

CALLBACK

From NASA's Aviation Safety Reporting System



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Interactions in Sync



– or Not?



In the 1700's, David Hume observed that, "He is happy whom circumstances suit his temper; but he is more excellent who suits his temper to any circumstance." A century and a half later, Dale Carnegie admonished, "When dealing with people, remember you are not dealing with creatures of logic, but creatures of emotion." These precepts, ever present in aviation, can be constructive when examining human interactions that occur during aviation incidents.

While aviation, in general, aspires to excellence, many aviation decisions and actions involve interaction between at least two persons. During an interaction, individual nuance, emotion, and uniqueness are frequently at play. Egos are present and often evident. Authority or control issues, seniority, job knowledge, or turf wars may also be involved. At times, key personalities work together with extraordinary success, and on other occasions, teamwork is less effective.

Conventional wisdom suggests that personal nuance, emotion, or uniqueness in an aviation interaction is axiomatic to the safety and efficiency of the operation itself. Importance of these interactions is thus captured in the continual process of improving Crew Resource Management (CRM) and flight safety.

This month *CALLBACK* shares narratives that reveal personal interaction and nuance in each incident. Interactions range from positive to negative, major to minor, and serious to amusing, but in each situation is a lesson to garner.

Practice Makes Almost Perfect

An airline Captain and a jump seating pilot described CRM that exhibited judgment, discretion, and temperance. The problem that they experienced tested their situational awareness with distractions, workload, and time pressure.

From the Captain's report:

■ *During a fairly typical tight visual approach, ... we noticed that flaps were indicating 25 instead of the selected 40 during the landing checklist at about 1,300 feet AGL. We initiated a go-around, which was mostly normal other than flaps staying at 25 even when put to 15. We had an exceptional jump seater who was previously in the training department and an invaluable member of the crew.*

As we handled the aviating and communicating, he handed me a QRH turned to the Trailing Edge Flaps Disagree

Checklist, which we confirmed and began. I handed aircraft control to my First Officer (FO) along with the radios. We had about 7.5 on the fuel, so we decided quickly that we were going to our alternate. ... I ran the checklist and programmed up the runway and communicated with Dispatch through ACARS, notifying them of our decision and need for landing data.

We [got priority handling] out of an abundance of caution. The [cabin] crew and ... passengers were notified of our new destination. ... The FO did an exceptional job of staying between the flaps 25 overspeed and the gear warning horn [speed], and also landed the plane.

Always having an alternate is helpful, as a baseline of required fuel is available when an issue like this arises. Our bingo fuel was for a clean configuration and we were [stuck with] flaps 25, but it was valuable information.

From the Jump Seater's report:

■ *The Captain (CA) was the Pilot Flying (PF) and was flying a visual approach. ... As the CA was on a right base visual to the runway and selecting landings flaps, the trailing edge flaps remained at position 25 and not the commanded 40 flaps for landing. The CA executed a missed approach and elected to divert. ... The CA handed the jet over to the FO, who became the PF. The CA completed the Trailing Edge Flap Disagree Checklist and contacted Dispatch. The FO made the landing. We taxied to the gate and debriefed.*

We started this event with 6.3 Fuel on Board (FOB) and landed ... with 4.3. The crew did an outstanding job on this abnormal event. As a former [check pilot], the CA and I had a ... good rapport. I noticed the flaps stuck at 25 while on right base. It was not until the CA and FO were conducting the landing checklist that they noticed the flaps stuck at 25. I elected not to interject early as the speed was good, weather was CAVU and the crew were maneuvering with radio calls. When the CA executed the missed approach and asked for flaps 15 and they did not move, I advised the FO to leave the flap handle where he had placed it. I could tell the crew was getting a bit overloaded and was happy when the CA turned the autopilot on and handed the jet over to the FO. I told the crew they had a trailing edge flap disagree and opened the QRH to the proper checklist. I advised the FO to watch the speed and try not to overspeed the flaps and also to leave the power up a little to silence the gear horn.

The CA and FO worked very well together during this event. I interjected myself when needed, and the CA used me as a resource and for advice. I didn't know that the FO is a fairly new pilot, and [were I the Captain], I would have landed the jet. We debriefed this event and I advised the CA not to keep reviewing the QRH...to make sure all items were completed or not missed while on approach below 1,000 feet AGL.... The crew did an outstanding job on this abnormal event.

Quietly Left Holding the Bag

A C680A crew was issued a holding clearance which was interpreted differently by the Captain than the First Officer. The flight was subsequently uneventful, but twice notable.

■ We were on a flight to MDW. Due to delays, we were asked to hold...southwest of the Peoria VOR on the 200 degree radial with 10 NM legs. Initially I had set right turns in the FMS, because the Controller did not specify that they wanted us to make non-standard turns. The Captain then instructed me to change it to left turns because we were instructed to hold 'southwest' of the VOR. To avoid an argument, I asked the Controller to verify they wanted us to hold southwest of the VOR. The Controller confirmed that fact. So, there we were in a hold over the Peoria VOR making non-standard turns without the Controller asking us to do it. We held for 45 minutes, and the Controller did not say anything to us about it, so I'm guessing we were not creating a conflict. In the future, I will ask specifically if left or right turns are wanted if there is any doubt.

From the Cabin to the Cockpit

This Flight Attendant described rationale to persuade some captains to modify their use of the seat belt signs in flight. The genesis was a desire for a safer overall flight operation.

■ This report...raises awareness about the consistent misuse of the seatbelt sign by a significant number of flight deck crews.... On the past five flights, captains have insisted upon leaving the seat belt sign on for the entire flight. Some...make an announcement prior to takeoff advising that the sign will be left on for the entire flight.... Flying times range between 6.5 and 9.5 hours. On past flights, I have attempted to employ and educate using CRM strategies with some captains in order to understand their reasoning...for keeping the sign on. Most express concerns about liability related to passenger injury due to unexpected severe turbulence. Others state they are doing flight attendants a favor by not cycling the sign off during late night flights—minimizing need for compliance checks.

I'm deeply concerned [about] the negative safety culture this type of behavior is creating – a dangerous risk

for passengers and crew. It encourages passengers to disobey the sign while fostering complacency among flight attendants.... During my last flight, FAs stopped enforcing the requirement for passengers to be buckled due to the sign being constantly on and the lack of turbulence. Their reasoning [was] understandable: belts were unnecessary due to the smooth ride. At one point, I counted at least 15 passengers in the aisle while the sign was on. This occurred about seven hours into the flight.... I witness this more often on long...flights.

A Diverging Dispatch Discussion

A B737 Captain questioned the Dispatcher regarding the unusual fuel load. Remarks and attitudes expressed in the conversation appeared unrelated to the fuel issue at hand.

■ The dispatch release had a note [that an] alternate was added due to possible rain at destination, Nashville. We were in an 800. Dispatch planned the fuel with approximately 13,000 pounds of tanker fuel. Our arrival fuel was planned at approximately 21,500 [pounds]. Although we were not close to maximum landing weight, the arrival fuel got my attention because this is probably the most fuel I have ever seen [for] tankering or landing...in my tenure at the company.

...The fuel load seemed a bit odd. Nashville airport doesn't have the longest runways, plus the note [was added] about the rain.... Keeping...priorities...in the proper order, I decided to call Dispatch.... [I asked] about the alternate added due to possible rain at the destination. [The Dispatcher] said that it wasn't going to start raining until after our arrival. This struck me as somewhat dismissive because we all know the forecast can be wrong.... I explained to him that it looked odd having that much tanker fuel with possible rain. He told me, "All the 'T's had been crossed, and all the 'I's had been dotted: everything has been done the right way, routine... etc." I said, "OK, but it just seems a little abnormal." He said, "Not to be snarky, but I dispatch more flights in a week than you fly in a year." I thought to myself, "Wow,...how many landings does this guy have in a heavy 800 on a short-ish wet runway?" Instead, I said something to the effect that, "Dispatch doesn't always do the smart thing. None of us do. No one is infallible." At that point the Dispatcher became really annoyed and asked me if I wanted to get the Chief Pilot on call involved. I declined and said that I was calling to see if it would be raining in Nashville for our arrival.

We all make mistakes. We are all on the same team. Feedback helps us discover our mistakes. Arrogance does not accept feedback. Help each other out by listening and being humble.

ASRS Alerts Issued in August 2019	
Subject of Alert	No. of Alerts
Aircraft or Aircraft Equipment	1
Airport Facility or Procedure	8
ATC Equipment or Procedure	8
TOTAL	17

477
 A Monthly Safety
 Newsletter from
 The NASA
 Aviation Safety
 Reporting System
 P.O. Box 189
 Moffett Field, CA
 94035-0189
<https://asrs.arc.nasa.gov>

August 2019 Report Intake	
Air Carrier/Air Taxi Pilots	5,833
General Aviation Pilots	1,500
Flight Attendants	973
Controllers	536
Military/Other	343
Mechanics	283
Dispatchers	198
TOTAL	9,666