed damage/failures. Management pressure expectations to be reduced, due to the fact that the AMTs and Crew Chiefs have the ultimate and final say on airworthiness decisions. We are told that management expects write ups and issues throughout the night on an OTS aircraft, but in turn show the opposite by failure of their word by inducing pressure. Most of these situations when later talked about seem to be disregarded as not a big deal and expected to happen based off experience of what supervision has seen, but when it comes to the actual event occurring, this ideology changes.

Narrative: 2

On the night of Day 0 working into Day 1 I was part of OTS (Out of Service) crew assigned to an A/C. After a complete lack of briefing and or turnover from anyone of the techs or crew chiefs of swing shift due to the fact they did not work the A/C and day shift was the last ones to do so and they never left a turnover for them either, at which point we had to deduce where the A/C was left off just from non routine write ups and from visually examining what was removed. Failure of the turnover had us start at the beginning thus inspecting the report and associated faults which were for a FLP1 CHK MECH DRIVE and FLP 2 CHK LH MECH DRIVE, with this information in hand we looked over the L/H wing on the aircraft and found that Track 3 was disassembled and was found to have mechanical failure in a few major parts. As we restarted all troubleshooting from scratch we performed a visual inspection of the area and found numerous discrepancies that were noted on non routine paperwork, out of which one discrepancy for a loose/worn attach link on FLAP 2 was to be left unwritten at the request of crew chief on duty due to the fact Track 3 was disassembled at the time there was no way of knowing any effects from that that would create issues/looseness to Track 2. This is a failure on us as techs to write up the issue even against the wishes of the crew chief. Upon the aircraft final sign off we reviewed the sign offs done here in ZZZ and noted that our concern was never addressed about the #2 flap even though the initial faults to the system were for Track1 and Track2. Even before the aircraft left ZZZ we had our doubts about management over involvement during the course of the aircraft′s OTS time here. The night of Day 1 we were not reassigned to the aircraft and neither was our crew chief due to managements concerns over the copious amounts of non routines generated the previous night shift, the constant pressure from management involvement towards an operational goal and not towards the actual safety was constantly felt and was observed by most everyone that had involvement in aircraft′s stay here and the ultimate reason that both techs and crew chiefs were under such ridiculous sustained pressure and scrupulous oversight was why ultimately the aircraft left without certain aspects of possibly unserviceable items to have been overlooked and thus letting an aircraft full of paying customers leave this station in questionable airworthiness and this issue has been an issue with our local management during every single OTS event. Cause: Pressure for aircraft progress at no regard to procedures, or restrictions to such procedures be it by equipment and or time, operational needs of the A/C being pushed against the airworthiness needs of the A/C, numerous crews of AMTs and crew chiefs being rotated through in hopes that they will find a crew that would comply with management requests better then the others and in hopes of bending/breaking some regulations for the operational need. Broken and/or missing equipment/tooling, improper/missing turn over paperwork from AMT and/or crew chiefs, decision making from supervision without any kind of paperwork or written approved deviation from reference material. Solution: Management pressure needs to stop, it is extremely unsafe and they especially good at inducing fear of being reprimanded into new and young AMTs during their probationary periods and they continue this trend of bullying into submission afterwards, at a time the A/C is OTS it is up to the AMTs and the Crew chiefs as to proper and correct actions as per our FAA approved reference material and any kind of deviation from such reference material with written authorization if needed. The operational needs of the A/C will and should always come in second place to safety. Technicians should not be scrutinized or looked down upon for doing their sworn duty to maintain the A/C in a airworthy condition as instructed to do so by the FAA rules and regulations and by the reference material that were agreed upon by the FAA and our company.

Synopsis

Maintenance technicians reported that while they were working on an aircraft with a flap issue the company management was not supportive of AMT's working to find root cause of the problem.

ACN: 2061958 *(3 of 50)*

Time / Day

Date : 202312
Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Environment

Light : Night

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : Commercial Fixed Wing
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Mission : Passenger
Flight Phase : Parked
Maintenance Status.Maintenance Deferred : Y
Maintenance Status.Records Complete : N
Maintenance Status.Released For Service : Y
Maintenance Status.Maintenance Type : Unscheduled Maintenance
Maintenance Status.Maintenance Items Involved : Inspection

Component

Aircraft Component : Fuselage Nose Cone
Aircraft Reference : X
Problem : Malfunctioning

Person

Location Of Person : Gate / Ramp / Line
Reporter Organization : Air Carrier
Function.Maintenance : Lead Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2061958
Human Factors : Troubleshooting
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Maintenance
Communication Breakdown.Party2 : Maintenance

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Maintenance

When Detected : Aircraft In Service At Gate
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

Aircraft arrived in ZZZ just after XA00 with a pilot report of lightning strike. The maintenance crew consulted with Maintenance Control and it was determined that the aircraft could continue in service, with reference to the AMM XX-XX-XX-XXX-XXX-X, for two flight cycles. I believe this is incorrect due to the fact that there was extensive damage to the nose area of the aircraft. Cause: The event occurred in my opinion, due to the fact that there were many aircraft out of service at the time, and that the aircraft was needed to cover the trip. Suggestion: Follow all maintenance manual procedures.

Synopsis

Maintenance Technician reported an aircraft with extensive damage to nose was approved for flight before repair.

ACN: 2061955 *(4 of 50)*

Time / Day

Date : 202312
Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : Regional Jet 200 ER/LR (CRJ200)
Operating Under FAR Part : Part 121
Mission : Passenger
Flight Phase : Parked

Person

Reporter Organization : Air Carrier
Function.Ground Personnel : Ramp
Function.Maintenance : Lead Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2061955
Human Factors : Communication Breakdown
Human Factors : Other / Unknown
Human Factors : Training / Qualification
Communication Breakdown.Party1 : Ground Personnel
Communication Breakdown.Party2 : Other

Events

Anomaly.Deviation / Discrepancy - Procedural : Hazardous Material Violation
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Maintenance
When Detected : Aircraft In Service At Gate
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

Fire extinguisher bottles are being shipped, issued, and handled without protective shunt caps on the squibs. The cardboard boxes are only labeled as nonflammable gas, not as explosive. When we receive the bottles, the squibs are installed on them and have only a non-ESD plastic cap over the squib connectors. The squibs should have shunts on from the

manufacturer, what are the venders doing with them? I brought this up in the past when there was only 1 cap in house. We were told we should make shunt caps via a supplement due to no inventory. Whoever is, doing the inspections, testing, shipping and squib tag should be aware of the need for the shunts at all times until installed on the aircraft. Suggestion: 1st educate the venders and shippers of the hazards associated with the squibs. 2nd make sure the squibs are shipped handled and stored with shunt caps on at all times. 3rd cartons need to be properly labeled as to the hazards contained inside.

Synopsis

Air carrier maintenance personnel reported the improper shipping and handling of fire extinguisher bottles. Reporter suggests additional training of shipping and handling personnel is needed.

ACN: 2061581 *(5 of 50)*

Time / Day

Date : 202312
Local Time Of Day : 1801-2400

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Corporate
Make Model Name : Bell Helicopter Textron Undifferentiated or Other Model
Crew Size.Number Of Crew : 1
Mission : Ferry / Re-Positioning
Flight Phase : Parked
Maintenance Status.Maintenance Deferred : N
Maintenance Status.Records Complete : Y
Maintenance Status.Released For Service : Y
Maintenance Status.Required / Correct Doc On Board : Y
Maintenance Status.Maintenance Type : Scheduled Maintenance
Maintenance Status.Maintenance Items Involved : Installation
Maintenance Status.Maintenance Items Involved : Inspection

Component

Aircraft Component : Tail Rotor Drive Gearbox
Aircraft Reference : X
Problem : Improperly Operated

Person : 1

Location Of Person : Repair Facility
Reporter Organization : Corporate
Function.Maintenance : Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
Qualification.Maintenance : Inspection Authority
Experience.Maintenance.Technician : 20
ASRS Report Number.Accession Number : 2061581

Person : 2

Location Of Person : Repair Facility
Reporter Organization : Corporate
Function.Maintenance : Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
Experience.Maintenance.Technician : 5
ASRS Report Number.Accession Number : 2061582

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Flight Crew
When Detected : Aircraft In Service At Gate
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Incorrect / Not Installed / Unavailable Part
Primary Problem : Incorrect / Not Installed / Unavailable Part

Narrative: 1

I was performing scheduled maintenance on a Bell 206L1+ for a 300-hour event. I completed the Tail Rotor section and all that entailed. Our maintenance facility was recently made aware that the pilot was performing his preflight inspection after receiving the aircraft from scheduled maintenance when he noticed the tail rotor gearbox oil cap was not installed. I was the individual who installed the cap, and another AMT verified its installation by performing a Safety and Security Check (SSC). At this point, the aircraft was looked at by two individuals who verified the cap was installed. After receiving notification of the cap not being installed, we talked amongst ourselves here at our maintenance facility and there are several other people, to include 2 pilots, that saw that the cap was installed prior to the Operational Check Flight (OCF) and the aircraft's departure from our facility to its destination. The aircraft underwent ground-runs and an OCF prior to leaving our facility with no visible signs of oil coming from the gearbox or anywhere else.

Narrative: 2

During 300 HR upon completion of servicing and inspection of the tail rotor gearbox area I was tasked with conducting a safety and security check (SSC) of the area prior to the cowling being installed. At the time of my inspection everything appeared and felt secure. After this action the aircraft underwent several ground runs with no evidence of oil leakage. It was also noted by other mechanics as well as pilots that the oil cap was installed at this time. The aircraft was then flown back to its destination. Upon arrival at its destination, during a preflight inspection, it was discovered the tail rotor gearbox servicing cap was not installed.

Synopsis

Helicopter maintenance technicians reported that after scheduled maintenance they learned a pilot discovered during preflight inspection the tail rotor gearbox oil cap was not installed.

ACN: 2060780 *(6 of 50)*

Time / Day

Date : 202312

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : A321
Operating Under FAR Part : Part 121
Mission : Passenger
Flight Phase : Parked

Person

Location Of Person : Gate / Ramp / Line
Reporter Organization : Air Carrier
Function.Ground Personnel : Ramp
Function.Maintenance : Lead Technician
Qualification.Maintenance : Powerplant
Qualification.Maintenance : Airframe
ASRS Report Number.Accession Number : 2060780
Human Factors : Troubleshooting
Human Factors : Workload
Human Factors : Time Pressure

Events

Anomaly.Deviation / Discrepancy - Procedural : Weight And Balance
Anomaly.Deviation / Discrepancy - Procedural : Hazardous Material Violation
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Maintenance
When Detected : Aircraft In Service At Gate
Result.General : Flight Cancelled / Delayed
Result.Flight Crew : Overcame Equipment Problem

Assessments

Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

I got an important/hazmat right before I was ready to close the flight, wasn't aware of the hazmat until it arrived plane side, not knowing that I could refuse the shipment I accepted it causing my crew to have to close up the aft cargo and reopen the front cargo to load the hazmat because on an airbus that's the only place it can go. At departure time I was notified that the restricted article wasn't showing on the final. Cause: Only being a crew chief for several weeks, receiving the hazmat at the last minute caused a lapse in judgement and a sort of panic to get it to the right cargo bin. The extra work caused the

delay, when I did the NOTOC I thought that would update the final to show that it was part of the final load. Solution: Did what I knew to do when I have items that aren't showing up in the final, call loads, open the flight back up, scan the item that wasn't showing and then finalize the flight one more time.

Synopsis

Air carrier Maintenance Lead Technician reported accepting a late arriving important parcel. The late parcel caused a departure delay in order to load in the cargo compartment and to issue a revised final load plan.

ACN: 2059864 *(7 of 50)*

Time / Day

Date : 202311
Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : No Aircraft
Operating Under FAR Part : Part 121
Mission : Passenger
Flight Phase : Parked

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Parts / Stores Personnel
ASRS Report Number.Accession Number : 2059864
Human Factors : Training / Qualification

Events

Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Hazardous Material Violation
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Maintenance
When Detected : Pre-flight
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

I received a pick in Company Software B for hazardous material. Proceeded to go to Company Software A to ship the material. Had made it all the way to booking flight and was given the shipping AWB (Airway Bill) in Company Software A. Once completed I went to my shipping on the other screen in Company Software B to complete the shipping to complete the other half. Wasn't aware that I needed to input the AWB that was given to close out the shipment in Company Software B. Cause: Lack in experience and shipping hazardous material. Suggestions: Company can return back to a 2 person sign off on all hazardous material shipments. Also each item shipping out on ground and air training.

Synopsis

Air carrier Stores Personnel reported the failure to include the AWB with the Hazmat parcel which is required to close the final DG summary. Reporter stated the lack of experience in shipping hazardous material contributed to the document mishandling.

ACN: 2059860 *(8 of 50)*

Time / Day

Date : 202311

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : No Aircraft
Operating Under FAR Part : Part 121

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2059860
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Maintenance
Communication Breakdown.Party2 : Ground Personnel

Events

Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Hazardous Material Violation
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Ground Personnel
When Detected : Routine Inspection
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

Last week there was an field service tools that were requested to be shipped. It was close to the departure time of the Aircraft X so I asked my fellow storekeeper to help me shipped the tools. Since it's a Aircraft X flight we have to do the shipment manually by just creating a special tag. Mechanic hand over the tools that he needs to check out. I asked him 2x if there is anything hazmat on the tools and he said NO. While I'm creating the special tag and shipping memo, my co worker is doing the packing and shipping. Tools was sent to the gate. Later in the night I tried to update the Tool location that I realized that it's Hazmat. I advised the Mechanic that one of the tool is Hazmat and can't be shipped back without proper documentation.

Synopsis

Air carrier Storekeeper reported the improper packaging and shipment of Hazmat tools by a fellow Storekeeper.

ACN: 2058249 *(9 of 50)*

Time / Day

Date : 202311

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B737 MAX 8
Operating Under FAR Part : Part 121
Flight Phase : Parked

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2058249
Human Factors : Confusion

Events

Anomaly.Deviation / Discrepancy - Procedural : MEL / CDL
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Maintenance
When Detected : Aircraft In Service At Gate
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Manuals
Contributing Factors / Situations : MEL
Contributing Factors / Situations : Procedure
Primary Problem : MEL

Narrative: 1

The maintenance section of the MEL is vague. Operative detector loops are verified to operate normally once each flight day. Once each flight day, verify each operative detector loop operates normally. Apply heat from an appropriate heat source to a detector element in the loop. The substitute test heat device must not produce heat greater than 450 degrees F. The temperature limit should be observed in the event fuel vapors exist in the area. It goes on to what to expect during the heat test. I found that the MEL can be interpreted as meaning to check each and every segment in the loop or the loop in total. If to check it in total, it does not say where or provide a maintenance reference for the AMM (Aircraft Maintenance Manual) to use to prove this test. It offers no approved tool to use to increase the temperature of the probe into the test range. If you are to check each and every loop segment that is part of the full loop individually, this task is near impossible in

the turn environment it was provided to me in. In speaking with Maintenance Control they said you just test the loop anywhere. But my concern there is that you could have multiple faults that compromised much more than one area. When you look in the IPC (Illustrated Parts Catalog), each segment of the major loop is called a loop unto itself. So without an approved Aircraft Maintenance Manual procedure for this heat task it leaves far too much to interpretation that I believe it should. Suggestion: I would have a specific Aircraft Maintenance Manual or Work Order listed that compels the Technician onto what the intended procedure, and what tooling approved to use for this.

Synopsis

B737 MAX 8 Technician reported the MEL procedure on testing the fire detection loop was vague and needs to provide more information and direction.

ACN: 2058245 *(10 of 50)*

Time / Day

Date : 202311

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : A319
Operating Under FAR Part : Part 121
Flight Phase : Parked
Maintenance Status.Maintenance Items Involved : Inspection

Component

Aircraft Component : Wing Access Panel
Aircraft Reference : X
Problem : Malfunctioning

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2058245

Events

Anomaly.Aircraft Equipment Problem : Critical
Detector.Person : Maintenance
When Detected : Routine Inspection
Result.General : Maintenance Action
Result.Aircraft : Aircraft Damaged

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Incorrect / Not Installed / Unavailable Part
Contributing Factors / Situations : Procedure
Primary Problem : Aircraft

Narrative: 1

Fuel tank entry mechanics found heavy corrosion on the attaching hardware and impact fuel panels 640cb and 640bb.

Synopsis

A319 Mechanic reported heavy corrosion was found on components of the fuel tank.

ACN: 2058239 *(11 of 50)*

Time / Day

Date : 202311
Local Time Of Day : 0001-0600

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Make Model Name : B737-800
Flight Phase : Parked
Maintenance Status.Maintenance Type : Scheduled Maintenance
Maintenance Status.Maintenance Items Involved : Installation

Component

Aircraft Component : Electrical Wiring & Connectors
Aircraft Reference : X
Problem : Improperly Operated

Person

Location Of Person : Gate / Ramp / Line
Reporter Organization : Air Carrier
Function.Maintenance : Inspector
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2058239
Human Factors : Time Pressure
Human Factors : Confusion

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Maintenance
When Detected : Aircraft In Service At Gate
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

During the replacement of an engine harness on Aircraft X, on engine #2, a connector was mistakenly removed. Due to the significant amount of AMT's present at the time of the job and trying to get the plane out on time, it may have been inadvertently missed during the

installation process. Suggestions: Be more organized and not allow time constraints to keep me from being certain with work.

Synopsis

Maintenance Inspector reported a connector was mistakenly removed during the replacement of an engine harness. Reporter stated time pressure was a contributing factor.

ACN: 2054307 *(12 of 50)*

Time / Day

Date : 202311

Place

Altitude.AGL.Single Value : 0

Aircraft : 1

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : Large Transport, Low Wing, 2 Turbojet Eng
Operating Under FAR Part : Part 121
Flight Phase.Other

Aircraft : 2

Reference : Y
Aircraft Operator : Air Carrier
Make Model Name : Commercial Fixed Wing
Operating Under FAR Part : Part 121
Flight Phase : Parked

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2054307

Events

Anomaly.Conflict : Ground Conflict, Critical
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Maintenance
When Detected.Other
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

While towing Aircraft X into Bay X there was a near miss with Aircraft Y which was located in bay Y. Aircraft X RH winglet almost made contact with Aircraft Y aft fuselage. The diagonal lines in Bay Y are not applicable for the Aircraft X type. They are also unlabeled. This has happened multiple times. Solution: We need to assess the towing lines in the hangar and make sure that they are labeled correctly, and they accurately represent which AC can be towed where. We also need to add new lines for pulling AC into the widebody bay straight.

Synopsis

Maintenance Technician reported a near miss while towing an aircraft when it almost made contact with another aircraft due to tow lines in the hangar not labeled.

ACN: 2053650 *(13 of 50)*

Time / Day

Date : 202311

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B737 MAX Series Undifferentiated
Mission : Passenger
Flight Phase : Parked
Maintenance Status.Maintenance Deferred : N
Maintenance Status.Maintenance Items Involved : Inspection

Component

Aircraft Component : Wheels/Tires/Brakes
Aircraft Reference : X
Problem : Failed

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
Qualification.Maintenance : Powerplant
Qualification.Maintenance : Airframe
ASRS Report Number.Accession Number : 2053650

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Detector.Person : Maintenance
When Detected : Routine Inspection
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Primary Problem : Aircraft

Narrative: 1

During a LOSA (Line Operations Safety Assessment) observation, mechanic found a #4 brake rotor drive clip cracked. While awaiting parts I inspected the brake and found a total of seven of the rotor drive clips cracked. Got with several other technicians including the grave shift new hire trainer and was told they are seeing this problem on MAX aircraft quite common, and occasionally on new gens. Might need to address the material used for the rotor drive clips! on this particular brake, every crack was found on the last rotor disk leaving me to believe it is a heat issue.

Synopsis

Aircraft Maintenance Technician reported multiple brake rotor drive clips cracked on 737 MAX aircraft.

ACN: 2053162 *(14 of 50)*

Time / Day

Date : 202311

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : No Aircraft
Operating Under FAR Part : Part 121

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Lead Technician
ASRS Report Number.Accession Number : 2053162
Human Factors : Training / Qualification

Events

Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Hazardous Material Violation
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Maintenance
When Detected : Routine Inspection
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

Opened aircraft engine oil cans were found on oxygen service cart near oxygen bottle service valves during morning shift equipment inspection. Crews need to be aware of the danger of oil and oxygen. And, correct disposal of used oil cans in the HAZMAT area.

Synopsis

Maintenance Lead Technician reported finding opened aircraft engine oil cans on the oxygen service cart near the oxygen bottle service valves during a routine inspection.

ACN: 2053161 *(15 of 50)*

Time / Day

Date : 202311

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B737 Undifferentiated or Other Model
Operating Under FAR Part : Part 121
Flight Phase : Parked

Component

Aircraft Component : Generator Drive
Aircraft Reference : X
Problem : Improperly Operated

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2053161
Human Factors : Situational Awareness

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Detector.Person : Maintenance
When Detected : Routine Inspection
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

The IDG's (Integrated Drive Generator) aluminum drain plug which gets torqued at block 2 step XX is often found cracked due to previous over torquing and/or previous use of improper tool (e.g. channel locks) as evidenced by mangled drain plug. An easy confirmation that this aluminum plug is cracked is: #1/ during increased tightening, suddenly the effort decreases, and #2/ visual inspection of crack under naked eye or magnifying glass. Suggest adding to block 2 step XX "warning: do not over torque drain

plug. If during torque sequence the effort required suddenly decreases, stop, and replace drain plug as 'suspected cracked'.

Synopsis

Aircraft Maintenance Technician reported that the IDG drain plug on B737 aircraft has been found to be cracked due to possible over-torquing.

ACN: 2051190 *(16 of 50)*

Time / Day

Date : 202310
Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Corporate
Make Model Name : Gulfstream III (G1159A)
Operating Under FAR Part : Part 91
Mission : Passenger
Flight Phase : Landing
Maintenance Status.Maintenance Deferred : Y
Maintenance Status.Records Complete : Y
Maintenance Status.Maintenance Items Involved : Installation

Component

Aircraft Component : Wheels/Tires/Brakes
Aircraft Reference : X
Problem : Improperly Operated

Person

Location Of Person : Repair Facility
Reporter Organization : FBO
Function.Maintenance : Lead Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
Experience.Maintenance.Lead Technician : 40
Experience.Maintenance.Technician : 50
ASRS Report Number.Accession Number : 2051190

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Flight Crew
When Detected : In-flight
Result.Aircraft : Aircraft Damaged

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

Gulfstream III departed our maintenance facility on Day 0 following replacement of the Emergency Brake Valve. After the replacement valve was installed, the installation was inspected. All 4 Brakes were bled. The Chief Pilot for this aircraft is also a training instructor. He also holds an A&P Maintenance Certificate. Maintenance hooked up 2 each Hydraulic flex lines in reverse. We informed the pilot that we had not performed the operational check portion of the valve installation. He stated that he wanted to do that himself and wanted to do a test flight following that. After the test flight he taxied to the local FBO and put the aircraft in position for a XA00 next day departure. The pilot never performed the operational check of the valve prior to test flight or prior to the XA00-departure next day. The checklist was not followed for either flight which calls for "Parking Brake Set / Aux Pump On and indicating 3,000 psi". If the Aux Pump had ever been operated the aircraft would not have been able to taxi the with brakes locked up. The before landing checklist calls for Aux Pump On and 3,000 indicated prior to landing. Since the lines were crossed this built up 3,000 psi to the brakes and caused all 4 to be locked up prior to touchdown. (see prevent situation / correct the situation below). Maintenance facility made policy change: Any component removed having more than one line will have all lines marked with color coded tie straps / color coded paint marker / color coded inspectors seal or tape to prevent any crossed connections. Only the Inspector is approved to remove the markings once verified to be correct. Chief Pilots are no longer allowed to perform operational checks of components replaced without maintenance personnel witnessing the event. It's easy to get complacent, the crew members need to actually follow the checklist.

Synopsis

Maintenance Technician reversed hydraulic flex lines when reassembling brake valve causing brakes to lock up on landing.

ACN: 2050590 *(17 of 50)*

Time / Day

Date : 202311

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B737 Undifferentiated or Other Model
Operating Under FAR Part : Part 121
Flight Phase : Parked
Maintenance Status.Maintenance Items Involved : Inspection

Person

Location Of Person : Gate / Ramp / Line
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2050590
Human Factors : Troubleshooting
Human Factors : Situational Awareness

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : Bird / Animal
Detector.Person : Maintenance
When Detected : Routine Inspection
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

During walkaround inspection of the fuselage, witnessed small red spot on lefthand side of radome lower section. Approximately the size of a quarter. Wasn't sure if it was a bird strike or a bug. cleaned off area and continued to inspect lefthand side of fuselage. Detailed inspection of leading edge, under wing area, landing gear, trailing edge flap area and exterior of engine cowling. Found no other evidence of bird strike. Meanwhile not seeing, the bird excrement and small amount of blood at the 5 o'clock position of the #1 engine intake, which required a bird strike inspection. I had slowed down and taken the time to read further into the MM (Maintenance Manual), it drove me to look at another MM. After inspecting the area in question, I had not seen any damage at all, and cleaned the small spot on the radome, per the first MM.

Synopsis

B737 Aircraft Maintenance Technician reported not performing a required bird strike inspection as the reporter did not see evidence of the bird strike on the engine intake during a walkaround inspection of the fuselage.

ACN: 2050589 *(18 of 50)*

Time / Day

Date : 202310

Aircraft

Reference : X
ATC / Advisory.Ramp : ZZZ
Aircraft Operator : Air Carrier
Make Model Name : B777 Undifferentiated or Other Model
Operating Under FAR Part : Part 121
Flight Phase : Parked

Component

Aircraft Component : Service/Access Door
Aircraft Reference : X
Problem : Failed

Person

Location Of Person : Gate / Ramp / Line
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2050589

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : MEL / CDL
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Maintenance
When Detected : Routine Inspection
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Aircraft

Narrative: 1

During routine ETOPS check found door/panel on #1 engine inboard thrust reverser upper hinge beam aft small door missing. Door was missing from panel. [Document] does not allow mid or aft access doors to be missing. There have been countless number of findings/damages/missing parts etc which causes un-necessary delays and sometimes cancellation. A lot of these can be prevented when a qualified technician does a walk around in a timely fashion. Allow all line mechanics to do general walkarounds on all flights..not just on ETOPS flights or scheduled service checks. mechanics should be allowed to do a general walk around on all through flights that come in and out of there assigned gates. Letter says no more walkarounds due to staffing levels at ZZZ....ok now

staffing levels are back to normal..we have hired 100s of new mechanics..also see updated and extensive ramp agent walk around below....why pay a mechanic to do a walk around when you can pay a ramp agent to do it and save lots of money.....this is not safe because ramp agents do not know what they are looking at, they are not trained, they are not qualified.....not trying to rant here.....just trying to emphasize on the importance of safety in this industry....its all about customer and aircraft safety..... Company X is all about safety -- so what happened to safety now?

Synopsis

Aircraft Technician found missing panel on engine thrust reverser during pre-departure walk around.

ACN: 2050585 *(19 of 50)*

Time / Day

Date : 202310

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B787 Dreamliner Undifferentiated or Other Model
Operating Under FAR Part : Part 121
Mission : Passenger
Flight Phase : Parked

Component

Aircraft Component : Oxygen System/Portable
Aircraft Reference : X
Problem : Design

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
Qualification.Maintenance : Powerplant
Qualification.Maintenance : Airframe
ASRS Report Number.Accession Number : 2050585

Events

Anomaly.Aircraft Equipment Problem : Critical
Detector.Person : Maintenance
When Detected : Routine Inspection
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Procedure
Primary Problem : Aircraft

Narrative: 1

Oxygen bottle was low, needed to be serviced. When servicing bottle found the batteries in the bottle corroded, possible causing a spark in the bottle. Note the airplane number was just generated (aircraft that the bottle came off is unknown) for this form to be completed. Have the B787 bottle checked more frequently (there is a longer time frame on the B787 bottles-due to the bottle), hydrostatic test and due date are longer times than the standard bottles on the other fleets. This B787 only gets checked when it needs servicing. Note I have seen (2) other times during servicing of this style of bottle-that had corroded batteries. They were both found because the test that gives you a green light was not coming on.

Synopsis

Maintenance Technician reported finding corroded batteries in a B787 portable oxygen bottle.

ACN: 2047663 *(20 of 50)*

Time / Day

Date : 202310
Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Military
Make Model Name : Bell Helicopter 412
Maintenance Status.Maintenance Type : Scheduled Maintenance
Maintenance Status.Maintenance Items Involved : Repair
Maintenance Status.Maintenance Items Involved : Inspection

Component

Aircraft Component : Engine Control
Aircraft Reference : X
Problem : Malfunctioning

Person

Location Of Person : Gate / Ramp / Line
Reporter Organization : Contracted Service
Function.Maintenance : Technician
Qualification.Maintenance : Powerplant
Qualification.Maintenance : Airframe
ASRS Report Number.Accession Number : 2047663

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Maintenance
When Detected : Routine Inspection
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

Engine bolt located after jamb of #1 engine twist grip and subsequent trouble shooting with magnet in inaccessible area adjacent to engine idle cutoff inner bellcrank. Bolt appears to be un-installed with anti-seize present and no safety wire installed in head of 12-point engine bolt. Last engine maintenance in area Day 1 per documented maintenance

records. Installation if engine verified. No other FOD found. Use of borescope, visually thru open panels, or magnet after disassembly/reassembly of engine components with performed.

Synopsis

Maintenance technician found un-installed engine bolt during maintenance troubleshooting due to jamb of engine twist grip.

ACN: 2040780 *(21 of 50)*

Time / Day

Date : 202309

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B767-300 and 300 ER
Operating Under FAR Part : Part 121

Component

Aircraft Component : Aircraft Furnishing
Aircraft Reference : X
Problem : Malfunctioning

Person

Location Of Person : Company
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2040780
Human Factors : Training / Qualification

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Maintenance
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Chart Or Publication
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Incorrect / Not Installed / Unavailable Part
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

The missing insulation blanket in the aft pit was causing temperatures above 112 degrees in lavatory area. The temperature at the duct in the aft cargo area where there was no insulation was reading 260F, possible fire hazard in an enclosed area. There is no value for experience techs. Maintenance Technician should begin their career by exploring the great learning experience a hanger environment can bring at the same time helping out the airlines with delays and cancellations.

Synopsis

Maintenance Technician reported missing insulation in the cargo pit causing high temperatures due to the pneumatic duct.

ACN: 2040479 *(22 of 50)*

Time / Day

Date : 202309
Local Time Of Day : 1801-2400

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : A320
Operating Under FAR Part : Part 121
Flight Phase : Parked
Maintenance Status.Maintenance Type : Unscheduled Maintenance
Maintenance Status.Maintenance Items Involved : Inspection
Maintenance Status.Maintenance Items Involved : Repair
Maintenance Status.Maintenance Items Involved : Testing
Maintenance Status.Maintenance Items Involved : Installation

Component

Aircraft Component : Hydraulic System
Aircraft Reference : X
Problem : Malfunctioning

Person : 1

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2040479
Human Factors : Communication Breakdown
Human Factors : Situational Awareness
Communication Breakdown.Party1 : Maintenance
Communication Breakdown.Party2 : Maintenance

Person : 2

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2040486
Human Factors : Communication Breakdown
Human Factors : Situational Awareness
Communication Breakdown.Party1 : Maintenance
Communication Breakdown.Party2 : Maintenance

Person : 3

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Lead Technician

ASRS Report Number.Accession Number : 2040485
Human Factors : Communication Breakdown
Human Factors : Situational Awareness
Communication Breakdown.Party1 : Maintenance
Communication Breakdown.Party2 : Maintenance

Person : 4

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2040480
Human Factors : Communication Breakdown
Human Factors : Situational Awareness
Communication Breakdown.Party1 : Maintenance
Communication Breakdown.Party2 : Maintenance

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Flight Deck / Cabin / Aircraft Event : Illness / Injury
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Maintenance
When Detected : Routine Inspection
Result.General : Physical Injury / Incapacitation

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

Person 2, Person 4 and I [Person 1] were assigned to Aircraft X. Landing gears doors were already in the down position. The Lead [Person 3] assigned us with removing the accumulator that was, causing a hydraulic leak. The Lead and I pulled breakers, depressurize the system, removing the head pressure. We removed the bottle placed on the table, replace the valve and packing reinstalled the bottle pressurize the system and the Lead pushed in all the breakers. then we refilled the green hydraulic reservoir. The accumulator still leaked, we received a new accumulator we replaced it, Person 2 and the Lead proceeded to go upstairs to the flight deck. The Lead was in an hurry to get the job done before night shift came on. The Lead stowed the manual gear drop and proceeded to turn on the system approx XE00 hours. At that time I was next to the green hydraulic system reservoir I went around to where the ladder that was inside the wheel well to look if the accumulator was leaking at that time before even knew it, the landing gear and ladder was lifting up and pushing me towards the landing gear wheel. My legs were caught in between the ladder. Person 4 next to me, screamed to get out of the way I wasn't quick enough. He tried radio over the radio to stop for me. I was able to get one foot out and get out of the way from the wheel, and then the ladder went up into the wheel well with the landing gear closing behind it. Suggestion: Slowing down.

Narrative: 2

There were three AMTs that were farmed out from the terminal to the hangar, we arrived at XA30 and were given a task to finish 2 service on another aircraft on the west ramp at spot X. At around XC00 we were then called out over the radio by our Lead to help find the problem as to why we had an air return on Aircraft X, the original write up was that the pilots reported losing all HYD pressure in the green system after takeoff causing him to manually drop the landing gear. The landing gear pins were already installed and we were told by Lead to standby, as he was going to pressurize HYDs in order to locate where the leak was coming from. We found the leak and were then instructed to begin removing the accumulator while the Lead went to locate and order our parts, we began to pull circuit breakers and depressurizing the green system in order to take the accumulator off. This was accomplished, aside from receiving parts which then arrived around XE30, which was just the joiner and the packing, after installing and leak checking, the leak was still present and bottle needed to be changed along with the joiner and packing, which we then were met by Person A, he assisted in finding the accumulator. after install, around XG00 Person 3 and I went to the cockpit to pressurize HYDS after getting the all clear From both Person A and Lead, Person 3 then stowed the manual gear down handle and pressurized HYDs, the gear doors then came up pinching Person 1 between the ladder and the MLG inboard tire, thankfully he was able to get out in time and only resulted in minor bruises and scrapes. Suggestion: The crew working the job should be the ones touching and carrying out the tests and work. We needed to be more safe when it came to locking out the gear doors, but the configuration of the plane wouldn't have been changed if the original crew was working the problem. No matter the time crunch.

Narrative: 3

Aircraft X had lost green sys hydraulic quantity after taking off flight crew accomplished a manual gear extension after an overweight uneventful landing aircraft was recovered by the ramp taken to a gate unloaded and eventually towed to the hanger MLG doors remained down and the manual extension handle still deployed sufficient hydraulic quantity remained so hydraulic power was applied to confirm source of leak I had assigned three technicians to replace the green sys hydraulic accumulator and ordered parts needed to fix the leak then my attention was on three other aircraft that were out of service including one that I had to take out for a run. I was the only qualified mechanic on shift to do so several hours later I stopped by to see how work was progressing on Aircraft X they had replaced a fitting and o ring on the accumulator serviced and re-pressurized the hydraulic system and it was still leaking we located the new accumulator and I assisted with its replacement then I went to the cockpit accidentally hit my knee on the manual gear extension handle so i cranked it to normal stowed position and with clearance applied hyd power and the gear doors came up and pinched a ladder that had been used for access causing damage to the door and to the ceiling of the MLG. Suggestion: Any time the MLG doors are down the collars / locks need to be installed and the manual maintenance access handles need to be pulled and safeties pins installed regardless of the condition or position of the doors are in when the aircraft is brought into the hanger or for that matter wherever the aircraft is because there had been three prior applications of hydraulic power prior to this event without incident and my distractions dedicated to other out of service aircraft and no prior experience on the aircraft type by the three new technicians i had assigned to this job all contributed to this very serious incident.

Narrative: 4

Person 1 and I were instructed by our Lead [Person 3] to come and look for hydraulic leak while he goes up in the cockpit to turn the pumps on. We found the leak coming from the green system accumulator and asked him to shut off the hydraulic pumps. He comes down and instructed us to depressurize the green system, and remove the on nut that is holding

the accumulator in place. The MLG gear doors were already opened and there was other mechanics working on a different task (overweight landing). So the accumulator was removed after depressurization, a new o ring and fitting were installed and the whole thing was put back together. We did a leak check and it was still leaking. Lead ordered a new accumulator bottle and instructed us to replace it. After doing so, he goes up in the cockpit this time and he stowed the manual gear drop handle then he turned the hydraulic pumps on which made the gear doors go up crushing the ladder. Suggestion: I think the lead was in a rush and did not provide us with enough information for the job.

Synopsis

Maintenance technicians working on an A320 aircraft reported inadvertent gear retraction causing minor injury to another technician.

ACN: 2039328 *(23 of 50)*

Time / Day

Date : 202309
Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Make Model Name : No Aircraft

Component

Aircraft Component : Fuel Booster Pump
Aircraft Reference : X
Problem : Malfunctioning

Person : 1

Location Of Person : Repair Facility
Reporter Organization : Air Carrier
Function.Maintenance : Technician
Qualification.Maintenance : Powerplant
Qualification.Maintenance : Airframe
ASRS Report Number.Accession Number : 2039328
Human Factors : Training / Qualification
Human Factors : Situational Awareness

Person : 2

Location Of Person : Repair Facility
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2039331
Human Factors : Training / Qualification
Human Factors : Situational Awareness

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Maintenance
When Detected.Other
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

Aircraft X, Person 2 and I were tasked to Remove and replace the inboard right hand wing fuel pump. Following the Aircraft Maintenance manual reference, we were up to the step to removing the pump. The fuel pump came out with ease using the tool that was called out in the Aircraft Maintenance manual, as soon as the pump was coming out the slide valve, the slide valve started to fall out of the wing, fuel started pouring right out of the wing, we tried to re install the fuel pump and slide valve to stop the fuel from coming out and was unsuccessful, so we got out of the way, we called our Leads and supervisor right away and the fire department was notified immediately. Cause: I believe that the reason this event occurred because the slide valve retaining pin malfunctioned allowing the slide valve to come out of the wing. Solution: Before removing the fuel pump, to transfer the fuel out of the wing and to inspect the slide valve retaining pin for damage and functionality.

Narrative: 2

[No additional information provided.]

Synopsis

Aircraft technicians reported fuel spill when removing wing tank fuel pump.

ACN: 2038548 *(24 of 50)*

Time / Day

Date : 202309
Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : A321
Operating Under FAR Part : Part 121
Flight Phase : Parked

Component

Aircraft Component : Generator Drive
Aircraft Reference : X
Problem : Improperly Operated

Person : 1

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
Qualification.Maintenance : Powerplant
Qualification.Maintenance : Airframe
ASRS Report Number.Accession Number : 2038548
Human Factors : Situational Awareness

Person : 2

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2038553
Human Factors : Situational Awareness

Person : 3

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2038552
Human Factors : Situational Awareness

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Maintenance
When Detected.Other
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Equipment / Tooling
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

Two other mechanics and I serviced IDGs (integrated drive generator) IAW (In Accordance With) the PS (Periodic Service Check) check because it was low. We used the correct browser and serviced it properly IAW the manual, we all double checked the work to make sure it was serviced properly. During flight the flight crew got a message saying the IDG temperature was too high. After landing the mechanics began troubleshooting the problem and saw a reddish color fluid, they believe its X but we don't have a X browser we only have a green browser (Y) and a purple browser (skydrol). When we serviced the IDG we opened up the lid of the browser and made sure it was [the] right fluid. As of right now there is a sample of the fluid in the IDG that was sent out to be inspected for any contaminates. Cause: Someone somewhere most likely serviced IDGs with a contaminated browser or serviced the IDG with a browser that said Y but had skydrol or X inside. Suggestions: Opening and emptying the browser to see the bottom half if there's any contaminates inside.

Narrative: 2

During the PS (Periodic Service Check) check of Aircraft X, we found both engines IDG (integrated drive generator) oil level below limits. We acquired the correct oil servicing unit and adapters, visually checked the content within the unit with our best ability. Then my 2 co-workers serviced one IDG each under my observation, afterwards we both visually checked the oil level being within the limits after servicing and oil in the sight glass looked normal, all maintenance actions are within the compliance of required AMM. The plane flew the following day, and I was made aware that both IDG over heated with possible contamination noticed after the flight. I'm willing to cooperate with any investigation that may occur to bring this to a close and hopefully make improve for future maintenance.

Narrative: 3

We were assigned to do the PS (Periodic Service Check) check on Aircraft X A321 neo. During the check, we found both IDG (integrated drive generator) oil level low. IAW (In Accordance With) job card we were required to service both IDG IAW AMM as mentioned in the job card. Technician Person 1 and Technician Person 2 brought the Y browser to the plane, I double checked the browser, it was the right one. We serviced both IDG between limits as required by the AMM mentioned above. All the step was accomplished correctly. We got the information that the red fluid was found mixed with the Y oil. I am pretty sure now that the browser container was contaminated with the wrong fluid before we use that browser. We were unable to see it during the first drop before to service both IDG because

we work at night the vision is not so perfect. That unknown fluid might be at the bottom of the browser. I propose the management to drop all the fluid inside of the browser. To investigate so that this serious incident never happened again.

Synopsis

Maintenance technicians serviced aircraft IDG with possible contaminated fluid.

ACN: 2036377 *(25 of 50)*

Time / Day

Date : 202309

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B767 Undifferentiated or Other Model
Operating Under FAR Part : Part 121
Flight Phase : Parked

Component

Aircraft Component : Turbine Engine
Aircraft Reference : X
Problem : Malfunctioning

Person

Location Of Person : Repair Facility
Reporter Organization : Air Carrier
Function.Maintenance : Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2036377
Human Factors : Situational Awareness

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : MEL / CDL
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Automation : Aircraft Other Automation
Detector.Person : Maintenance
When Detected.Other
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : MEL
Primary Problem : Human Factors

Narrative: 1

#1 eng was deactivated and placed on MEL (XXXXXX) due to #1 eng High Pressure Shut-Off Valve being on MEL XXXXXXY). There was an item that was deferred (XXXXXZ) that had to be fixed and required reactivating engine for sheet metal to gain access. After

reactivating #1 eng and deploying. realized that engine was working. When I saw that the original report was Thrust REV 1 did not deploy; figured it was OK to close log as operations checking normally both deploying and stowing. It was brought to my attention the next day that the log should never have been closed because it was tied to the High Pressure Shut-Off Valve being on MEL. I closed the MEL due to the original PIREP and did not notice the updates on the log.

Synopsis

Maintenance Technician incorrectly closed an MEL on a B767 item due to not reading all of the logbook updates.

ACN: 2033529 *(26 of 50)*

Time / Day

Date : 202309

Place

Altitude.AGL.Single Value : 0

Aircraft : 1

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B737-800
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : None
Flight Phase : Taxi

Aircraft : 2

Reference : Y
Aircraft Operator : Air Carrier
Make Model Name : B737-800
Flight Plan : None
Flight Phase : Parked

Person : 1

Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Maintenance : Technician
Qualification.Maintenance : Powerplant
Qualification.Maintenance : Airframe
ASRS Report Number.Accession Number : 2033529
Human Factors : Distraction
Human Factors : Other / Unknown
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Maintenance
Communication Breakdown.Party2 : Ground Personnel

Person : 2

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Ground Personnel : Ramp
ASRS Report Number.Accession Number : 2033531
Human Factors : Communication Breakdown
Human Factors : Situational Awareness
Communication Breakdown.Party1 : Ground Personnel
Communication Breakdown.Party2 : Maintenance

Person : 3

Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Maintenance : Lead Technician
Qualification.Maintenance : Powerplant
Qualification.Maintenance : Airframe
ASRS Report Number.Accession Number : 2033530
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Maintenance
Communication Breakdown.Party2 : Ground Personnel

Events

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Ground Event / Encounter : Aircraft
Detector.Person : Maintenance
Detector.Person : Ground Personnel
When Detected : Taxi
Result.Aircraft : Aircraft Damaged

Assessments

Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

I was sitting right seat (FOs (First Officer) seat) handling radios, taxiing Aircraft X from Gate XX to hangar for an upcoming event. While approaching the front of the hangar for parking, engines at idle coasting to the end of the lead in line while guided by a marshaller, I noticed a jolt just prior to reaching the end. It was at this time the marshaller gave us a stop signal. At this time, I felt that we may have contacted the aircraft parked to the left of us Aircraft Y since I ensured there were no objects on the apron as we were approaching the hangar (i.e. chocks, cones, etc.). I then instructed the left seat operator (Captain's seat) to set brakes and shut down both engines. I then radioed Ramp Control to notify them we were shut down and that movement was terminated at hangar. I then radioed my Supervisor and advised him that there may have been aircraft contact between the two aircrafts and that we would assess. Once I was removed from the aircraft, I noticed that Winglet-to-Winglet and Strakelet-to-Strakelet contact was made. I informed my Supervisor of the findings, asked him to come to our location, shut down the aircraft and secured the area.

Narrative: 2

During aircraft move from spot XX to hangar, left winglet of Aircraft X made contact with right winglet of Aircraft Y in front of hangar. I was performing the aircraft marshalling and it appeared that there was enough clearance from each aircraft winglet as I was guiding Aircraft X forward. From there as I was guiding Aircraft X the left winglet made contact with the right winglet and aircraft movement was stopped in place.

Narrative: 3

I was assigned to taxi Aircraft X from gate XX to hanger. I picked up our marshaller in front of the hanger and started my turn and approach. I noted that there was an aircraft to my left and where we were being marshaled into was close to that aircraft. I mentioned to the right seater Person 1 that we looked close to the aircraft and proceeded to approach very slowly. The person marshalling us, Person 2, has many years of experience

performing this duty. He could see better than I could how close we were. As we were making our closest approach to the other aircraft I slowed to a stop to allow for me to see how close we were. I could not see my wing tip, and we were still being directed to come forward which I complied with. I had to increase thrust to move the plane forward and as it did it started to pull to the left. I stopped immediately and shut down.

Synopsis

Two onboard air carrier Mechanics and one Ground Marshaller reported a ground encounter with a parked aircraft during aircraft repositioning to a hangar. Marshaller stated he misjudged the lack of winglet clearance.

ACN: 2033522 *(27 of 50)*

Time / Day

Date : 202309

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B737 MAX 8
Operating Under FAR Part : Part 121
Mission : Passenger
Flight Phase : Parked

Component

Aircraft Component : Wheel Assemblies
Aircraft Reference : X
Problem : Design

Person

Location Of Person : Gate / Ramp / Line
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2033522
Human Factors : Other / Unknown

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Maintenance
When Detected : Aircraft In Service At Gate
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Aircraft

Narrative: 1

#4 Main landing gear (MLG) Wheel Assembly was low tire pressure to the point where both #4 and #3 MLG tires had to be changed right before departure time. The cause of this was the #4 MLG wheel Assembly valve stem not being torqued from back shop and was so loose that it came off when removing the valve core removal tool. The valve stem assembly on the 737 MAX fleet MLG wheels do not have any safety device like safety wire. This is a dangerous design flaw. I would consider having an audit of whatever back shop

works these tires and to make the valve stem safetied. Maybe make this an inspection task item for the back shop and maybe also add a torque stripe after torquing.

Synopsis

Aircraft Maintenance Technician reported a suspected design issue regarding the lack of safety wire on the main landing gear valve stem assembly.

ACN: 2032488 *(28 of 50)*

Time / Day

Date : 202308
Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : A321
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Mission : Passenger
Flight Phase : Parked

Component

Aircraft Component : Hydraulic System
Aircraft Reference : X
Problem : Failed

Person

Location Of Person : Repair Facility
Reporter Organization : Air Carrier
Function.Maintenance : Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2032488
Human Factors : Other / Unknown

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Automation : Aircraft Other Automation
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Overcame Equipment Problem
Result.Flight Crew : Landed in Emergency Condition

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Human Factors
Primary Problem : Aircraft

Narrative: 1

EO (Engineering Order) XXXXXXXX issued for A321nx aircraft. Problem wasn't addressed until after potential catastrophic failure. Aircraft had an air interrupt. Lost green hydraulic system. Had to deploy the gear manually and EO was not accomplished at this time. The failure for this item is exactly why this EO has been issued for this fleet. Cause: EO not accomplished as a result of this failure. The replaced part is the one that needs to be upgraded in the EO to avoid a hydraulic fluid loss. Solution: Every aircraft that this EO applies to should have the EO accomplished immediately. Waiting until a potential catastrophic failure is reckless. Even after this failure management still didn't do the EO, stated it would take too long.

Synopsis

Aircraft Maintenance Technician reported aircraft had hydraulic system failure due to non-accomplishment of aircraft modification.

ACN: 2032484 *(29 of 50)*

Time / Day

Date : 202308

Place

Altitude.AGL.Single Value : 0

Aircraft : 1

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B777-200
Operating Under FAR Part : Part 121
Flight Phase : Parked

Aircraft : 2

Reference : Y
Make Model Name : Commercial Fixed Wing
Flight Phase : Parked

Aircraft : 3

Reference : Z
Make Model Name : Commercial Fixed Wing
Flight Phase : Parked

Person : 1

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2032484
Human Factors : Situational Awareness

Person : 2

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2032486
Human Factors : Situational Awareness

Events

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Ground Event / Encounter : Aircraft
Detector.Person : Maintenance
When Detected.Other
Result.Aircraft : Aircraft Damaged

Assessments

Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure

Contributing Factors / Situations : Staffing
Primary Problem : Human Factors

Narrative: 1

Aircraft X was moved into [the] center hangar to be set up for RON (Routine Overnight) work. The Aircraft was to be moved in deep so that two narrow body aircraft could be parked behind Aircraft X. Aircraft Y was moved out of the south hanger so that Aircraft X could be moved into the hangar. Lead Technician and crew held a huddle prior to moving Aircraft Y out of the hangar and they reviewed the move of Aircraft Y out of the hangar, the move of Aircraft X into the hangar, followed by the move of Aircraft Y back into the south hanger. After hookup of the tow tractor, the crew members took their positions and the Lead Technician went to the marshal in position. I joined the Lead Technician at that position. The Lead Technician marshalled in the tug driver and the wing walkers moved in with the aircraft. As Aircraft X got close to the parking spot, I moved to the front of Aircraft Z to observe the distance between the #1 engine nose cowl on Aircraft X and the radome on Aircraft Z. The Lead Technician slowed the movement of Aircraft X as it approached the parking spot and a popping sound then occurred. I turned and walked back to see the radome of Aircraft X resting on the leading edge of Aircraft Z left wing. The Lead Technician then motioned the driver to push Aircraft X back. The crew then gathered to place chocks under wheels, disconnect tow bar, hook up power, and position the entry stand.

Narrative: 2

While parking Aircraft X in the hanger, as guide man I did not pay enough attention to clearance on nose of Aircraft X and leading edge of Aircraft Z causing impact damage of radome and leading edge slat.

Synopsis

Aircraft Maintenance Technician towing an aircraft into the hangar struck the wing of another aircraft with the radome of the aircraft under tow.

ACN: 2030501 *(30 of 50)*

Time / Day

Date : 202308
Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : A300
Flight Phase : Parked
Maintenance Status.Maintenance Type : Scheduled Maintenance
Maintenance Status.Maintenance Items Involved : Inspection

Component

Aircraft Component : Wing Access Panel
Aircraft Reference : X
Problem : Failed

Person

Location Of Person : Repair Facility
Reporter Organization : Air Carrier
Function.Maintenance : Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2030501
Human Factors : Other / Unknown

Events

Anomaly.Aircraft Equipment Problem : Critical
Detector.Person : Flight Crew
When Detected : Routine Inspection
Result.General : Maintenance Action
Result.Aircraft : Aircraft Damaged

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Human Factors
Primary Problem : Aircraft

Narrative: 1

On the weekend of Day 0 - Day 3 I was performing several maintenance tasks on Aircraft X, one of those being lubrication of slat, ball drive screw nut, and slat roller assy. I was alone performing this task for both wings. I opened each panel, performed lube task, then

closed access. Ref A300 AMM XX-XX-XX. The aircraft departed Day 3 night from ZZZ1-ZZZ. Upon landing and walk-around inspection performed by pilot [they informed us] that two inboard leading edge panels were missing. Field service was sent up to ZZZ and verified all hardware was installed on the aircraft from where the panel left. When the panel left the aircraft it tucks underneath the panel outboard of it and it made that one depart the aircraft as well. To my understanding, I performed the task at hand correctly and closed access correctly. There is a bracket on the aircraft that is either missing, or damaged that caused the blow out panel to leave the aircraft, and other aircraft I believe have been reported to have that damaged, or missing as well.

Synopsis

Aircraft Maintenance Technician reported wing access panels departed the aircraft inflight due to possible missing or damaged part.

ACN: 2030003 *(31 of 50)*

Time / Day

Date : 202202
Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B757 Undifferentiated or Other Model
Operating Under FAR Part : Part 121
Mission : Passenger
Flight Phase : Parked
Maintenance Status.Maintenance Type : Scheduled Maintenance
Maintenance Status.Maintenance Items Involved : Inspection

Component

Aircraft Component : Exterior Pax/Crew Door
Aircraft Reference : X
Problem : Improperly Operated

Person : 1

Location Of Person : Repair Facility
Reporter Organization : Contracted Service
Function.Maintenance : Technician
Function.Maintenance : Inspector
Qualification.Maintenance : Powerplant
Qualification.Maintenance : Airframe
ASRS Report Number.Accession Number : 2030003
Human Factors : Workload
Human Factors : Situational Awareness

Person : 2

Location Of Person : Repair Facility
Reporter Organization : Contracted Service
Function.Maintenance : Inspector
Function.Maintenance : Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2030007
Human Factors : Situational Awareness

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Deviation / Discrepancy - Procedural : Maintenance

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Maintenance
When Detected : Routine Inspection
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

Aircraft arrived at ZZZ for a scheduled-check scheduled for the specified timeframe. During this check I signed off the install inspection of the body torque tube for one of the doors found with the discrepancies. This was discovered yesterday at our vendor at ZZZ1, both the L4 and R4 door assist actuator B nuts were found disconnected when the sidewall panels just forward of the L4 and R4 door cut outs were removed on the aircraft. They were both found with the red streamers still attached. This aircraft was inducted to ZZZ1 for scheduled check several months later. Due to the elapsed time, I cannot recall the exact cause of the discrepancy. Multiple maintenance operations occurring at the same time or overlooked maintenance steps is the assumption.

Narrative: 2

b-nut was not installed on pneumatic line for the emergency door assist actuator streamer was installed on pneumatic line with the information i was presented, my statement is as followed due to the time of the event and how long it was i can't recall

Synopsis

Aircraft Maintenance Inspector and Technician reported incorrect sign-off of cabin door assist actuator during previous maintenance visit.

ACN: 2028354 *(32 of 50)*

Time / Day

Date : 202308

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
ATC / Advisory.Ramp : ZZZ
Aircraft Operator : Air Carrier
Make Model Name : B787 Dreamliner Undifferentiated or Other Model
Flight Phase : Taxi

Person

Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Contracted Service
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2028354

Events

Anomaly.Conflict : Ground Conflict, Critical
Anomaly.Ground Event / Encounter : Other / Unknown
Detector.Person : Maintenance
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

My partner and I were bringing up an aircraft into gate X, Person A was marshalling me into the gate when a Company maintenance pick up come from my right, goes into the safety area, goes behind my partner (real close) goes under the cab part of the jet way, back into the safety area to go park into what I believe are their offices, all of those while we are moving a 787 into the gate. This happened at around XA:15pm at gate X ZZZ.

Synopsis

B787 Technician reported being marshaled into the gate when a service vehicle entered the safety area passing close by the Technician and Marshaller.

ACN: 2028082 *(33 of 50)*

Time / Day

Date : 202308

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Make Model Name : Commercial Fixed Wing
Flight Phase : Parked
Maintenance Status.Maintenance Deferred : N
Maintenance Status.Maintenance Items Involved : Repair

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Lead Technician
ASRS Report Number.Accession Number : 2028082
Human Factors : Situational Awareness
Human Factors : Troubleshooting
Human Factors : Confusion

Events

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Ground Event / Encounter : Loss Of Aircraft Control
Detector.Person : Maintenance
When Detected : Routine Inspection
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

During the performance of the work card XX-XX-XX, at some point the nose of the aircraft started to roll off the spot 3 center line. Moving approximately 14 ft. before coming to rest against scissor lift and being re-chocked. Potential that the nose wheel chock were not properly positioned / orientated / worn. With the Emergency / Parking Brake Accumulator pressure released combined with the slop of the hangar floor could be contributing factors. Suggestion: In Step XX.X, of W/C XX-XX-XX define chocking the landing gear as: "Place chocks at all three landing gear wheels". In Step XX.Y. add a caution note; "Caution: Not having all three main landing gear checked while the Emergency / Parking Brake Accumulator pressure released, may cause damage and/or injury.

Synopsis

Maintenance Supervisor reported only a nose wheel chock was used for an aircraft parked in the hangar and it was improperly positioned resulting in the aircraft rolling into a scissor lift.

ACN: 2028067 *(34 of 50)*

Time / Day

Date : 202308

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B737-800
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Mission : Passenger
Flight Phase : Parked

Component

Aircraft Component : Escape Rope
Aircraft Reference : X
Problem : Failed

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2028067
Human Factors : Training / Qualification
Human Factors : Situational Awareness

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Flight Crew
When Detected : Pre-flight
Result.General : Release Refused / Aircraft Not Accepted

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

Flight crew wrote up both flight deck escape rope compartments opened on their own, both ropes fell out of compartments. Mechanics found both escape ropes unattached to air-frame, and thus would not have been able to be used for their functions in the event of an emergency. Also found both ropes without cotter pins installed, thus allowing anchors to release anchor plate. Found on Aircraft X prior to departure for Flight XXXX on Day 0.

Review task or task cards or work areas involving dual maintenance on flight deck escape ropes.

Synopsis

Maintenance Technician reported that during preflight the flight crew found the aircraft flight crew escape ropes were not installed properly.

ACN: 2027475 *(35 of 50)*

Time / Day

Date : 202308

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : No Aircraft
Operating Under FAR Part : Part 121
Mission : Passenger

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Parts / Stores Personnel
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2027475
Human Factors : Training / Qualification
Human Factors : Confusion

Events

Anomaly.Deviation / Discrepancy - Procedural : Hazardous Material Violation
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Maintenance
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

As a safety rep Person 1 was informed that there was a situation where a stores clerk processed an item (squib) XX-XXXX CARTRIDGE, on their end of receiving. The stores clerk was certain that the cartridge being hazmat 1.4 explosive that inspection was needing to process it further for tagging processes and procedures. The stores clerk waited to see if the inspector was going to catch the item or process it thru. At which point the inspector Person 2 proceeded to finalize the item without tagging it with required washer stamp and wire or shelf life item date expiration. This is when the stores clerk asked another inspector, Person 3, about it if it should have been tagged or not. His reply was ″Yes″ it should have been however software program shows inspect ″X″ tag ″Y″. It seems that with this being the case inspector Person 2 only verified the part to the paperwork and proceeded to finalize the transaction. With the confusion on software program as a similar item YY-YYYY CARTRIDGE, CARGO EXT BOTTLE is an INSP ″X″ and TAG ″X″. where

the washer and the date code would be stamped with a stamp kit and wire attaching it to the squib for shelf life and date codes. It was pulled from the receiving area and taken to supervisor’s office for further examination. The inspector that brought it up to Person 2. His biggest concern was that it had been known for a few days and yet supervision had not briefed the inspectors on the potential of the mishap to watch out for during their receiving duties on any of the three shifts, it was only known about by the few parties involved. Person 1 asked if anyone had processed a report about this event and at this point no one had done so. At the current date Person 1 is unaware of any other reports filed or any standing of the part in question regarding its disposition or status. Suggested Resolution: training for stores receiving.

Synopsis

Air carrier Safety Representative reported inconsistencies of aircraft hazmat components tagging during ground processing. Reporter suggested more training for stores clerks.

ACN: 2026576 *(36 of 50)*

Time / Day

Date : 202308

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B737-900
Operating Under FAR Part : Part 121
Mission : Passenger
Flight Phase : Parked

Person : 1

Location Of Person : Hangar / Base
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2026576
Human Factors : Training / Qualification
Human Factors : Situational Awareness

Person : 2

Location Of Person : Hangar / Base
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2026578
Human Factors : Training / Qualification
Human Factors : Situational Awareness

Events

Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Maintenance
When Detected.Other
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Manuals
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

performed removal of panels (wing to body), panel numbers were 195BL and 195CL, gained access to requested area, attempted to remove requested particles from two fasteners, in the process my work partner had used a Dremel tool to help the process. originally had used dry sanding method and proved to not be effective on surface. the next

step I used the Dremel tool and when I saw surface that I did not intend to be removed coming off I immediately stopped, tried to think of a possible better solution to the problem on the bolts but sanding was the only other method at time I could think of. as soon as I knew something was messed up I went to the inspector and asked what it was supposed to look like on the surface to verify that the problem had occurred. once I saw that had become messed up, I started to look for my lead and try to get help on what the next course of action should be. he informed me he would be right back and was. the question posed if I think there could have been a way to prevent it, better training and more help on knowing the aircraft and what we are dealing with. I believe that training is a big factor in this given that what we worked on is a serious part of an aircraft and have very severe impact on safety with the plane. also having experienced guys around who can help us understand better or better documentation on work cards than just a few simple lines to say to do something. the drawling's that were attached to the work card that i used to try and research what I was dealing with weren't sufficient in detail as to what it was. I personally feel responsible for not saying or doing more to try and help prevent this given what happen.

Narrative: 2

Upon receiving information from the inspector after removing panels, I was told to get the sealant off until the strap was completely clean. After using the plastic scraper to get the thicker part of the sealant off then I moved to scotch bright. If I had gone to the manual and read, that I am to use the minimal amount of material to take the sealant off I would have been aware of the fact that even scotch bright is unsafe to use. When the 400-grit sandpaper was not working around the base of the high lock fastener I tried to get it off with a scotch bright dremel pad. I mistook a grinding pad for a stiff scotch bright pad. After taking the grinding pad to the metal and it immediately took the primer off of the metal I stopped. Due to not reading into the manual failed in adhering to rules against certain materials used on the paint and primer of the failsafe strap. Suggestion: Better training on how to access branching aircraft maintenance manual references.

Synopsis

Aircraft Maintenance Technicians reported improper removal of 737-900 aircraft wing structure protective coatings and material.

ACN: 2024817 *(37 of 50)*

Time / Day

Date : 202308
Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : Regional Jet 200 ER/LR (CRJ200)
Operating Under FAR Part : Part 121
Maintenance Status.Maintenance Type : Scheduled Maintenance
Maintenance Status.Maintenance Items Involved : Installation
Maintenance Status.Maintenance Items Involved : Repair
Maintenance Status.Maintenance Items Involved : Inspection

Component

Aircraft Component : Gear Up Lock
Aircraft Reference : X
Problem : Malfunctioning

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2024817
Human Factors : Other / Unknown

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Detector.Person : Maintenance
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

I was doing a 100-hour inspection and found that the uplock roller was not moving freely on lefthand landing gear and per 100-hour inspection, it had to move freely. I made a

write-up about it not moving freely and decided to change the uplock brackets and roller pin in accordance with the CMM (Component Maintenance Manual). I had thought that I had correctly installed the uplock brackets but I mistakenly installed them upside down. Uplock brackets were mistakenly installed upside down. Do a gear swing of the aircraft to make sure that the job was done correctly.

Synopsis

Aircraft Maintenance Technician reported incorrectly installing landing gear uplock brackets and had mistakenly installed them upside-down.

ACN: 2024499 *(38 of 50)*

Time / Day

Date : 202308

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : No Aircraft

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Parts / Stores Personnel
Function.Maintenance : Lead Technician
Function.Maintenance : Inspector
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2024499
Human Factors : Troubleshooting

Events

Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Hazardous Material Violation
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Maintenance
Result.General : Work Refused

Assessments

Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

On Day 0, while working at Parts Receiving, noticed a box of PSU (Passenger Service Unit) panels with O2 generators. I asked the storekeeper if they need inspection tags. Person told me no, the computer software system is designed for these parts to go right to binning after they process it. I told the person usually PSU panels have a shelf life, also HAZMAT if it has a O2 generator or not. So to put shelf life, need a tag. In this case, goes right to bin without a tag. I looked at the stock balance and it shows shelf life 180 months and HAZMAT part, tag- X- inspection -X. I told the person to hold the parts and notify Lead to find out if it needs a tag. Very next day the record was changed to show inspection ‟Y″& tag ‟Y″but still show shelf life 180. Per GMM (General Maintenance Manual) it should show ‟999,″which means have to go look up shelf life items, including vital information in notes pertaining to the part number. Notes say if PSU has O2 generator, need to get the part number off the generator and go to Work Order to find out what the shelf life is. Some may have 12 years and some may have 15-year shelf life depending the part

number of the generator. Then shelf life is calculated to the lowest date on all the generators in PSU. This will not happen when you put a generic shelf life such as 180 months. PSU could end up with a 15-year shelf life when actuality, generator may expire in 12 years, 3 years out of date and expired generator could end up in bin or plane. By looking at the aviation maintenance software history it appears the stock balance is changed on shelf life and HAZMAT, including tagging requirements by 3rd party individuals, probably have not much experience in aircraft parts. At this stage, company is looking at getting rid of inspection from all receiving parts and give that work to storekeepers, Person A as a Quality Control Inspector is very concerned if that's the right decision. If I did not happen to walk by those parts and asked questions, would have gone to bin without a tag with no shelf life. Even if the shelf life shows does the storekeepers know how to read notes and go to appropriate Work Order and tag the shelf life correctly? Currently the stock balance shows a generic 180 months instead of "999."Violation of GMM.

Synopsis

Aircraft Technician reported PSU units with O2 generators were not being processed as a HAZMAT part and were being improperly tagged without the proper shelf life information.

ACN: 2023499 *(39 of 50)*

Time / Day

Date : 202212
Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US

Environment

Light : Daylight

Aircraft

Reference : X
Aircraft Operator : Personal
Make Model Name : Amateur/Home Built/Experimental
Operating Under FAR Part.Other
Mission : Personal
Maintenance Status.Maintenance Deferred : N
Maintenance Status.Records Complete : Y
Maintenance Status.Maintenance Type : Scheduled Maintenance
Maintenance Status.Maintenance Items Involved : Inspection

Component

Aircraft Component : Engine
Aircraft Reference : X
Problem : Malfunctioning

Person

Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Personal
Function.Flight Crew : Pilot Flying
Function.Maintenance : Other / Unknown
Qualification.Maintenance : Repairman
Qualification.Other
ASRS Report Number.Accession Number : 2023499
Human Factors : Situational Awareness
Human Factors : Training / Qualification
Human Factors : Troubleshooting

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Anomaly.Ground Event / Encounter : Loss Of Aircraft Control
Detector.Person : Flight Crew
When Detected : In-flight

Result.Flight Crew : Landed in Emergency Condition
Result.Aircraft : Aircraft Damaged

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Equipment / Tooling
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

I have been performing maintenance on this experimental exhibition category aircraft that I own. I believed I could perform the required military phase inspections myself due to it being experimental. I performed maintenance on an experimental plane I built. I have been informed the condition inspections needed to be signed off by an A&P mechanic, which they were not. While I was flying the aircraft it experienced a loss of power and was damaged during landing. There were no injuries but it is possible the loss of power was maintenance related. I am not sure yet.

Synopsis

Helicopter owner/pilot reported performing own maintenance due to experimental exhibition category. The helicopter experienced a loss of power during a flight and was damaged upon landing.

ACN: 2023427 *(40 of 50)*

Time / Day

Date : 202307
Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : Any Unknown or Unlisted Aircraft Manufacturer
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Mission : Passenger
Flight Phase : Parked
Maintenance Status.Maintenance Deferred : Y
Maintenance Status.Released For Service : Y
Maintenance Status.Maintenance Type : Unscheduled Maintenance
Maintenance Status.Maintenance Items Involved : Work Cards
Maintenance Status.Maintenance Items Involved : Installation

Component

Aircraft Component : ILS/VOR
Aircraft Reference : X
Problem : Improperly Operated

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2023427
Human Factors : Situational Awareness

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : MEL / CDL
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Other Person
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

On Day 0 working Aircraft X performed re installation of vertical stabilizer tip (4) aft fairing. I was notified on Day 1 that Aircraft X had flown multiple flight legs with two Circuit Breakers (C/Bs) not closed. On rethinking the task I did not think requirement of pulling C/Bs for aft portion of tip which do not contain VOR antennas failed to follow all steps per the Aircraft Maintenance Manual (AMM).

Synopsis

Aircraft Technician reported missing step in maintenance procedure to restore circuit breakers for VOR antenna.

ACN: 2022066 *(41 of 50)*

Time / Day

Date : 202307

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : A320
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Phase : Parked

Component

Aircraft Component : Turbine Engine Thrust Reverser
Aircraft Reference : X
Problem : Design

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2022066

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Maintenance
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Chart Or Publication
Contributing Factors / Situations : Incorrect / Not Installed / Unavailable Part
Contributing Factors / Situations : Manuals
Contributing Factors / Situations : Procedure
Primary Problem : Manuals

Narrative: 1

Report subject - Left C-Duct Thrust Reverser Harness. Reason for report. To correct and update IPC (Illustrated Parts Catalog) parts lists, assembly instructions, and associated illustrations. Prevent wrong part number installation and possible malfunction of associated wiring and aircraft thrust reverser system. Engineering request to revise the associated work order has been made and corrections have been agreed to and process to revise has been initiated. Primary issue is for the backshell on Connector 905P. The harness installation requires a 90-degree backshell for Connector 905P per IPC. The 90-

degree backshell provides less bend radius for the wire versus a straight backshell which would make it susceptible to higher stress and possible malfunction of the wire. Associated parts lists and illustrations show a straight backshell but should reflect a 90-degree backshell on all IPCs and illustrations. Connector 905P connects to the left thrust reverser stow and lock proximity sensor. This is a critical indication for the flight crew. Suggested resolution - work with Airbus, Company A, Company B to correct and update IPC parts lists, assembly instructions, and associated illustrations. Report subject - Right C-Duct Thrust Reverser Harness. Reason for report - to correct and update IPC (Illustrated Parts Catalog) parts lists, assembly instructions, and associated illustrations. Prevent wrong part number installation and possible malfunction of associated wiring and aircraft thrust reverser system. Engineering request to revise the associated work order has been made and corrections have been agreed to and process to revise has been initiated. Primary issue is for the backshell on Connector 904P. The harness installation requires a 45-degree backshell for Connector 904P per IPC. The 45-degree backshell provides less bend radius for the wire versus a straight or 90-degree backshell, which would make it susceptible to higher stress and possible malfunction of the wire. Associated parts lists and illustrations show a straight or 90-degree but should reflect a 45-degree backshell on all IPCs and illustrations. Connector 904P connects to the right thrust reverser stow and lock proximity sensor and is a critical indication for the flight crew. Suggested resolution - work with Airbus, Company A, Company B to correct and update IPC parts lists, assembly instructions, and associated illustrations.

Synopsis

A320 Maintenance Technician reported that the incorrect part was listed in the Illustrated Parts Catalog (IPC) and needs to be corrected and updated. The installation of the incorrect part as instructed in the current IPC could lead to possible malfunction of the aircraft’s thrust reverser system.

ACN: 2021140 *(42 of 50)*

Time / Day

Date : 202307

Place

Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : A320
Operating Under FAR Part : Part 121
Flight Phase : Parked

Person : 1

Location Of Person : Repair Facility
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2021140
Human Factors : Training / Qualification
Human Factors : Situational Awareness

Person : 2

Location Of Person : Repair Facility
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2021141
Human Factors : Training / Qualification
Human Factors : Situational Awareness

Person : 3

Location Of Person : Repair Facility
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2021142
Human Factors : Training / Qualification

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Ground Event / Encounter : Fuel Issue
Detector.Person : Maintenance
When Detected : Routine Inspection
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

Supervisor assigned job to a late part that arrived to aircraft. All three mechanics were unfamiliar with job but were aware of the danger of fuel spilling. Arrived at aircraft, pulled breakers before turning on power, and created logbook write-up shorty after. Turned on power, noticed it had 3000 fuel, and asked older mechanics about defueling but after looking into the AMM (Aircraft Maintenance Manual). There was nothing that had details about transferring fuel beforehand, so continued. Proceeded to use the tool referenced in the manual to unseat the valve and started turning. There was a little fuel dripping from the seal as we turned it counterclockwise but not nearly enough for the manual that showed maximum of one bucket, so we kept turning until it started to have a lot of resistance and then proceeded to open the drain plug because then manual said to after the turning stopped. The drain plug showed no signs of fuel so we kept turning because the manual said only in steps beforehand to check the fuel flowing from the valve only after taking the assembly off. As we were turning the valve the keeper lock fell off from the body and dropped into the bucket and then the valve gave out, dropping the cover into the bucket and with a lot of resistance. We managed to lock the valve back in partially. I then had one of the mechanics go tell the Lead that we needed help and we tried to get the valve back in but it was locked in place. To add to this all three mechanics were reading the manual independently and wasn't following one single person reading off the manual. The reference to change the fuel pump had very vague points and at one point told the Mechanic after taking the fuel pump off to gauge the amount that would possible to work with. The manual should reference fuel transferring beforehand to prevent larger spills along with a maximum amount of fuel total before using a fuel truck to drain the fuel if there is too much to transfer all in one wing. The manual highly highlighted the danger of cutting safety wire in red but had other warning orange.

Narrative: 2

When we were working on Aircraft X, my coworkers were changing left wing tank inboard boost pump. I was helping them after I had done my jobs on the aircraft. We followed AMM (Aircraft Maintenance Manual) steps to remove, but the boost pump is stuck and hard to remove. While I was reviewing the AMM to find a solution related to this problem, other technicians removed the pump but fuel was coming out from the bank. They tried to put the pump back to the tank to stop the fuel, but that did not work. So I helped them put the bump back, also did not work. Because we could not stop and fuel leak, I went to grab fuel leak kit to clean the fuel. At the same time we notified the supervisors.

Narrative: 3

I was following fuel pump AMM (Aircraft Maintenance Manual) task removal. Once the pump was removed fuel came out after following step in accordance with AMM. Fuel was out on ramp. Then, we tried to reinstall pump but could not because retaining pin and spring assembly failed. I ask did we have to defuel but the AMM didn't call for a defuel.

Synopsis

A320 technicians reported the Aircraft Maintenance Manual (AMM) did not clearly provide defuel instructions for a fuel pump removal procedure. After removing the pump, fuel began to leak, spilling all over on the ramp.

ACN: 2020865 *(43 of 50)*

Time / Day

Date : 202307
Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B737-800
Operating Under FAR Part : Part 121
Mission : Passenger
Flight Phase : Parked

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Parts / Stores Personnel
Function.Maintenance : Lead Technician
Qualification.Maintenance : Avionics
Qualification.Maintenance : Powerplant
Qualification.Maintenance : Airframe
ASRS Report Number.Accession Number : 2020865
Human Factors : Workload
Human Factors : Training / Qualification

Events

Anomaly.Deviation / Discrepancy - Procedural : Hazardous Material Violation
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Ground Personnel
When Detected.Other
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Software and Automation
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

AWB (Airway Bill) XXX-XXXXXXXX was booked at cargo desk from ZZZ to ZZZ1 and on to ZZZ1 to ZZZZ. The 14-piece trek bicycle with 2 dg batteries was accepted by employee Person A. Then the piece was relocated to the DG rack in ZZZ by employee. The 14 piece with 2 DG was planned by Person B for flight Aircraft X in Cart X. The cart was then

relocated to XX where the flight gate changed, and the ramp failed to relocate the freight and it was refused in the emergency response system at gate XXX. The cart was then transferred to back to ZZZ warehouse where Person C was tasked with replanning. When I replanned, it I looked in the cart compared the AWB and went to input the data. When manifesting the trip for Aircraft Y I pushed NOTOC the system read NO DG so I proceeded to plan the flight for on time departure. That flight then went to ZZZ1 were all 14 pieces was loaded into a cargo container by another employee where the undeclared DG went international to ZZZZ. Cause: When replanning a cart that the is being reused for a same destination the flight and different flight number the process is drag and drop. When a NOTOC is refused it then shows in the system as NO DG. indicating that NO DGs are on the flight. The manager showed me that there are 2 little window Icon the click on that opens new windows to show DGs. I asked why was this never covered in training for this position and she replied I will get back to you on this issue! Suggestions: Training on rebooking DG in new cargo system.

Synopsis

Maintenance Stores Personnel reported he mistakenly advanced a hazmat parcel as a "No hazmat on board NOTOC". This mistake resulted in the undocumented air transport of hazmat.

ACN: 2017583 *(44 of 50)*

Time / Day

Date : 202307

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : Any Unknown or Unlisted Aircraft Manufacturer
Operating Under FAR Part : Part 121
Mission : Passenger

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Ground Personnel : Other / Unknown
Function.Maintenance : Other / Unknown
ASRS Report Number.Accession Number : 2017583
Human Factors : Workload
Human Factors : Time Pressure

Events

Anomaly.Deviation / Discrepancy - Procedural : Hazardous Material Violation
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Other Person
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

On Day 0 I was made aware of a Dangerous Goods Discrepancy for XX-XXXX-X-XXX. When completing a cycle count I was unaware that XX-XXXX-X-XXX was located inside the box with XX-XXXX-X-XXY. And at no time was I aware that there was any hazmat and I do not recall cycle counting any hazmat.

Synopsis

Air carrier Ground Personnel reported being notified of a box containing two Dangerous Goods (DG) components combined in one box. Reporter stated he was not aware of any DG in the box.

ACN: 2017070 *(45 of 50)*

Time / Day

Date : 202307

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B737 Undifferentiated or Other Model
Operating Under FAR Part : Part 121
Flight Phase : Parked
Maintenance Status.Maintenance Type : Scheduled Maintenance
Maintenance Status.Maintenance Items Involved : Repair

Component

Aircraft Component : Powerplant Fuel System
Aircraft Reference : X
Problem : Design

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2017070

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Flight Deck / Cabin / Aircraft Event : Smoke / Fire / Fumes / Odor
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Maintenance
When Detected : Routine Inspection
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Manuals
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

EA (Engineering Authorization) doesn’t require sufficient fuel nozzle leak check to prevent possible in-service engine fires. Nitrogen leak check with a leak test solution is a "CFM best practice"but has not been adopted by Company A in this EA, nor has Boeing included it in the remove and replace of the nozzles in their AMM (Aircraft Maintenance Manual). The nitro leak check can be found in the adjustment/test section just after fuel nozzle section. This nitrogen leak test needs to be included in the Leap 1B Fuel Nozzle post replacement work card. Proof is a recent incident. During the required "idle leak check"after full set of fuel nozzles were replaced, our technicians discovered an oil leak,

but no fuel leak. After a 70% part power engine run using bag method at drain lines, a significant fuel leak developed in the hot section. Other report [from weeks ago] of hot section fires support the need to do a best practice leak check. In the interim while tooling and leak detector liquid are on order, I feel need to require EA be revised to require a high power engine run after fuel nozzles are replaced or proper nitrogen test equipment tooling and leak detector can be used. Suggested resolution - an immediate resolution. In the interim, while tooling and leak detector liquid are on delay due to availability of leak check - not owned - and tooling repairs needed, I relay this feedback from the technicians on the floor: Require EA be revised to require a high power engine run after fuel nozzles are replaced and a subsequent opening of the core cowls to inspect for fuel stains, leaks in manifold, and nozzles area.

Synopsis

B737 Technician reported that an EA (Engineering Authorization) does not have a sufficient fuel nozzle leak check process after fuel nozzle post-replacement work is completed. If the leak test is not performed and a potential problem goes undetected, the reporter states that it can lead to in-service engine fires.

ACN: 2010947 *(46 of 50)*

Time / Day

Date : 202306
Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Make Model Name : Beechjet 400
Flight Phase : Parked
Maintenance Status.Maintenance Type : Scheduled Maintenance
Maintenance Status.Maintenance Items Involved : Installation
Maintenance Status.Maintenance Items Involved : Work Cards
Maintenance Status.Maintenance Items Involved : Inspection

Component

Aircraft Component : Exterior Pax/Crew Door
Problem : Design

Person : 1

Location Of Person : Repair Facility
Reporter Organization : Contracted Service
Function.Maintenance : Lead Technician
Qualification.Maintenance : Powerplant
Qualification.Maintenance : Airframe
ASRS Report Number.Accession Number : 2010947
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Maintenance
Communication Breakdown.Party2 : Maintenance

Person : 2

Location Of Person : Repair Facility
Reporter Organization : Contracted Service
Function.Maintenance : Inspector
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2011261

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Maintenance

When Detected.Other
Result.General : Work Refused

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Incorrect / Not Installed / Unavailable Part
Primary Problem : Incorrect / Not Installed / Unavailable Part

Narrative: 1

ZZZ Maintenance facility received main cabin door steps for a BeechJet 400XP. Prior to installing the steps on the aircraft the technician verified part number in the manufactures Illustrated Parts Catalog (IPC). It was found that the part number received was not effective for our serial number of aircraft. The technician notified maintenance control of this discrepancy in hopes that they had documentation from the manufacturer stating we could use the part number received. Maintenance control told the technician that we are allowed to use all the part numbers of stairs in the IPC no matter the effectivity. They could not provide any documentation showing this from the manufacturer. After phone calls from the manufacturer they stated they did not have any documentation showing all stairs were applicable to all serial number of aircraft. Maintenance control continued to try and pressure the technician into making a bad decision and install the stairs on the aircraft without documentation because they said and I quote "We have been doing it like that for years." This creates a bad culture, an unsafe aircraft condition and noncompliance with the manufacturer manual. Encourage maintenance control to comply with the manufacturer maintenance manual at all cost.

Narrative: 2

BeechJet 400XP was in for routine/ non-routine maintenance at ZZZ. A set of air-stair-stairs were to be replaced and a lead maintenance noticed the Parts Number (PN) on the manual did not appear in the Illustrated Parts Catalog (IPC) Quality Control was alerted. I contacted Person A and was told to contact the Person B and another person. The answer was the following from Maintenance Controller. "The IPC doesn't list an effectivity code for these stairs. They are approved for all 400 series aircraft. " A maintenance lead and I challenged that answer and asked for something in writing that states we can install them on the aircraft. I responded with: "We can't force the installer to sign the release for this event. If, the end user which determines airworthiness of a part (mechanic) discovers a conflict in traceability and proper identification of the part he's doing the right thing no matter the component. "The manual is a document that provides the installer data to determine airworthiness, in this case the installer has conflicting data." I/ we received the following answer from Maintenance Controller." I'm done with this... rob the stair assembly or whatever parts need from Aircraft Y and get us a Color X aircraft please! " Upon inspecting the stairs on the other aircraft (donor) before removal the PN was checked. It was discovered the effectivity is incorrect for the installation on the other aircraft. Maintenance and Quality Control both were assertive with Maintenance Controller, and did not install the stairs that were to be removed and installed on the original aircraft. We still had the effectivity issue. In the meantime, Quality Control and Maintenance at ZZZ started email chains with Company explaining the issue. Maintenance and Quality Control were looking for a solution not engaging in a back and forth. I, being involved in this issue began to gather information from individuals on the floor. A conversation took place between Maintenance Controller and a maintenance lead. Paraphrasing the leads words: [Instead of finding a solution they (Maintenance Controller) became more and

more agitated to the point it was bordering on a threat, it was very uncomfortable. They said we're just making stuff up cuz we don't want to fix it. Keeping this short as possible the result was an inspector in ZZZ contacted Company and sorted out the effectivity and the correct assembly that appears in the IPC was shipped and installed. My over all concern is we are creating a hazard an opportunity for a safety escape. A quick example: a young mechanic and or an unassertive one feels the pressure installs an incorrect part or something of that nature because Maintenance Controller is "demanding it be done". The next time it could be a navigation download or incorrect push rod for a trim tab we must address this issue. Company must update their IPC for the 400 which is the root cause for this entire situation. Mechanics and pilots have a symbiotic relationship with one goal, preserving human life, by providing a safe product. Maintenance Controller must be trained/ counseled covering what authority they have and do not. Maintenance Controller does not have the final say, nor are in any position to demand anything that is obviously outside of FAR's, company manuals and Policy. Young mechanics need to be educated on the exact role of Maintenance Controller and understand their direction and leadership come from the Maintenance manager, production managers and leads not Maintenance Controller. Maintenance Controller does not make airworthy decisions for anyone, the techs, leads, and pilots make that decision. Maintenance Controller does however, release the aircraft back into service. However, that release is 100% predicated on the signatures, paperwork, and final determination of airworthiness completed by maintenance and Quality Control pilots.

Synopsis

Aircraft Maintenance Technician reported pressure from Maintenance Control department to install incorrect part onto airplane.

ACN: 2008358 *(47 of 50)*

Time / Day

Date : 202206

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : A300
Operating Under FAR Part : Part 121
Mission : Cargo / Freight / Delivery
Flight Phase : Parked
Maintenance Status.Maintenance Type : Unscheduled Maintenance
Maintenance Status.Maintenance Items Involved : Inspection

Person

Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Maintenance : Technician
ASRS Report Number.Accession Number : 2008358
Human Factors : Situational Awareness
Human Factors : Training / Qualification

Events

Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Maintenance
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

While helping preform a job card (Aileron Servo Controls), I was in the cockpit when I noticed what appeared to be broken snap wire on the guarded switch to the agent discharge for the cargo compartment fire extinguisher. When I pulled on the guarded switch to check if the snap wire was indeed broken I accidentally discharged the #1 fire extinguisher bottle to the forward pit. I should have pulled the circuit breaker before checking the guard switch to prevent to fire extinguisher bottle from discharging.

Synopsis

Aircraft Maintenance Technician reported an inadvertent discharge of the cargo pit fire extinguisher bottle during a maintenance check.

ACN: 2008352 *(48 of 50)*

Time / Day

Date : 202306
Local Time Of Day : 1801-2400

Place

Altitude.AGL.Single Value : 0

Environment

Light : Night

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B737 MAX 8
Operating Under FAR Part : Part 121
Mission : Passenger
Flight Phase : Parked
Maintenance Status.Maintenance Type : Unscheduled Maintenance

Component

Aircraft Component : Turbine Engine Thrust Reverser
Aircraft Reference : X
Problem : Malfunctioning

Person : 1

Location Of Person : Gate / Ramp / Line
Reporter Organization : Contracted Service
Function.Maintenance : Technician
Qualification.Maintenance : Powerplant
Qualification.Maintenance : Airframe
ASRS Report Number.Accession Number : 2008352
Human Factors : Training / Qualification
Human Factors : Time Pressure
Human Factors : Distraction

Person : 2

Location Of Person : Gate / Ramp / Line
Reporter Organization : Contracted Service
Function.Maintenance : Technician
Qualification.Maintenance : Powerplant
Qualification.Maintenance : Airframe
ASRS Report Number.Accession Number : 2008353
Human Factors : Time Pressure
Human Factors : Distraction
Human Factors : Training / Qualification

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : MEL / CDL
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Maintenance
When Detected.Other
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Staffing
Primary Problem : Human Factors

Narrative: 1

I was given a gate call tonight on a MAX 8 for a maintenance light. I am a probationary mechanic with helicopter experience and King Air experience. I have no 737 or big jet experience, none the less I went out with confidence in my abilities of reading the manuals and the few months of experience on the aircraft. AMT 2 another probationary mechanic with 4 months of experience on the aircraft came to help me out to the best of his abilities, He also has only 4 months of 737 experience. We arrived at the aircraft and I have personally never worked with the Multi-Functional Display (MFD) but tried to work my way through it. We found that there was a #2 thrust reverser fault. We were first going to troubleshoot the TR (Thrust Reverser) by cycling it and running a bite test. Unfortunately before we got to that we directed by the lead mechanic to defer the #2 TR. So we started looking into the deferral procedure for the #2 TR in which me and AMT 2 have never performed before. We started with adding the inboard TR lock to the #2 ENG then came back up the ramp to read more into the deferral procedure. We had the gate personnel hassling us on how long it will take along with the flight attendant who was very impatient with us. We then added safety wire to the #2 TR to restrict forward movement and then I got on the phone with maintenance control to verify all the procedures were done properly. We then downgraded the aircraft to CAT 1 status and proceeded to fill out the paperwork along with the aircraft log book paperwork. At this point we were approached by the gate attendant who asked "how much longer". We proceeded to say we are just doing paperwork and will let you know but then the pilot said "well if you guys are just doing paperwork we can start boarding so by the time you are done the aircraft would be boarded". We finished the paperwork and added the correct placarding and sent the aircraft on its way fully confidant for the safety of the passengers and crew. It wasn't till later in the shift that AMT 2 informed me that we never locked out the outboard TR with the lockout bolt. We immediately went to supervision to notify them of the situation. I contribute this to a lack of training on the aircraft. I have never deferred a thrust reverser in my career in aviation and felt thrown to the wolves. We were pressured by the flight crew and the gate personnel. We believed that we performed everything correctly but found a missed step in our deferral.

Narrative: 2

A fellow coworker received a gate call for a Max 8 for a maintenance light. I decided to go with him and assist on the call. We both are on probation and have four months of 737 experience under our belts. After arriving at the aircraft, we notice there was a fault for the #2 Thrust Reversers. We decided to troubleshoot the T/R (Thrust Reverser) but was

soon directed by our lead mechanic to defer the T/R. Neither one of us has encountered this problem before, so we started to look up the procedure for the deferral. First, we started the task by locking out the inboard TR. Next, we went back up to the jetway to continue reading the task. While reading and trying to figure out what to do next we were bombarded by flight attendants' and gate agent's impatiently asking questions on what is wrong, how much longer, why is it taking so long. Trying to handle the situation accordingly and professionally we continued with safety wiring the #2 TR handle to the stowed position. While my Fellow coworker was on the phone with Maintenance Control I was filling out the logbook and trying to see how to downgrade the aircraft to a CAT 1 status. During this process, we were still being asked questions about boarding and how long it would take. Our response was we will let them know. We are working as fast as the matter allows us. Then, the pilot told the gate agent that if they are doing the paperwork they can start boarding now. Thinking that we performed the job correctly we released the plane back to the crew. It wasn't until later when I read the task again to get a better understanding without feeling pressured, rushed or without proper guidance I recall that we did not pin the outboard T/R sleeve. I brought it to my coworker's attention, and we immediately notified our supervisors of our mistake.

Synopsis

Maintenance Technicians reported missing a procedural step when deferring a thrust reverser while the aircraft was at the gate prior to departure.

ACN: 2005229 *(49 of 50)*

Time / Day

Date : 202306
Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC
Light : Night

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B747-400
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Cargo / Freight / Delivery
Flight Phase : Parked
Maintenance Status.Maintenance Deferred : Y
Maintenance Status.Records Complete : Y
Maintenance Status.Released For Service : Y
Maintenance Status.Required / Correct Doc On Board : Y
Maintenance Status.Maintenance Type : Scheduled Maintenance
Maintenance Status.Maintenance Items Involved : Repair
Maintenance Status.Maintenance Items Involved : Inspection

Component : 1

Aircraft Component : Drinkable/Waste Water Syst
Aircraft Reference : X
Problem : Malfunctioning
Problem : Improperly Operated

Component : 2

Aircraft Component : Minimum Equipment List (MEL)
Aircraft Reference : X
Problem : Improperly Operated

Component : 3

Aircraft Component : Aircraft Logbook(s)
Aircraft Reference : X
Problem : Improperly Operated

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
Experience.Maintenance.Lead Technician : 10
Experience.Maintenance.Technician : 10
ASRS Report Number.Accession Number : 2005229
Human Factors : Communication Breakdown
Human Factors : Troubleshooting
Communication Breakdown.Party1 : Maintenance
Communication Breakdown.Party2 : Other

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : MEL / CDL
Detector.Person : Other Person
Detector.Person : Flight Crew
Were Passengers Involved In Event : N
When Detected : Pre-flight
When Detected : Aircraft In Service At Gate
When Detected : Routine Inspection
Result.General : Flight Cancelled / Delayed

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

Aircraft X arrived in ZZZ1 for a fuel and tech stop upon post and pre-flight inspection Maintenance tech found water pouring out of the CAC door area the Maintenance tech contacted Maintenance control and advised them of the finding. They were informed to deferred maintenance instruction and deactivate the water system and keep the plane moving to next stop, after which the aircraft was going to ZZZ for Maintenance and will be addressed. The aircraft arrived in ZZZ on Date 1 and the Maintenance Manager of ZZZ told ZZZ staff to not get into anything and keep the plane green and they just wrote off the leak as not found. When asked if they worked it, he threatened myself saying he would never put his team on the spot again, and is releasing the aircraft into service with a known leak into a compartment that has computers and Inertial Reference Units (IRU). Company has very poor to no accountability and zero concerns from FAA as they always seem to get out of any investigation here is the email First off understand the following: That Plane was never supposed to come here. They had no place to park in ZZZ2 and asked if we can make room for it at the very last minute. We were told to not work anything since everything was planned for another station but, we elected to. The plan was to keep the plane Green so that we didn't risk starting something that could potentially AOG the plane. Don't you ever put my team on the spot like that ever again. I understand they didn't find a leak but this is what's causing the brake problems. The computers are soaked in flight the system gets serviced and with the APU running its

pouring water. And if they did do any looking the cooling duct for the brake computer would be obvious it's laying in the water under the rack.

Synopsis

Maintenance Manager reported non compliance with MEL procedure and incorrect maintenance practices led to water leaking into the Lower avionics compartment, causing system failures on a B747 aircraft.

ACN: 2000321 *(50 of 50)*

Time / Day

Date : 202211

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B777-200
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Flight Phase : Parked
Maintenance Status.Maintenance Deferred : Y
Maintenance Status.Records Complete : N
Maintenance Status.Released For Service : Y
Maintenance Status.Required / Correct Doc On Board : N
Maintenance Status.Maintenance Type : Unscheduled Maintenance
Maintenance Status.Maintenance Items Involved : Testing
Maintenance Status.Maintenance Items Involved : Inspection

Component : 1

Aircraft Component : AC Generator/Alternator
Aircraft Reference : X
Problem : Malfunctioning

Component : 2

Aircraft Component : Minimum Equipment List (MEL)
Aircraft Reference : X
Problem : Improperly Operated

Component : 3

Aircraft Component : Aircraft Logbook(s)
Aircraft Reference : X
Problem : Improperly Operated

Person

Location Of Person : Hangar / Base
Reporter Organization : Air Carrier
Function.Maintenance : Technician
Qualification.Maintenance : Airframe
Qualification.Maintenance : Powerplant
ASRS Report Number.Accession Number : 2000321
Human Factors : Communication Breakdown

Human Factors : Situational Awareness
Human Factors : Troubleshooting
Human Factors : Human-Machine Interface
Communication Breakdown.Party1 : Maintenance
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : MEL / CDL
Anomaly.Deviation / Discrepancy - Procedural : Maintenance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Automation : Aircraft Other Automation
Detector.Person : Maintenance
When Detected : Aircraft In Service At Gate
When Detected : In-flight
Result.General : Flight Cancelled / Delayed
Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

Aircraft X was in ZZZ and had a fault on the Integrated drive generator and an ELEC GEN OFF EICAS Advisory message. The techs applied MEL 24-XX-X. There is concern with the T/S.

Synopsis

Technician reported concerns over trouble shooting and the correct application of an MEL while working in a B777-200.