

CALLBACK

From NASA's Aviation Safety Reporting System



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Every new year in aviation begins with efforts to examine past performance with expressed goals of improving flight safety and driving optimism for the future. Organizations and individuals alike, committed to maximizing flight safety, study incidents, mistakes, errors, policies, procedures, techniques, and more to realize any gain in their endeavors. For an individual, this process may ignite in a resolution proclaimed at the start of the new year, or at any other time.

This month, *CALLBACK* presents recent, reported incidents from aviation personnel and disciplines wherein reporters have made deliberate, distinct resolutions to change for better the way they may accomplish a specific task or goal. Many are stated directly. Others are implied or may be gleaned, deduced, or inferred. Appreciate each of the reporters' New Year's Resolutions, as well as your own.

Part 91 – Maintenance Accountability

An AMT and an Inspector described this incident and failures that spawned at least one new Maintenance policy.

From the Technician's report:

■ *Was finishing up a [C172] engine change. Installed cable linkages without cotter keys so rigging adjustments could easily be made. Started having issues with the alternator producing power. For this reason, I was not able to do a full range engine operational check because the aircraft's only power source was off the aircraft battery. Had to leave... to pick my son up. I informed the other mechanic that I had to leave, and he was to install the new alternator and to call me if the new alternator passed an operational check. I did not hear anything back. Found out...that there was an in-flight emergency for the aircraft in regards to the throttle linkage. The other mechanic released the aircraft by signing the log books. I did not have the opportunity to finish the maintenance procedures. From this point forward, no one will be signing log books for someone else's work, regardless of the owner/operator pushing for a timeline.*

From the Inspector's report:

■ *I was the inspector who returned the airplane to service after engine installation. I suspect that the cotter pin was not installed in the bolt and castle nut connecting the cable to the lever arm on the carburetor. I must have failed to see that when I inspected the installation.*

Part 121 – Rule Number One

Engine vibration resulted in personal insight for the First Officer on this commercial fixed wing aircraft. The revelations will likely result in some resolutions.

■ *Whilst beginning the descent via the STAR, we experienced icing conditions, and Engine 2 started to experience high vibrations (4.1). I noticed this immediately as pilot monitoring and informed the Captain, who was pilot flying. He passed control over to me and proceeded to go into the QRH. We worked together to resolve the issue, passing the controls back and forth a total of two times. During this event, neither of us had realized that the aircraft was in the wrong automation mode and would not respect the crossing altitudes. As soon as the aircraft had gone through the altitude we noticed and corrected. Cause: Task saturation. Captain used VS mode to expedite the descent in order to get us out of the conditions that were causing the event, however, I failed to notice that we were in an automation mode that did not respect crossing altitudes due to task saturation. Suggestions: Smoother passing of controls. Ensuring the aircraft is in the desired automation before passing over; or being clearer as to what mode is currently being used. Instead of passing controls back and forth, as pilot monitoring initially, I could have been the one to read the QRH, reducing the number of role swaps and, therefore, chance of miscommunication.*

Parts 91 and 121 – A Priority Dilemma

Priorities and competing responsibilities combined to produce original thoughts and probable new personal policies for this Air Traffic Controller.

■ *I was working satellite radar. CVG was landing Runway 27. Aircraft X called me VFR 6 miles north of the Runway 27 final, southbound approximately 1800 feet, asking for his IFR clearance to Walton at 3000 feet, 20 miles due south. Due to the airspace configuration and complexity, this was not a great space to be in. I immediately felt pressure, due to the Runway 27 final being full of aircraft at that time. I made the foolish decision to issue the IFR [clearance], thinking I could maneuver him through the traffic, particularly once he got to 3000 feet. Given his type aircraft and the small confines of the space I had, this quickly turned to the wrong call. Approximately 4 miles north of final, still below MVA, I*

turned the aircraft west to avoid the aircraft on final, though ensuring he could provide his own obstacle and terrain clearance, making another mistake. As a result, Aircraft X got 2.75 miles and 500 feet from Aircraft Y on final, paralleling him. In retrospect, the obvious thing I should have done is told Aircraft X to maintain VFR and vector east to where the aircraft on Runway 27 final are at a higher altitude, though this would have immediately conflicted with LUK airport to the east. My urgency to issue the IFR was unnecessary. Recommendation: I need to remember that an aircraft that is VFR asking for their IFR is not entitled to it immediately, and they can maintain VFR until I can get them into a better position to issue IFR. Also, I cannot issue headings below the MVA. That was somewhat of a panic vector and not something I've done before.

Part 121 – SOP Discipline Again

A commercial fixed wing crew shared some resolutions after being deceived and seduced by a false glideslope.

From the First Officer's report:

■ As we were approaching ALB, we were on a downwind leg vector of 350 degrees. The weather was hazy with few clouds around 3,000 feet, but VMC. The Tower queried us if we had the airport in sight. The Captain confirmed he saw it to his left and informed the Tower that we had it in sight. We were then cleared to accomplish a visual approach. I continued on 350 degrees to slow the aircraft and begin adding flaps. We also began a descent to 2,000 feet prior to initiating a left base leg. As we were descending, we saw indications that we were well above glideslope, which turned out to be a false glideslope. We entered 1,600 into the altitude selector on a dogleg to final of 19. We had the ILS 19 approach loaded and selected to back up our visual approach to 19. We still showed to be considerably high, so we selected 1,000 feet. As we approached 1,000 feet, we realized the glideslope had been false, as we visually looked low...I disconnected the autopilot and flew visually to a normal landing. The Tower also notified [us] right after we realized we were following a false glideslope of a low altitude indication. Cause: Task saturation along with experiencing a false glideslope on a visual approach backed up with an ILS led to descending lower than a desired altitude on an approach. Suggestion: Crews...need to be aware of a false glideslope...approaching ILS 19 at ALB on a left base. I also should extend downwind longer in the future to give more time and recognize a false glideslope more quickly. In hazy conditions with only the pilot monitoring having the runway continually in sight, it would be more prudent to have vectors to a longer final.

From the Captain's report:

■ Cause: PF was distracted by a bad glideslope indication and followed it down to an undesirably low altitude. PM was distracted running a checklist and did not notice the undesired descent being initiated. Suggestion: Proper adherence to SOP would have both pilots verify changes to the altitude preselector. This allows either pilot to catch and correct a potential mistake before it becomes an issue.

Part 121 – The Fog of Fatigue

A B767 Captain faced the fog of fatigue during the landing. Introspection and presumed recurring resolutions followed.

■ During landing...into ZZZ, just before flare, we got slow and I added power. As we got into the flare region, the tail strike warning went off, and I immediately pressed the go-around switches and called, "Go around." During go-around, the aircraft made contact with the runway. It did not bounce, nor was it a hard landing. We stayed in the pattern and returned on the ILS... During post flight we inspected the tail strike indicator with Maintenance, and there were indications of a probable tail strike. I got in really late from ZZZ1...and there were no rooms available. I got on the waiting list, and by the time I actually got a room and got into said room and lay down, the phone rang shortly thereafter. I got no rest. Further, ZZZ1 was day one, and despite my best attempts to get significant sleep, I only averaged around 5 hours. In retrospect, at the time of arrival, I was more tired than I planned or anticipated.

Part 91 – That Sinking Feeling

This Mooney M20 solo pilot will, no doubt, practice some new resolutions following this Human Factors incident.

■ Planned landing on Runway XX. Post annual check flight. Checklist consulted on downwind and gear switch lowered. Proceeded to downwind and final. No gear horn audible, but down gear position light not confirmed. Aircraft landed gear up. No injuries, no major damage except prop, belly [panels], and possibly engine. Gear lowered normally when raised off ground. Incident could have been prevented by checking and rechecking gear down indicator light, as gear switch was not completely down.

The reports featured in CALLBACK are offered in the spirit of stimulating thought and discussion. While NASA ASRS does not verify or validate reports, we encourage you, our readers, to explore them and draw your own conclusions.

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[UAS/Drone Safety Reporting](#)

ASRS Alerts Issued in November 2025	
Subject of Alert	No. of Alerts
Aircraft or Aircraft Equipment	4
Airport Facility or Procedure	11
ATC Equipment or Procedure	12
Hazard to Flight	1
Other	1
TOTAL	29

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November 2025 Report Intake	
Air Carrier/Air Taxi Pilots	4,739
General Aviation Pilots	1,388
Flight Attendants	1,371
Military/Other	650
Mechanics	249
Controllers	240
Dispatchers	206
TOTAL	8,843