

ASRS Database Report Set

Air Carrier (FAR 121) Flight Crew Fatigue Reports

Report Set Description	A sampling of reports referencing air carrier (FAR 121) flight crew fatigue issues and duty periods.
Update Number	28
Date of Update.....	January 31, 2019
Number of Records in Report Set	50
Number of New Records in Report Set.....	30
Type of Records in Report Set	For each update, new records received at ASRS will displace a like number of the oldest records in the Report Set, with the objective of providing the fifty most recent relevant ASRS Database records. Records within this Report Set have been screened to assure their relevance to the topic.

National Aeronautics and
Space Administration

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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.

A handwritten signature in cursive script, appearing to read "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: 1587139 *(1 of 50)*

Synopsis

B737 Captain reported overshooting an altitude restriction on approach into MMMX, citing fatigue as a factor.

ACN: 1586797 *(2 of 50)*

Synopsis

Air carrier First Officer reported an incorrect go-around profile due to failure to arm the approach.

ACN: 1584292 *(3 of 50)*

Synopsis

B737 First Officer reported an altitude overshoot due to autopilot usage while evading weather.

ACN: 1584285 *(4 of 50)*

Synopsis

B737 flight crew reported a taxiway incursion due to confusion and fatigue.

ACN: 1583604 *(5 of 50)*

Synopsis

EMB-145 flight crew reported they failed to shut down the Number 2 engine when they left the aircraft at the end of their duty day. Fatigue was cited as contributing.

ACN: 1582329 *(6 of 50)*

Synopsis

E175 First Officer reported that inexperience and a breakdown in communication with the Captain contributed to an overspeed below 10,000 feet.

ACN: 1582231 *(7 of 50)*

Synopsis

CRJ-700 flight crew reported executing a go-around after receiving an GPWS flap configuration warning.

ACN: 1581852 *(8 of 50)*

Synopsis

Air carrier Captain reported company personnel delayed pushback to avoid an out of duty time situation.

ACN: 1581159 *(9 of 50)*

Synopsis

B757 Captain reported missing ATC instructions due to fatigue.

ACN: 1579409 *(10 of 50)*

Synopsis

CRJ-700 Captain reported overshooting a crossing restriction on the assigned RNAV departure.

ACN: 1579045 *(11 of 50)*

Synopsis

Air Carrier pilot reported miscommunication between flight crew while initiating a go-around due to windshear and turbulence.

ACN: 1576898 *(12 of 50)*

Synopsis

B737NG flight crew reported landing without clearance following a wake turbulence encounter. Fatigue was cited as a contributing factor.

ACN: 1576009 *(13 of 50)*

Synopsis

Widebody transport Captain reported that they were instructed to go-around due to base under attack.

ACN: 1573269 *(14 of 50)*

Synopsis

B787 Captain reported entering a hold pattern with a standard right turn which was incorrect for this fix.

ACN: 1571289 *(15 of 50)*

Synopsis

Captain reported fatigue led him to depart from an incorrect intersection from which he was cleared for takeoff.

ACN: 1570265 *(16 of 50)*

Synopsis

B737-800 Captain reported executing a missed approach to a runway due to an un-stabilized approach due to fatigue.

ACN: 1570183 *(17 of 50)*

Synopsis

B777 Captain reported a continuous issue with the crew rest area.

ACN: 1570097 *(18 of 50)*

Synopsis

A321 flight crew reported the aircraft failed to honor a properly programmed altitude constraint on descent in managed speed and managed vertical path mode.

ACN: 1568449 *(19 of 50)*

Synopsis

Widebody Transport flight crew reported being high and fast and not meeting stabilized approach criteria before landing.

ACN: 1566422 *(20 of 50)*

Synopsis

A319 Flight Crew reported working around conflicting deferred items may have violated the MEL.

ACN: 1565772 *(21 of 50)*

Synopsis

B767 flight crew reported that flight attendants were injured due to turbulence during descent.

ACN: 1561371 *(22 of 50)*

Synopsis

Air carrier Captain reported high workload led to an unstabilized approach to IAD. Reporter cited fatigue as contributing to the event.

ACN: 1559742 *(23 of 50)*

Synopsis

B757-200 First Officer reported calling in sick for their recurrent training.

ACN: 1557710 *(24 of 50)*

Synopsis

Air Carrier pilot reported responding to a questionable "caution terrain" EGPWS warning.

ACN: 1555874 *(25 of 50)*

Synopsis

Air carrier First Officer reported a track deviation occurred on arrival into DEN following multiple ATC changes to the arrival clearance. Fatigue was cited as a contributing factor.

ACN: 1548230 *(26 of 50)*

Synopsis

CRJ-900 First Officer reported using excessive rate-of-descent and consequently the Captain directed a level off just prior to the crew receiving an EGPWS.

ACN: 1546652 *(27 of 50)*

Synopsis

B767 flight crew reported that they taxied past the intended taxiway not realizing there was a gate change and due to fatigue.

ACN: 1539385 *(28 of 50)*

Synopsis

B747-400 Captain reported the aircraft started rolling while at the parking ramp.

ACN: 1538375 *(29 of 50)*

Synopsis

Air Carrier First Officer reported a disagreement with the FAR Part 117 requirement for long haul flights as it pertains to required rest breaks.

ACN: 1535961 *(30 of 50)*

Synopsis

EMB-175 flight crew reported electrical issues on start up which resulted in a lengthy maintenance procedure. With the addition of time pressure from gate agents, the Captain concluded the event with a fatigue call.

ACN: 1535684 *(31 of 50)*

Synopsis

B767-300 flight crew reported speed and track deviations occurred following a wake turbulence encounter departing WSSS.

ACN: 1533137 *(32 of 50)*

Synopsis

Air Carrier Captain reported he intended to fly even though he was fatigued, due to fear of his airline refusing to accept his fatigue claim.

ACN: 1532610 *(33 of 50)*

Synopsis

CRJ-900 flight crew reported ATC issued a low altitude alert when they descended below charted altitude on the approach.

ACN: 1523764 *(34 of 50)*

Synopsis

B767-300 flight crew reported that they got the master caution for TE Flaps Disagree and LE Slats Disagree.

ACN: 1523092 *(35 of 50)*

Synopsis

B737NG Captain reported being subjected to "pilot pushing" pressure to depart with an unwanted aircraft.

ACN: 1521128 *(36 of 50)*

Synopsis

B737 First Officer reported incorrectly executing an ATC assigned missed approach due to being fatigued.

ACN: 1516729 *(37 of 50)*

Synopsis

Air carrier Relief Pilot reported being fatigued enroute due to a short rest period in flight due to a breakdown of CRM.

ACN: 1516175 *(38 of 50)*

Synopsis

Air carrier flight crew reported fuel issues during approach and landing in weather/turbulence that was worse than forecasted.

ACN: 1515991 *(39 of 50)*

Synopsis

Boeing 777-300ER Captain reported that the crew rest area is inadequate and unacceptable for crew rest.

ACN: 1512489 *(40 of 50)*

Synopsis

B777 Captain reported a go-around after an unstable approach.

ACN: 1511632 *(41 of 50)*

Synopsis

B737 First Officer reported continuing an unstabilized approach contrary to SOP. Fatigue and distractions were cited as contributing.

ACN: 1507590 *(42 of 50)*

Synopsis

B767 Captain reported inadequate rest for a long flight due to loud passengers seated near the crew rest area.

ACN: 1506429 *(43 of 50)*

Synopsis

Air Carrier First Officer pilot reported that after resting and getting ready for an early morning flight, scheduling called and pushed back the show time past the maximum duty day.

ACN: 1504566 *(44 of 50)*

Synopsis

B757 Captain accepted the duty time extension available under FAR 117. After the flight, the pilot felt in hindsight that by accepting the extension, crew scheduling had filled their coverage issue, and they were no longer concerned about possible fatigue issues.

ACN: 1504384 *(45 of 50)*

Synopsis

B737 flight crew reported being unable to depart prior to fatigue setting in due to an equipment problem at the destination airport.

ACN: 1504281 *(46 of 50)*

Synopsis

EMB-170 Captain reported he forgot to request an amended flight release due to fatigue.

ACN: 1503650 *(47 of 50)*

Synopsis

Air carrier flight crew reported completion of an unauthorized autoland after receiving a request from the company.

ACN: 1503033 *(48 of 50)*

Synopsis

An Air Carrier flight crew reported that after the glideslope was captured some unknown reason the aircraft suddenly pitched down.

ACN: 1498775 *(49 of 50)*

Synopsis

A regional jet pilot reported experiencing multiple physical symptoms resulting in an inability to continue the flight. A diversion to a suitable airport to seek medical help was accomplished.

ACN: 1447721 *(50 of 50)*

Synopsis

CRJ-200 flight crew and Dispatcher reported the hurried crew departed without a new release.

Report Narratives

Time / Day

Date : 201810
Local Time Of Day : 0601-1200

Place

Locale Reference.ATC Facility : MMFR.ARTCC
State Reference : FO
Altitude.MSL.Single Value : 12000

Environment

Flight Conditions : VMC

Aircraft

Reference : X
ATC / Advisory.Center : MMFR
Aircraft Operator : Air Carrier
Make Model Name : B737 Undifferentiated or Other Model
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Nav In Use.Localizer/Glideslope/ILS : 05R
Flight Phase : Descent
Route In Use.STAR : TIKEB1C

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
Experience.Flight Crew.Total : 6755
ASRS Report Number.Accession Number : 1587139
Human Factors : Fatigue
Human Factors : Situational Awareness

Events

Anomaly.ATC Issue : All Types
Anomaly.Deviation - Altitude : Overshoot
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : Clearance
Detector.Person : Flight Crew

When Detected : In-flight
Result.Flight Crew : Returned To Clearance
Result.Flight Crew : Became Reoriented

Assessments

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

Narrative: 1

[Ready to depart on] all-nighter [to MMMX]. As Captain I reviewed the airport pages at home as it has been over 6 months since I've flown into MMMX. Maintenance delay due to aircraft would not move during pushback...refused aircraft after 1 hour delay troubleshoot. Brought new aircraft from the hangar. I asked the First Officer (FO) if he was ok for flight, he said he was ok, I agreed, but we both talked about fatigue possibly being an issue later due to the delay. Aircraft was cleaned and departed the gate finally (3 hours and 34 minutes late). We briefed the flight at the gate and agreed the biggest threat would be fatigue and high altitude terrain. FO said he hadn't been to MMMX in over 3 months. Captain was pilot flying. Takeoff and cruise were uneventful, but both of us agreed fatigue was setting in. We both stayed caffeinated enroute and as the sun came up it seemed to wake us up a bit. During cruise we both reviewed all the 10-7, STAR and Approach pages and notes about the descent and speeds for the approach. We both looked at and reviewed the legs pages for the TIKEB 1C page and the ILS DME 2 RWY 05R. All legs and altitudes checked. Completed a further review and briefed the approach in entirety. Pilot Flying (PF) completed landing assessment due to high altitude airport. Weather was 2000 scattered to broken and another layer at about 8000 feet. MMFR center cleared us to descend via the TIKEB 1C and we started the descent on profile with 12,000 set in the altitude window. Center then cleared us direct to MAVEK which we entered in the legs page, confirmed and realized we were a little [high] on the profile due to the shortcut, so PF selected level change to ensure we got down in time to configure. Below FL200 and at 220 knots we lowered the flaps to 1 with speedbrakes extended to ensure meeting the altitude constraint (12,000 feet) at MAVEK. PF began slowing in the descent in order to configure at MAVEK. We switched to Approach [who] cleared us for the ILS DME 2 RWY 05R Approach. Controller asked us to maintain 200 knots for traffic behind us. The Pilot Monitoring (PM) told the Controller we needed to slow as per company policy and controller gave us 190 (this was a major distraction for both pilots)...at the time we were slower than that and PF put in 190 in the speed window...aircraft already in level change, lowered nose to gain speed back....Now cleared for the approach, PF set 7600 in the altitude window. Lowered the gear prior to MAVEK to begin configuring. Mistake was not reselecting VNAV. The descent continued and then PF felt uncomfortable with visual ground contact below/between the clouds. Checking the approach plate noticed MAVEK should have crossed at 12000...PF clicked autopilot off, left autothrottle on for speed protection, PF leveled off the aircraft immediately, just prior to MAVEK at 10000 feet. Aircraft was almost at MAVEK at level off so PF maintained current altitude and checked the approach plate for highest terrain and noticed we were still 2000 feet above the highest terrain on the approach chart. PM reset altitude to 9700 feet to again get back on descent profile after crossing MAVEK. We got back on profile, fully configured the flaps for landing and broke out underneath the clouds just past MEX05. We were configured at VREF+10 for the turn, armed the localizer and then glideslope captured both were stabilized and took over visually backed up with ILS with field in sight and VASIs prior to PLAZA. Uneventful landing and rollout. Approach never contacted us to check altitude, no other traffic was around and we received no radar altimeter or EGPWS alerts. #1 factor was fatigue due to 3 1/2 hour maintenance delay...Briefed at the gate as the biggest

threat...and it was. #2 ATC asking to maintain speed when we wanted to configure to ensure a stable approach was a huge distraction to both pilots. [It] took attention away from altitude, which should have been the highest priority. #3 when cleared for the approach should have ensured the FMC was in VNAV prior to selecting the lower approach altitude. Although not fatigued at the gate, both pilots knew it would be a factor and should have assessed the possibility of fatigue later (We took off after we should have already landed at MMMX). BIG lesson learned was to ensure selecting VNAV and checking in VNAV prior to selecting lowest approach altitude to ensure altitude constraints were met. I will incorporate this crosscheck every time just like execute/LNAV. PM did a great job assisting PF with flap configuration and altitude constraints after initial level off. Fatigue was definitely a factor and both the Captain and FO will submit fatigue reports.

Synopsis

B737 Captain reported overshooting an altitude restriction on approach into MMMX, citing fatigue as a factor.

Time / Day

Date : 201810
Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZZ.Airport
State Reference : FO
Altitude.MSL.Single Value : 5000

Environment

Weather Elements / Visibility : Icing
Weather Elements / Visibility : Turbulence
Light : Daylight

Aircraft

Reference : X
ATC / Advisory.Tower : ZZZZ
Aircraft Operator : Air Carrier
Make Model Name : Commercial Fixed Wing
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Flight Phase : Final Approach
Route In Use : Vectors

Component

Aircraft Component : Altitude Hold/Capture
Aircraft Reference : X
Problem : Improperly Operated

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : First Officer
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Flight Instructor
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Instrument
Experience.Flight Crew.Total : 2290
Experience.Flight Crew.Last 90 Days : 177
Experience.Flight Crew.Type : 388
ASRS Report Number.Accession Number : 1586797
Human Factors : Situational Awareness
Human Factors : Human-Machine Interface
Human Factors : Fatigue

Events

Anomaly.Deviation - Speed : All Types

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Inflight Event / Encounter : Unstabilized Approach

Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Executed Go Around / Missed Approach

Assessments

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Weather

Primary Problem : Human Factors

Narrative: 1

We were on a RNAV Approach at ZZZZ. We were given vectors and an altitude for the approach. Just before the FAF I checked and the VAPP was armed, but I forgot to deselect the "ALT SEL" mode. We made the airplane level off at the selected altitude (probably 5000 ft). With this our vertical guidance turned off, so when I noticed it I called for the go around. During the go around I forgot to push the TO/GA button. I've made the required calls for the go around, but the airplane didn't initiate a climb (because the TO/GA haven't been pushed). Because of that the airplane accelerated fast, so the Captain called me to check on the airspeed that was going fast toward the max structural airspeed, that was the time we noticed that the flaps were still at the 10 position. By that time we had oversped the flaps by 47 knots. After that we got vectors to another approach that happened without problems. It was a 3 day pairing that started with PM flights on the first two days and on the last day we had a [early morning] shuttle time. I went to bed, but couldn't fall asleep until passed midnight. I woke up after a bad night of sleep. I had woke up 4 times that night. So I believe fatigue was definitely a factor.

Synopsis

Air carrier First Officer reported an incorrect go-around profile due to failure to arm the approach.

Time / Day

Date : 201810
Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Relative Position.Distance.Nautical Miles : 1
Altitude.MSL.Single Value : 6000

Environment

Weather Elements / Visibility : Thunderstorm
Light : Daylight

Aircraft

Reference : X
ATC / Advisory.TRACON : ZZZ
Aircraft Operator : Air Carrier
Make Model Name : B737-800
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Flight Phase : Descent
Airspace.Class B : ZZZ

Component

Aircraft Component : Autopilot
Aircraft Reference : X
Problem : Improperly Operated

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : First Officer
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Instrument
Experience.Flight Crew.Last 90 Days : 310
ASRS Report Number.Accession Number : 1584292
Human Factors : Training / Qualification
Human Factors : Fatigue
Human Factors : Situational Awareness

Events

Anomaly.Deviation - Altitude : Overshoot
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : Clearance
Detector.Person : Air Traffic Control
When Detected : In-flight
Result.Flight Crew : Returned To Clearance
Result.Flight Crew : Overcame Equipment Problem
Result.Flight Crew : FLC Overrode Automation

Assessments

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

Narrative: 1

We were descending via the [Arrival] into ZZZ. After ZZZZZ we requested deviations around cell build ups on the arrival. Approach approved and said "Direct ZZZZZ1 when able and descend to 6000 feet." I used CWS (Control Wheel Steering) to avoid the cells. We reset the FMC to direct ZZZZZ1 and were descending to 6000 feet. I was high due to still avoiding some lower buildups but turned toward ZZZZZ1 and was descending to be at ZZZZZ1 by 6000 feet. Everything seemed fine until I noticed that it didn't look like the aircraft was going to level at 6000 feet. I was trying to figure out "what is it doing now" when I realized that I had not gone from CWS back to CMD on the autopilot. I reacted - a little too late - and the aircraft descended below 6000 feet by about 400 feet. Approach queried as to our altitude and we responded that we were aware and correcting. The correct altitude was re-established and CMD was re-engaged, the rest of the approach and landing was completed without incident.

This was a bonehead mistake. I don't use CWS much, and in an attempt to keep the ride smooth for the passengers opted to use this mode instead of Heading Select. I should have told the PM (Pilot Monitoring) to help me remember to reengage CMD since I don't use CWS much, this is a busy part of the flight and I was a little tired - in the Yellow. This would have helped maintain the shared mental model and prevent this rookie mistake.

Synopsis

B737 First Officer reported an altitude overshoot due to autopilot usage while evading weather.

Time / Day

Date : 201810
Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : SEA.Airport
State Reference : WA
Altitude.AGL.Single Value : 0

Environment

Light : Dawn

Aircraft

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 : IFR
Flight Phase : Taxi

Person : 1

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Not Flying
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Instrument
Experience.Flight Crew.Last 90 Days : 297
ASRS Report Number.Accession Number : 1584285
Human Factors : Fatigue
Human Factors : Confusion

Person : 2

Reference : 2
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Pilot Flying
Function.Flight Crew : First Officer
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Instrument
Experience.Flight Crew.Last 90 Days : 449
ASRS Report Number.Accession Number : 1584837
Human Factors : Confusion

Events

Anomaly.Deviation - Procedural : Clearance
Anomaly.Ground Incursion : Taxiway
Detector.Person : Air Traffic Control
When Detected : Taxi
Result.Flight Crew : Requested ATC Assistance / Clarification
Result.Air Traffic Control : Provided Assistance

Assessments

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

Narrative: 1

Tired after four days and should have called out fatigued but I decided to push on. It was a very simple taxi clearance; Bravo to Quebec to hold short of 34C. In my mind after taxiing onto Bravo it would be the next right turn, when in fact it was the second turn. After realizing what I had done, it was too late to continue on Bravo. ATC advised us of the mistake and told us to continue on Papa to hold short of 34C. ATC then cleared us to cross 34C to Tango to Quebec to get us back to the end of 34C.

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

B737 flight crew reported a taxiway incursion due to confusion and fatigue.

Time / Day

Date : 201810

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 : Air Carrier

Make Model Name : EMB ERJ 145 ER/LR

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Mission : Passenger

Flight Phase : Parked

Component

Aircraft Component : Turbine Engine

Aircraft Reference : X

Problem : Improperly Operated

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Captain

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Commercial

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Instrument

ASRS Report Number.Accession Number : 1583604

Human Factors : Situational Awareness

Human Factors : Fatigue

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Not Flying

Function.Flight Crew : First Officer

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Commercial

ASRS Report Number.Accession Number : 1584107
Human Factors : Fatigue
Human Factors : Situational Awareness

Events

Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Ground Event / Encounter : Other / Unknown
Detector.Person : Flight Crew
When Detected : Pre-flight
Result.General : None Reported / Taken

Assessments

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

Narrative: 1

After arriving at the gate, I left the number 2 engine running after leaving the aircraft. The First Officer and I read the Shutdown Checklist and it called for thrust levers idle, [but] I did not confirm that the engine was actually shut down. I found out that it was left running from the next flight crew taking over the aircraft about 20 minutes after I had left the aircraft.

I think that this happened due to being fatigued. We had worked 8.78 hrs of flight time and 13 hrs on duty yesterday followed by a minimum rest. On the approach, I had made a few minor errors that the First Officer caught while going over the Descent and Approach Checklist, one of them being fasten seatbelt sign. I felt fine leaving [the departure airport] being fully alert and about half way through the flight I could feel the fatigue setting in. Either way this could have been prevented by checking that the engine is actually off when the Shutdown Checklist is accomplished.

Narrative: 2

The number 2 engine was left running after leaving the aircraft. I had read the Shutdown Checklist but we had not confirmed by reference to the gauges that the engine was actually shut down. The crew that was flying the aircraft after us arrived about 20 minutes after we left the plane and they called the Captain to advise.

The Captain and I had 8.78 hours of flight time the day before and had to rise early the next morning for this flight. I believe that fatigue was a significant factor for this event and I could see signs of fatigue in both of us on this final leg of the day. This could have been prevented if we had checked the gauges to confirm that the engines were shut down. On my post flight walk around, it was very loud at our gate with ours and many other nearby aircraft APU's and engines were running. I do look up at the engine to check the blades when I am near the nose of the aircraft. The galley truck was blocking my view of the engine #2 and after I went around the truck, I continued inspection starting with the side of aircraft, leading edge and landing gear and did not look up at the engine blades.

Checking the gauges at shutdown and visual checking the engine on post-flight could have been prevented this event.

Synopsis

EMB-145 flight crew reported they failed to shut down the Number 2 engine when they left the aircraft at the end of their duty day. Fatigue was cited as contributing.

Time / Day

Date : 201809

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : LGA.Airport

State Reference : US

Altitude.MSL.Single Value : 4000

Aircraft

Reference : X

ATC / Advisory.Tower : LGA

Aircraft Operator : Air Carrier

Make Model Name : EMB ERJ 170/175 ER/LR

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Takeoff

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

ASRS Report Number.Accession Number : 1582329

Human Factors : Training / Qualification

Human Factors : Fatigue

Human Factors : Workload

Human Factors : Communication Breakdown

Human Factors : Distraction

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Deviation - Speed : All Types

Anomaly.Deviation - Procedural : FAR

Anomaly.Deviation - Procedural : Published Material / Policy

Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Became Reoriented

Assessments

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

Narrative: 1

After nearly a 3 hour sit I was somewhat mentally fatigued. We had set up for a departure out of DCA but were asked if we could depart Runway 33. I had ran the numbers so we knew we could depart Runway 33 so we accepted it. I changed the V speeds, set Runway 33 as the departure runway on the flight plan page, and set flaps to 4. Since this was my first flaps 4 take off, I failed to set up a flaps 4 takeoff on the MCDU since I was unaware I had to do it. We were cleared to line up and wait for Runway 33 but when I pressed the Takeoff configure it stated "no takeoff flaps" so we canceled our Takeoff clearance and the Captain set the MCDU for a flaps 4 departure. When it came time for the takeoff roll I advanced the thrust levers to where the auto throttles typically take over and called out TOGA. As we accelerated I realized that Takeoff didn't not come on the FMA and that the auto throttles did not further advance the throttles. Since we were on a short runway I briskly advanced the throttles to ensure we had adequate power for the takeoff but accidentally pushed one throttle past the toga detent which activated reserve thrust. We rotated and on the climb out the command bars went way up so I slowly pitched up towards them without fully meeting them since it seemed excessive. The Captain was concerned with the pitch angle so he told me to pitch it down which led to a rapid acceleration with reserve thrust engaged. I manipulated the throttles to the best of my abilities while attempting to follow the flight director for vertical and lateral guidance since we were on a RNAV departure. We were closing in on our limit of 4000ft so the captain told me to pitch down while the FD was still indicating a shallow climb so I lowered the nose, brought the throttles to idle but sped to approximately 263k. We did not bust any altitudes or aircraft limitations, but did exceed 250 below 10,000. I can confirm that my inexperience with flying without auto throttles, a flap 4 take off, and a breakdown in communication all contributed to this event. I was a little startled by the risk of not having full power on a short runway so I focused on getting off the ground, up to a safe altitude, and did not communicate the fact that we were on RSV (reserve) power and auto throttles were not engaged.

Synopsis

E175 First Officer reported that inexperience and a breakdown in communication with the Captain contributed to an overspeed below 10,000 feet.

Time / Day

Date : 201810
Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.MSL.Single Value : 4000

Environment

Flight Conditions : VMC
Light : Dawn

Aircraft

Reference : X
ATC / Advisory.Tower : ZZZ
Aircraft Operator : Air Carrier
Make Model Name : Regional Jet 700 ER/LR (CRJ700)
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Flight Phase : Initial Approach
Airspace.Class B : ZZZ

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Not Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1582231
Human Factors : Fatigue
Human Factors : Situational Awareness
Human Factors : Confusion

Events

Anomaly.Deviation - Altitude : Crossing Restriction Not Met
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Anomaly.Inflight Event / Encounter : CFTT / CFIT
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Executed Go Around / Missed Approach

Assessments

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

Narrative: 1

Day 4 early morning leg. During short vectors to visual approach ATC cleared us to maintain 4000 until established and cleared us for a visual approach. The First Officer (FO), Pilot Flying (PF), maintained 4000 instead of descending to 3000 feet which would have been the FAF altitude and appropriate altitude in order to properly intercept the GS or visual flight path. After established on the localizer course and seeing that the GS was below us by over a dot and a half, I instructed her that she needed to descend to 3000 prior to the FAF to capture the GS. She selected VS down .9 which made us high at the FAF and still not on GS. Autopilot was on at the time and she deselected autopilot (AP) and took manual control of the aircraft at approximately 3500 feet inside the FAF. I asked her once we were back on GS from her manual correction if she wanted AP reengaged. We attempted to reengage but got LOC/PITCH due to incorrect mode selected prior to AP. Our configuration at this time was gear down and flaps 30. We made the 1000 foot call out but she stated stable in error. I made the 500 call out and in error stated stable. At that time we got the audible warning of terrain/flaps and I instructed a go around and when I went to raise flaps to 8 I knew then what we had messed up. We performed the go around, I notified the Flight Attendant (FA) and the passengers that we went around and would be on the ground shortly, re-entered the traffic pattern and landed uneventfully. Cause was being tired from a 0330 wake-up for the van time didn't help, but the root cause was failing to adhere to the checklists and normal flows. There were opportunities as a crew to catch our mistake prior to the warning but we failed, either out of bad habits or being tired...or both. Executing the go around immediately when something wasn't right was the appropriate action. There was no hesitation or either of us trying to troubleshoot or "solve" the problem there. It was go around, re-setup, and try again. Personally, this was a wake up, no matter the crew experience (the FO was senior to me), being tired means check and double check myself and the crew actions because the simplest of things can be missed.

Synopsis

CRJ-700 flight crew reported executing a go-around after receiving an GPWS flap configuration warning.

Time / Day

Date : 201809
Local Time Of Day : 1801-2400

Place

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

Environment

Weather Elements / Visibility : Thunderstorm

Aircraft

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

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Instrument
Experience.Flight Crew.Total : 22800
Experience.Flight Crew.Last 90 Days : 204
Experience.Flight Crew.Type : 3192
ASRS Report Number.Accession Number : 1581852
Human Factors : Communication Breakdown
Human Factors : Fatigue
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Other

Events

Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : FAR
Detector.Person : Flight Crew
When Detected : Aircraft In Service At Gate
Result.General : Flight Cancelled / Delayed

Assessments

Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Weather
Primary Problem : Ambiguous

Narrative: 1

The company intentionally circumvented a Federal Aviation Regulation (FAR117). Because we were an international flight and there was no relief pilot scheduled (no augmentation) our maximum actual flight time was limited to 9 hours. There were thunderstorms in the departure corridor and many aircraft were waiting at the runway for takeoff. Also, there was in-trail spacing. If we were to pushback from the gate when we were ready, our 9 hour clock would start and we could potentially time-out while waiting at the runway. For this reason, ZZZ Operations held us at the gate with an updated pushback time of XA: 30. When XA: 30 approached we requested a push crew on Operations frequency. The response was that we were going to be held at the gate until XB:00. We then questioned the reason for the delayed push and were advised that ZZZ1 Operations had called and requested it because they feared that we would time out. I advised the Operations Center that we would accept no further delay for pushback.

We pushed back at XA: 35; we were originally scheduled for departure at XX: 20. The artificial delay pushed the First Officer and myself deeper into our Window of Circadian Low (WOCL). I advised the [Chief Pilot] that I would file a [report]. The [Chief Pilot] replied that he checked in the ZZZ1 Operations Center and that no one admitted to making a phone call to ZZZ. My suspicion is that it was ZZZ Operations (not ZZZ1) who held us at the gate to prevent a potential cancellation.

The initial delay from XX: 20 to XA: 00 was because of thunderstorms; lightning had forced a ramp closure and the delay could not be prevented. It was not until XA: 30 that we became aware of being artificially held from XA:00 to XA: 30 (with an additional potential delay until XB:00). The flight was successfully completed. We landed 2 hours and 16 minutes late in ZZZ2. We were both exhausted.

NOTE: response from ZZZ Operations was that this was in fact a decision made by them.

Synopsis

Air carrier Captain reported company personnel delayed pushback to avoid an out of duty time situation.

Time / Day

Date : 201809
Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.MSL.Single Value : 6000

Environment

Flight Conditions : VMC

Aircraft

Reference : X
ATC / Advisory.TRACON : ZZZ
Aircraft Operator : Air Carrier
Make Model Name : B757 Undifferentiated or Other Model
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Flight Phase : Final Approach
Route In Use : Vectors
Airspace.Class B : ZZZ

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Air Traffic Control : Approach
Function.Flight Crew : Pilot Flying
Function.Flight Crew : Captain
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Instrument
Experience.Flight Crew.Last 90 Days : 250
Experience.Flight Crew.Type : 1073
ASRS Report Number.Accession Number : 1581159
Human Factors : Fatigue
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew
Communication Breakdown.Party2 : ATC

Events

Anomaly.Flight Deck / Cabin / Aircraft Event : Other / Unknown
Anomaly.Deviation - Track / Heading : All Types
Anomaly.Deviation - Procedural : Clearance

Detector.Person : Flight Crew
Detector.Person : Air Traffic Control
When Detected : In-flight
Result.Flight Crew : Became Reoriented
Result.Air Traffic Control : Provided Assistance

Assessments

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

Narrative: 1

I was very tired from the scheduled red-eye and maintenance delay. ATC gave me what I thought was a late runway change. I thought I changed the transition in the FMC, but realized I had not when ATC asked where I was headed after I missed the turn at ZZZZZ on the RNAV arrival into ZZZ. I had initially been given [Runway] XXC. ATC gave us headings from that point on and vectored us on to ILS XXR.

Synopsis

B757 Captain reported missing ATC instructions due to fatigue.

Time / Day

Date : 201809

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : DTW.Airport

State Reference : MI

Altitude.MSL.Single Value : 9000

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.TRACON : D21

Aircraft Operator : Air Carrier

Make Model Name : Regional Jet 700 ER/LR (CRJ700)

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Flight Phase : Climb

Route In Use.SID : LIDDS ONE

Airspace.Class B : DTW

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Captain

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Instrument

ASRS Report Number.Accession Number : 1579409

Human Factors : Fatigue

Human Factors : Distraction

Events

Anomaly.Deviation - Altitude : Overshoot

Anomaly.Deviation - Altitude : Crossing Restriction Not Met

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Deviation - Procedural : Clearance

Detector.Person : Air Traffic Control

When Detected : In-flight

Result.Air Traffic Control : Issued New Clearance

Assessments

Contributing Factors / Situations : Human Factors

Primary Problem : Human Factors

Narrative: 1

On the LIDDS 1 RNAV departure out of DTW we leveled at the first crossing restriction per our clearance of climb via except maintain 7000 [ft]. Prior to JOELU we were told to proceed direct KZLOV after JOELU. I asked the FO/PM (First Officer/Pilot Monitoring) to configure the FMS per ATC's instructions. After JOELU I set 15000 [ft.] in the altitude pre-select and confirmed it with the FO. I then proceeded to climb to that altitude. Around 9000 ft. we were told to climb and maintain 17000 [ft.] and then received a phone number to copy. As soon as they said this I had realized my error.

[This event] occurred after an early commute. I woke up at XX:00am to catch an [early] flight. After arriving in DTW, my schedule was modified to include a new flight not originally scheduled. In the brief I did not list new departures out of DTW as a threat, but rather focused on the LLWS. Below 10,000 ft. I was not keeping conversation to only pertinent flight matters, but discussing [CRJ]700 differences as I had not flown one in a while. I did cross check the altitude with the FO(PM) and he confirmed the altitude. Not that it was his job ultimately to catch my error but there was a breakdown of CRM here. Complacency also kept me from correctly adhering to the fundamental execution of a departure procedure and listening for standard phraseology - in this I simply acted in error. The Aviation Instructors Handbook would define this as a "slip".

I suggest not commuting early without proper rest. Briefing an obvious threat - complacency due to familiarity of DTW remained even though we had an entirely new set of departures. Making more space for the PM to feel as though he can speak up. Also per the Aviation Instructors Handbook, it is recommended to use reminders and develop routines to reduce errors. Many use the nose wheel light as a reminder that they are cleared to land. I have several of these triggers in place to remind me of various task in different phases of flight. I will be developing one as well for climb via clearances.

Synopsis

CRJ-700 Captain reported overshooting a crossing restriction on the assigned RNAV departure.

Time / Day

Date : 201809

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : DEN.Airport

State Reference : CO

Environment

Flight Conditions : VMC

Weather Elements / Visibility : Windshear

Weather Elements / Visibility : Turbulence

Aircraft

Reference : X

ATC / Advisory.TRACON : D01

Aircraft Operator : Air Carrier

Make Model Name : Large Transport, Low Wing, 2 Turbojet Eng

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Initial Approach

Airspace.Class B : DEN

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

ASRS Report Number.Accession Number : 1579045

Human Factors : Fatigue

Human Factors : Situational Awareness

Human Factors : Workload

Human Factors : Communication Breakdown

Human Factors : Confusion

Human Factors : Distraction

Human Factors : Human-Machine Interface

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Deviation - Speed : All Types

Anomaly.Deviation - Track / Heading : All Types

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Deviation - Procedural : Clearance

Anomaly.Inflight Event / Encounter : Weather / Turbulence
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Detector.Person : Flight Crew
When Detected : In-flight
Result.General : Flight Cancelled / Delayed
Result.Flight Crew : Requested ATC Assistance / Clarification
Result.Flight Crew : Executed Go Around / Missed Approach
Result.Flight Crew : Became Reoriented
Result.Air Traffic Control : Issued New Clearance
Result.Air Traffic Control : Issued Advisory / Alert

Assessments

Contributing Factors / Situations : Environment - Non Weather Related
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Contributing Factors / Situations : Weather
Primary Problem : Weather

Narrative: 1

While being vectored for Runway 16L, DEN Approach gave us direct KIKME. As the Pilot Flying, I slowed the aircraft to 180 knots and called for flaps 2. DEN Approach advised Windshear Alert for 16L with windshear +35 knots. The Pilot Monitoring inquired about 16R and started loading 16R into our box. DEN Approach advised windshear alerts for 16R also. The Pilot Monitoring advised we would take 17R and started loading the box with 17R. I felt comfortable with the change to 17R because I had a visual on the airport and we had time to load 17R. I believed with [our] current position, visual conditions and our speed, the Pilot Monitoring would be able to brief the appropriate items after loading the box. I did slow the aircraft even further to 165-170 knots and selected a more squared off heading for the 17R LOC to allow more time for the runway change. Although early, the Pilot Monitoring asked if I wanted gear down. I knew that would help us slow even faster and reduce workload, so I called gear down and flaps 3.

We started experiencing increasing turbulence and my scan alternated from inside to outside. Our airspeed was fluctuating from the turbulence/windshear. As I transitioned from inside to outside focus, I realized we were overshooting the LOC for 17R. I disconnected the autopilot and started hand-flying to make the correction for the LOC. We were still outside (approximately 5 miles) of JOSEE and we were at an appropriate glideslope intercept for 17R. The Pilot Monitoring was verifying the box and talking to ATC. The turbulence/windshear increased. I scanned the PFD to verify the LOC and GS and realized we were shedding airspeed rapidly. At the same time, the Pilot Monitoring stated "... watch your speed." We were closing in on VIs. I increased the throttle because I believed the airspeed was due to increasing windshear/turbulence. I then realized the autothrust was off and I stated the autothrust was off and I lowered the nose of the aircraft to assist/stop the airspeed decay and increased the thrust levers. The airspeed increase away from VIs. I heard the Pilot Monitoring say, "I turned the autothrust off..." and, "...I am redirecting us to JOSEE."

As my assessment of the situation became clear with an unexpected autothrust disconnection, windshear/turbulence and below the glideslope, I felt a go-around was warranted and the safest course of action even though we were still high enough not to violate our stabilized approach criteria. I called go-around and pushed the thrust levers to TOGA and pulled the thrust levers back in an effort not to overspeed. Simultaneously, the

turbulence/windshear increased even more. Although trying to apply smooth thrust inputs, the airspeed was abnormally erratic and unpredictable. The turbulence/windshear was affecting our climb rate and stability. The airspeed exceeded the flap setting limitations. I reduced the thrust levers further and continued a climb to reduce the speed. I called for the Pilot Monitoring to set an altitude. I cannot remember if I called for a specific altitude or not, but my intention was for the Pilot Monitoring to communicate with DEN for an altitude. We were passing 8,500 MSL when I called for an altitude and was getting the airspeed back to a normal condition. As the airspeed was normalizing, I called for the autothrust to be re-engaged. The Pilot Monitoring stated he had controls and stated he wanted 10,000 MSL. I advised DEN we were climbing to 10,000 MSL. DEN advised to stop climb at 9,000 MSL and state intentions. I advised we wanted vectors to assess the weather situation. The original Pilot Monitoring leveled us at 9,000 and stated, you have controls and I resumed Pilot Flying duties. We took delayed vectors while we reviewed our fuel status and pulled weather for COS.

I asked the Pilot Monitoring what happened with the autothrust and he stated he saw our airspeed increasing before he could activate the approach so he disconnected the autothrust and pulled the thrust lever to approximately 50%. The Pilot Monitoring stated he announced his actions when he disconnected the autothrust by saying, "...autothrust disconnected - you have the thrust levers." As I was hand flying the aircraft onto the LOC while experiencing increasing turbulence/windshear, I did not hear the Pilot Monitoring state the autothrust was disconnected. Admittedly, I was very focused on hand flying the aircraft, monitoring the ATC communication regarding windshear, our present position and the increasing turbulence/windshear while mentally preparing for a potential go-around that I missed the Pilot Monitoring state he turned the autothrust off. I was not expecting the autothrust to be disconnected. I was performing increasing instrument scans, but dismissed the initial airspeed trend indicator and contributed it to the turbulence/windshear instead of the autothrust being disconnected by the Pilot Monitoring.

After delayed vectors, the wind event moving across DEN subsided and we were assigned 16L and vectored to the approach. As the Pilot Flying, a landing to 16L occurred without further abnormal events. A logbook entry was made for Flap Overspeed and Severe Turbulence due to the large, abrupt changes in altitude and large variations in airspeed from turbulence/windshear.

After landing and discussing the event, the Pilot Monitoring and I agreed we lost proper pilot-to-pilot communication. I failed to hear and verbalize the autothrust was disconnected. He failed to hear me acknowledge the autothrust was disconnected. Also, the Pilot Monitoring thought I called for him to take control when I actually called for an altitude during the go-around. The turbulence/windshear was a significant factor in our miscommunication, combined with workload and possible fatigue from a second night of double red-eye flights. Small errors were being trapped on our descent into DEN. We both agreed a better course of action would have been to ask for delayed vectors when we were told the second runway was experiencing a Windshear Alert.

Synopsis

Air Carrier pilot reported miscommunication between flight crew while initiating a go-around due to windshear and turbulence.

Time / Day

Date : 201809

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : LAX.Airport

State Reference : CA

Altitude.AGL.Single Value : 2000

Environment

Flight Conditions : VMC

Aircraft : 1

Reference : X

ATC / Advisory.TRACON : SCT

Aircraft Operator : Air Carrier

Make Model Name : B737 Next Generation Undifferentiated

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Final Approach

Route In Use : Visual Approach

Route In Use.STAR : HLYWD1

Airspace.Class B : LAX

Aircraft : 2

Reference : Y

ATC / Advisory.TRACON : SCT

Make Model Name : B737 Undifferentiated or Other Model

Flight Plan : IFR

Flight Phase : Final Approach

Airspace.Class B : LAX

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1576898

Human Factors : Communication Breakdown

Human Factors : Fatigue

Human Factors : Situational Awareness

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : ATC

Analyst Callback : Attempted

Person : 2

Reference : 2
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : First Officer
Function.Flight Crew : Pilot Not Flying
ASRS Report Number.Accession Number : 1576901

Events

Anomaly.Deviation - Procedural : Landing Without Clearance
Anomaly.Inflight Event / Encounter : Wake Vortex Encounter
Detector.Person : Flight Crew
When Detected : In-flight
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Environment - Non Weather Related
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

LAX Approach Control cleared us to maintain 180 kias to LIMMA, cleared visual 25L. Tower frequency was preset on VHF #1 in standby mode and forgot to obtain landing clearance from LAX Tower. Attributing to our error was: not being told to contact Tower by Approach, encountering some wake turbulence from preceding 737 on final while Captain was hand flying/adjusting to a slightly higher glide path to avoid, possibly some fatigue from our 10hr duty day/7.5hr flight time/day 4 of the trip after a 12hr layover, following an [early] arrival the day before.

Narrative: 2

We landed 25L without clearance from LAX Tower. Approximately 10-12 miles from airport, SoCal Approach cleared us to "maintain 180 knots until Limma, cleared Visual Approach 25L." I didn't hear or read back the switch to Tower and was planning to query Approach if not switched by Limma (FAF). During the Arrival (HLYWD1) and Approach, we hit 4-5 pockets of pretty strong wake turbulence starting about 100nm from the airport. We hit 1-2 more pockets of wake turbulence between 10-20nm from airport and we briefed that the Pilot Flying (PF) (Captain (CA)) would fly 1/4-1/2 dot high on the glideslope to stay above the wake turbulence until touchdown. It was pretty bumpy below 1000' and I believe we were both focused on the wake turbulence and flying slightly high on glideslope and forgot to query Approach on the switch to Tower.

The runway was clear and it was an uneventful landing. We had made the callouts on final and at 1000' the CA (PF) stated cleared to land and I (First Officer (FO)/PM) didn't catch the mistake. When exiting the runway, Approach called us on the radio and asked us to switch Tower. We then noted that Approach was still the primary frequency and Tower was in standby. We were both monitoring Guard frequency and heard no calls. Tower gave us normal taxi instructions. We asked Tower if we needed to call him on the land line and he said no.

Regardless of the manual frequency push from Approach we made the mistake here and should have done better. I believe we were both tired. We were on day 4 of a 4 day trip, we had 7.5 hours of block time that day, a 10 hour duty day, and we were landing at our home base which made us more comfortable. That day, we had worked hard dodging thunderstorms. No excuses and want to own the mistake and learn from it.

Synopsis

B737NG flight crew reported landing without clearance following a wake turbulence encounter. Fatigue was cited as a contributing factor.

Time / Day

Date : 201808
Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZZ.Airport
State Reference : FO
Altitude.AGL.Single Value : 300

Aircraft

Reference : X
ATC / Advisory.Center : ZZZZ
Aircraft Operator : Air Carrier
Make Model Name : Widebody Transport
Crew Size.Number Of Crew : 4
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Cargo / Freight
Flight Phase : Initial Approach

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Commercial
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1576009
Human Factors : Situational Awareness
Human Factors : Fatigue

Events

Anomaly.Deviation - Procedural : FAR
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Diverted
Result.Flight Crew : Took Evasive Action
Result.Flight Crew : Executed Go Around / Missed Approach
Result.Air Traffic Control : Issued Advisory / Alert
Result.Air Traffic Control : Provided Assistance

Assessments

Contributing Factors / Situations : Airport
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Environment - Non Weather Related
Primary Problem : Environment - Non Weather Related

Narrative: 1

First leg for IOE (Initial Operating Experience) OFO (Operational Experience First Officer) in the right seat. LCA (Line Check Airman) Pilot Flying (Pilot Flying). 4 man crew (LCA, OFO, 2 FOs), Mechanic and Loadmaster.

On arrival, night VFR in ZZZZ winds 350/25G35 Runway XXR. FMC reserves 12.6 with ZZZZ1 as alternate. To mitigate SAFIRE (Small Arms Fire) MANPAD (Man-Portable Air Defense) threat, [we] turned all exterior lights off passing 16,000 feet as suggested by company Jeppesen Charts. Short Final, passing approximately 300 feet AGL. Pilot Flying called for landing lights, shortly followed by Tower Controller directing a go-around due to base under attack. [We] executed a go-around and began to divert to ZZZZ1. Per ATC, ZZZZ was closed indefinitely. About third of the way to ZZZZ1, ATC notified that we may proceed to ZZZZ1, but due to their field and fuel situation, we would be stuck there and asked our intentions. As a crew, we decided to turn around and divert to ZZZZ2 immediately. [We] called Dispatch via Satcom to advise of our intentions. ZZZZ2 winds 360/25G35. Landed safely with 12.4K fuel, FMC Reserves 12.6K.

Local handler [at ZZZZ2] was unable to get our flight plan package ZZZZ2-ZZZZ. I had to use my personal phone to download package to transfer it to my computer and print it using Loadmaster's printer. Approximately 2 hours after landing ZZZZ2, Ground advised ZZZZ was open but ZZZZ2 closed due to a security threat on the field, [a] suspicious package. Approximately 3.5 hours after landing, ZZZZ2 opened and at the same time Dispatch notified via ACARS that we were going to be offloaded in ZZZZ2 and proceed to ZZZZ3 due to lack of duty time. [We] called Dispatch and advised we can proceed to ZZZZ with their concurrence. MOD (Manager on Duty) and Dispatch agreed. Uneventful flight from ZZZZ2 to ZZZZ.

Once in ZZZZ, we were advised the base was hit close to the flight line where we parked near Final Approach path to Runway XXR and a second attack on the other side of the base. Dispatch was unable to get permits to proceed to ZZZZ3 and began to work on permits to fly to ZZZZ4. It took almost 6 hours to get flight plan and permits to fly to ZZZZ4, during which time [the] crew took turns to rest. Local handler unable to get flight plan package and had to utilize same procedure as in ZZZZ2. By the time flight plan was in hand, crew was past their contractual duty day. As a crew, we decided to press on in order not to crew rest in ZZZZ and expose crew/aircraft to another possible attack.

Flight ZZZZ-ZZZZ4 [was] uneventful. Day began [and] ended [almost 23 hours later]. Looking back at this flight, scheduling first leg of OE going into a war zone may not be the ideal situation for training. ZZZZ is a high elevation airport surrounded by very high terrain and the possibility of an attack make this a high threat environment. Using ZZZZ1 as an alternate even though the airfield did not have the proper support for a departure is a set up for failure. Crews expect to go to their filed alternate when things go wrong and for a crew to find out that an alternate is not a good option while diverting creates an even higher threat due to lack of loiter fuel. Operations and Dispatch should thoroughly ensure that an alternate is fully capable to support arrivals/departures prior to filing as an alternate for contingency planning.

No handler support and lack of crew members ability to retrieve Flight Plan Paperwork for departure after a divert lacks contingency planning in remote areas. I am attaching a Flight Crew Report filed to highlight lack of communication ability and possible solutions. As a side tone, ZZZZ, ZZZZ1 and ZZZZ2 lack proper layover facilities for civilian crews to

crew-rest. Exposing crew and aircraft to a possible attack should be planned with higher than normal contingency planning to mitigate crew rest and aircraft asset exposure.

Synopsis

Widebody transport Captain reported that they were instructed to go-around due to base under attack.

Time / Day

Date : 201808

Place

Locale Reference.ATC Facility : ZZZ.ARTCC
State Reference : US
Altitude.MSL.Single Value : 35000

Environment

Flight Conditions : VMC

Aircraft

Reference : X
ATC / Advisory.Center : ZZZ
Aircraft Operator : Air Carrier
Make Model Name : B787 Dreamliner Undifferentiated or Other Model
Crew Size.Number Of Crew : 3
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Flight Phase : Descent
Airspace.Class A : ZZZ

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Pilot Not Flying
Function.Flight Crew : First Officer
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Instrument
Experience.Flight Crew.Total : 11316
Experience.Flight Crew.Type : 2125
ASRS Report Number.Accession Number : 1573269
Human Factors : Confusion
Human Factors : Fatigue
Human Factors : Situational Awareness
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Deviation - Track / Heading : All Types
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : FAR
Anomaly.Deviation - Procedural : Clearance
Detector.Person : Air Traffic Control

When Detected : In-flight

Result.Flight Crew : Requested ATC Assistance / Clarification

Result.Flight Crew : Became Reoriented

Result.Air Traffic Control : Provided Assistance

Assessments

Contributing Factors / Situations : Airspace Structure

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Procedure

Primary Problem : Human Factors

Narrative: 1

We were instructed to hold at a fix on airway. The instruction "hold as published" was not used. We entered standard right turn. On outbound leg, we were told that it was a left pattern. I reviewed JeppsPro High Alt, but did not see any holding pattern at the fix. Other holding patterns were shown, so I assumed that it was standard entry. After we were told that we turned in the wrong direction, a closer analysis of JeppsPro showed that the fixes were not selected, and the holding patterns shown were over nav aids (which were selected). As soon as the fixes were highlighted, the correct holding pattern was shown. This error is also attributed to the fatigue, since this was a third leg of 4 leg [while] pairing with crew of 3. With crew of 3 there is significant degradation of alertness and many minor errors, such as missed communication, slow responses, etc., were shown on this leg and subsequent leg. We were all fatigued with only about two 3 hour rest periods in about 20 hour period.

Synopsis

B787 Captain reported entering a hold pattern with a standard right turn which was incorrect for this fix.

Time / Day

Date : 201808

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Tower : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : Medium Transport, Low Wing, 2 Turbojet Eng

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Taxi

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

ASRS Report Number.Accession Number : 1571289

Human Factors : Fatigue

Human Factors : Situational Awareness

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Deviation - Procedural : Clearance

Anomaly.Ground Incursion : Taxiway

Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Became Reoriented

Assessments

Contributing Factors / Situations : Airport
Contributing Factors / Situations : Chart Or Publication
Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

In ZZZ we were given the instructions to taxi XX to the intersection of XXR and XX1 for takeoff. While on XX1 at the hold short line for XXR the FO (First Officer) said, "You are on XX2 not XX1," I looked up and did see an XX2 location sign out to my left, at this time we were cleared to line up and wait from XX1, which added a bit of urgency, I immediately repositioned on the next taxi way over where the FO had pointed to, and entered the runway from there. We lined up and took off without incident, ATC didn't say anything about it, but the whole thing didn't seem right and once we got to altitude I reviewed the taxi diagram again, and recalled a couple of other things. We had absolutely been on the correct taxi way, XX1, the first time, I had even remembered saying while on XX, "Here is X20, XX1 is next;" and then being at that taxiway behind another aircraft which was cleared to takeoff from XX1. So the FO was incorrect and we actually moved from XX1 (the correct taxiway) to XX2 (the incorrect taxiway) when we did what he said. The reason we saw the XX2 location sign was because it was between XX1 and XX2, so we were not actually on XX2. I absolutely believe my incorrect response to the FO's allegation was 99% fatigue related.

I had a day trip, a four day, and another day trip lined up for a total of six days on and this happened on the last leg of day six. The four day in the middle was mentally and physically exhausting, and after two close to minimum rest overnights, I started my day-trip on day six with an early morning turn, then a two and a half hour sit with an ZZZ turn left to go. I considered calling in fatigued on the sit due to how out-of-it and exhausted I was feeling, but after grabbing a cup of coffee I felt decent and decided to press on, only to find out when I got to the plane that the FO I would be doing the last two legs with was on his first leg off of IOE (Initial Operational Experience). I'd been expecting a senior FO, so at this revelation I immediately regretted not calling in fatigued, which in hind sight, is the wrong approach to take to fatigue. Whether or not I call in fatigued should not be based on who I am flying with, I should not expect a senior FO to carry part of my weight or "keep an eye on me," I'm either fit to fly or I am not, and if I'm not alert enough to fly with a brand new FO then I'm not alert enough to be flying. At this point calling in fatigued would have no doubt meant delaying passengers and the crew, which I try to be considerate of and avoid, but in the interest of safety I should not have let it stop me from calling in fatigued either.

Had I not been exhausted and already a little on edge from a couple of stupid little things I did from being so worn out (like trying to taxi with the parking brake on), then immediately swooping over to the next taxiway, just because someone who has been on the line for two weeks told me it was the right one with confidence, would not EVER have been my response. I know much better than this and I feel my normal response to this situation would have been to tell tower we needed a minute, and for the FO and I to review the taxi diagram and our location together. The intersection we did takeoff from gave us more runway, so it was not a performance hazard in this instance, but it was still a deviation from an ATC clearance and could have been worse.

Fatigue was the main factor for this incident. Some other minor factors were that I am a newer captain, in my three months as captain it has just worked out that I have worked with mainly senior FOs and other reserve captains (which isn't to say that a senior person couldn't have made the new FOs mistake, just that I need to make sure I don't let working

with experienced/knowledgeable pilots allow me to develop complacency when it comes to listening to the person I'm working with, we BOTH need to stop and see regardless of their experience level).

I've flown while tired, but this is the first time I've ever flown fatigued, I learned a lot from it and absolutely won't hesitate to call off fatigued in the future if I think I'm nearing this point.

Synopsis

Captain reported fatigue led him to depart from an incorrect intersection from which he was cleared for takeoff.

Time / Day

Date : 201808

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ABQ.Airport

State Reference : NM

Altitude.AGL.Single Value : 1000

Environment

Flight Conditions : VMC

Light : Night

Aircraft

Reference : X

ATC / Advisory.Tower : ABQ

Aircraft Operator : Air Carrier

Make Model Name : B737-800

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Flight Phase : Final Approach

Route In Use : Visual Approach

Airspace.Class C : ABQ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Captain

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Multiengine

ASRS Report Number.Accession Number : 1570265

Human Factors : Fatigue

Events

Anomaly.Inflight Event / Encounter : Unstabilized Approach

Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Executed Go Around / Missed Approach

Assessments

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

Narrative: 1

We were approaching ABQ from the southeast, and were cleared the visual for Runway 3 from too high and too fast of a position. This was the end of our day and had taken a lengthy delay leaving [the departure airport], we unwisely tried to make the approach work, but below 1,000 feet I knew that I was forcing a bad situation and initiated a go-around. We got vectors around and landed on Runway 8.

We had flown a transcontinental red eye, short adequate rest at best, then flew through a high work load weather event on the east coast. Our flight to ABQ got delayed by 1:24 due to catering and ground crew issues. All told, after flying 11:59 in a twenty four period that involved a red eye, I was more tired than I realized and it had a definite impact on my judgement.

Synopsis

B737-800 Captain reported executing a missed approach to a runway due to an un-stabilized approach due to fatigue.

Time / Day

Date : 201808

Place

Locale Reference.ATC Facility : ZZZ.ARTCC
State Reference : US

Aircraft

Reference : X
ATC / Advisory.Center : ZZZ
Aircraft Operator : Air Carrier
Make Model Name : B777 Undifferentiated or Other Model
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Flight Phase : Cruise
Airspace.Class A : ZZZ

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Crew Rest Area
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Not Flying
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
Experience.Flight Crew.Total : 21000
Experience.Flight Crew.Last 90 Days : 200
Experience.Flight Crew.Type : 4546
ASRS Report Number.Accession Number : 1570183
Human Factors : Fatigue

Events

Anomaly.Flight Deck / Cabin / Aircraft Event : Other / Unknown
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : FAR
Detector.Person : Flight Attendant
Detector.Person : Flight Crew
When Detected : In-flight
Result.General : None Reported / Taken

Assessments

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

Narrative: 1

Approximately one hour and fifteen minutes before the end of my break I was startled awake from a deep sleep by a loud bang outside/against the crew bunk. One of the flight attendants apologized profusely for "accidentally dropping a dish which hit the floor and the wall of the bunk." I asked her why there were carts in the area when company policy is for carts to not be placed in the area after the first meal service and for the duration of the flight. She apologized again and said that she would try to be more careful. I emphasized that the carts were not supposed to be there and she said she would try to be more careful. I would like to point out that this was a VERY nice and professional crew but that they simply are not getting the message from Operations. I do not blame most of the flight attendants for this - they are not correcting the problem because they are not being told by management to correct the problem. This should be handled institutionally by [management] to ALL flight attendants who work the 777 models.

Meanwhile my FAR117 mandated crew rest was grossly disturbed and I could not fall back asleep. What makes this even more critical is that this city pair was recently approved for an FRMS (Fatigue Risk Management System) exemption.

This gross safety violation has been occurring for the almost four years that I have been based in ZZZ. There should be NO carts or carriers or any personal belongings placed by door 1L during the flight. Yet it just keeps happening.

Synopsis

B777 Captain reported a continuous issue with the crew rest area.

Time / Day

Date : 201808

Local Time Of Day : 0601-1200

Place

Locale Reference.ATC Facility : ZBW.ARTCC

State Reference : NH

Altitude.MSL.Single Value : 23200

Environment

Flight Conditions : IMC

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Center : ZBW

Aircraft Operator : Air Carrier

Make Model Name : A321

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Nav In Use : GPS

Flight Phase : Descent

Route In Use.STAR : JFUND 2

Airspace.Class A : ZBW

Component

Aircraft Component : FMS/FMC

Aircraft Reference : X

Problem : Design

Problem : Malfunctioning

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

ASRS Report Number.Accession Number : 1570097

Human Factors : Fatigue

Human Factors : Human-Machine Interface

Human Factors : Confusion

Person : 2

Reference : 2
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Not Flying
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Air Transport Pilot (ATP)
Experience.Flight Crew.Total : 15000
ASRS Report Number.Accession Number : 1570102
Human Factors : Distraction
Human Factors : Confusion
Human Factors : Fatigue

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Deviation - Altitude : Overshoot
Anomaly.Deviation - Procedural : Clearance
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Became Reoriented
Result.Flight Crew : Returned To Clearance

Assessments

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

Narrative: 1

I was Pilot Flying. We were assigned to descend via the JFUND2/Runway 04R transition. We had separately confirmed all constraints in the FMC, and I had briefed the arrival. We had left FL270 prior to the first altitude restriction using managed descent. The first constraint was at or above FL240 at MNSTA. We were in both managed airspeed and managed vertical path. I was reviewing the taxi plan and gate information when we noticed the aircraft had descended below FL240 about 800 feet prior to the fix. I immediately selected VS (Vertical Speed) and then initiated a short climb to FL240. We continued to use managed descent and the aircraft met all [other] constraints.

I have no idea why the aircraft did not perform as expected and desired. This was the way we were trained to fly the Airbus. We were tired and that could have contributed to the problem. Pilots should be trained not to trust the managed descent mode or not use it.

Narrative: 2

I'm aware of some of the weaknesses of the A320 [series] aircraft in managed descent, but I had never seen this happen. However, pilots I've flown with who have much more time on it than I have warned me of this potential. When we left FL270 "ALT CNST" was armed, and we both fully expected the aircraft to honor the FL240 restriction. I do not understand why it did not, but I know why I missed it. Divided attention, combined with fatigue at the end of a trip, and the timing of a frequency change took us both a step

further out of the loop of careful monitoring. We both caught it quickly, and the rest of the arrival the managed descent mode behaved as expected, so it did not appear to be a maintenance problem.

A more careful selection of the time for me to check back for write-ups, while we were still level, would have most likely avoided this problem. Divided attention, especially when tired and already a little slower, created the situation where my monitoring was not up to the requirements. As for the aircraft/PF (pilot flying) interface, I've seen the technique of using VS (Vertical Speed) and setting each individual altitude for at or above restrictions, but that is not the primary method taught on this fleet. I'm still unsure of the technical part of why the aircraft continued below the restriction.

Synopsis

A321 flight crew reported the aircraft failed to honor a properly programmed altitude constraint on descent in managed speed and managed vertical path mode.

Time / Day

Date : 201808
Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ELP.Airport
State Reference : TX
Relative Position.Angle.Radial : 222
Relative Position.Distance.Nautical Miles : 10
Altitude.MSL.Single Value : 8000

Environment

Flight Conditions : VMC
Light : Daylight

Aircraft

Reference : X
ATC / Advisory.Tower : ELP
Aircraft Operator : Air Carrier
Make Model Name : Widebody, Low Wing, 2 Turbojet Eng
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Cargo / Freight
Flight Phase : Final Approach
Route In Use : Visual Approach
Airspace.Class C : ELP

Person : 1

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Pilot Not Flying
Function.Flight Crew : First Officer
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
Experience.Flight Crew.Total : 8950
Experience.Flight Crew.Last 90 Days : 185
ASRS Report Number.Accession Number : 1568449
Human Factors : Fatigue
Human Factors : Time Pressure
Human Factors : Workload
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Person : 2

Reference : 2
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Pilot Flying
Function.Flight Crew : Captain
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Instrument
ASRS Report Number.Accession Number : 1568453
Human Factors : Distraction
Human Factors : Situational Awareness

Events

Anomaly.Deviation - Speed : All Types
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : FAR
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Became Reoriented

Assessments

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

Narrative: 1

We were operating to ELP. The first error in this chain of events is when I noticed we were level at 8,000 feet at an indicated airspeed of 280 knots going direct to AGUAS. I pointed out to the Captain that we needed to reduce our airspeed immediately. Shortly thereafter we began our speed reduction we were instructed to begin a descent to 6,000 feet and cleared visual 22. At this present time we were approximately 250 knots descending and roughly 16-17 miles from the field. The Captain was utilizing speed brakes during this descent and asked for slats to be extended at 240 knots. From that point forward I tried to back the Captain up with configuring as early as permissible with respect to aircraft limitations. With that being said, while I was doing my job to back him up, I was not nearly assertive enough in my other duties making him aware of our aircraft state with regard to our stabilized approach criteria. I mentioned that we were "high" and "fast", however, if I said we were "unstabilized" I don't recall it. At the very least I can say with confidence I wasn't said assertive enough if it was mentioned.

I think the Captain and myself had tunnel vision with getting the aircraft configured and on speed. I think there was some expectation bias as well that played into that we are accustomed to flying so many approaches where the FAF is 2-4 miles further out than this particular approach into ELP. Coupled with the higher altitude/higher TAS also compounded the chain of events that led to this unstabilized approach. As far as what caused the event. As crews we know that no single instance can cause the outcome of something. In this case I think we were left a little high by center control (some in part due to some ATC issues) and then on our own doing of being at such a high speed at 8,000 feet and a high altitude airport. A potential second contributing factor today was that this was only our second leg together. As is with each new trip with a coworker you try and get a feel for how they fly the airplane and when they like to configure for

approach to landing. I needed to be more assertive or just ask him when would you like to slow down and configure for approach, so that we are sharing the same mental model. I also had late van in but the night prior, and was only able to get about 2 hours of sleep in the sort. It's hard to also ignore the potential effects of fatigue as a potential contributing factor. Our evening was a late duty day and we were 22 minutes late arriving.

Narrative: 2

It was 15,000 scattered, and light winds. Unstable approach. I came on duty one hour prior to the flight. I had driven 2 hours to [my home airport] to jumpseat to work and had slept a few hours prior to this plus my normal 8 hours of sleep the prior morning and didn't think I was that tired at all. Felt decent. [At the next airport] I got a sleep room and also slept one hour prior to show. FO's (First Officer's) leg, we operated uneventfully and Captain departed to El Paso the same.

On our descent into El Paso was started a bit late as we had some trouble with ATC communication getting the descent further into El Paso and we were vectored off course 10 degrees while descending to 10,000 feet. Getting close to that altitude we were then cleared direct to the outer marker. While turning to go direct to the marker a descent through 10,000 was caught by the FO which was caught leveling at 8,000 at 280, I thought I had set 250 in the window but was distracted I suppose, which then at that point we were about 20 miles from the marker, which normally would be crossed at 5,100 feet. By the time I slowed the plane to 250 with speed brakes, to continue the descent we were now about 17 miles out and so I needed to lose airspeed and 2,900 feet of altitude in 15 to 17 miles.

We were cleared to 6,000 and the visual to Runway 22. (Looking back at this point I should have asked for a 360 and descended to altitude and started configuring early.) Instead I called for slats extend at 245 or so while descending with the spoilers fully extended. Then called for flaps 15 at around 205 while descending etc., then flaps 20 as soon as the speed allowed, the gear had been extended and I was slowing but the 1,000 AGL height and a discontinued approach had slipped right out of my mind thinking about getting the airplane configured and landed. We, unfortunately were not ready to land until approximately 200-300 feet, meaning on speed and on path fully configured. We were configured in time I think at or above 1,000 feet AGL, the speed was the big factor of somewhere between 150-160, so 20-30 above speed.

First, a 360 should have been done out when we realized to high. Second, a discontinued approach should have been initiated when the criteria above and approaching a 1,000 feet was not met, and a no fault go around could and should have been accomplished after that instead of trying to save the landing. I have never done anything like this before and have operated all over this world and have always tried to be stable and follow procedures to the T. I have done at least one discontinued approach maybe two in the last year or so and had no problem doing them. Why that was not done here was that the crew was focused on landing, not exceeding limitations configurations but in that completely lost track of 1,000 feet criteria and such. This will not happen again on my watch, I have a pain in the pit of my stomach cannot believe this could happen to me. As a pilot, I always thought that, as a Captain, have always strived for that, but got caught up in the flying event of the aircraft. I must be aware of the airport elevation, high TASs and very short final approach fix. Too short to not be configured at least 3-4 miles prior to reaching it on speed. Briefing it all at altitude, which was done completely I must say, must be followed by actions. After landing I wished I could go back and do the 360, discontinued approach or go-around. It would have been better than this feeling. The short final approach of 3.4 miles from VALTR to the runway, high altitude airport, faster TAS and a long runway will

play into a chain that leads to an unstable approach. Even being visual. It's better to treat this airport that AGUAS, which is 3.4 miles prior to the final approach fix to VALTR, should be treated as an end point. Meaning if not configured by AGUAS on altitude prior to or at this fix beware and be ready to discontinue this approach. Remember also, take all distances from the final approach fix and not the airport at this airport, as the FAF to the runway is at 1,250 feet or so, so you only have 250 feet to decide to discontinue this approach or not. Fly it that way. I will.

Synopsis

Widebody Transport flight crew reported being high and fast and not meeting stabilized approach criteria before landing.

Time / Day

Date : 201808

Local Time Of Day : 1801-2400

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 : A319

Operating Under FAR Part : Part 121

Mission : Passenger

Flight Phase : Parked

Component : 1

Aircraft Component : Ignition System

Aircraft Reference : X

Problem : Malfunctioning

Component : 2

Aircraft Component : Anticollision Light

Aircraft Reference : X

Problem : Failed

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Experience.Flight Crew.Total : 5240

Experience.Flight Crew.Type : 2438

ASRS Report Number.Accession Number : 1566422

Human Factors : Time Pressure

Human Factors : Fatigue

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer
Function.Flight Crew : Pilot Flying
Experience.Flight Crew.Last 90 Days : 100
Experience.Flight Crew.Type : 2087
ASRS Report Number.Accession Number : 1566385
Human Factors : Situational Awareness

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : MEL
Detector.Person : Flight Crew
When Detected : Aircraft In Service At Gate
Result.Flight Crew : Overcame Equipment Problem

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Environment - Non Weather Related
Contributing Factors / Situations : MEL
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

Our routing, for thunderstorm avoidance, added about 25 mins to the normal scheduled flight time. As a result, we arrived into ZZZ 26mins late (running the aircraft at maximum possible forward speed and acquiring any and every short cut we could wheedle out of ATC). Scheduled for a 61 min turn in ZZZ, we now had yet another aircraft change (again, originally scheduled to keep the same aircraft all day) AND, our 26 min late arrival changed our 61 min turn time into 35 mins, again with us changing planes (pull full paperwork, evaluate aircraft status, weather at destination, enroute weather, fuel requirements, etc). As we were evaluating the status of [the] aircraft, we discovered that the aircraft's rotating beacon was deferred inoperative (this was a night flight). Also, the aircraft had ignition problems requiring a "manual start procedure". Problem here is the A319/320 flight manual requires the First Officer (F/O) verify that the beacon is working prior to attempting a manual engine start (assumption is more head's down time to start engine using this procedure, hence ensure beacon on to warn ground personnel of engine starting process). With the beacon deferred inoperative, we opted to call Technical Support Maintenance Control. At the airframes desk we tried to come up with a safe procedure that we could employ to allow us to fly [the] aircraft, without violating the intent of the flight manual (ensure the safety of the ground crew). After getting off the phone, and per our discussion, I briefed my F/O on the planned sequence of events. Once complete, I walked down to the lead of our ground crew and advised him of the same. We would close the door and pull the jetway. We did not require electrical power from the jetway nor an air cart for starting. We would turn on our white wingtip strobe lights as a warning during engine start. We would start our first engine in the gate area with our ground crew essentially standing guard to keep any wayward intruders from wandering too close to our engines and getting hurt. Once we have a good start on our first engine, we would call for pushback clearance and once cleared, secure our strobes (allowing the 'wanded' wing walkers to be our protection as we moved away from the gate). When clear of our push personnel, we would taxi to a somewhat remote area to start our second engine (away from potential areas for ground personnel).

We completed the above as quickly as safety allowed. Once airborne, we re-evaluated what had transpired. We decided we had acted with safety as the foremost and utmost priority, the fact is our manual states the beacon MUST be on. No deferred inoperative option. Since the procedures utilized were fabricated on the spot between myself and Maintenance Control, they undoubtedly were not the best plan. I had been assured that we were ok to go by our experts at Maintenance Control, but now question the validity of that assurance. With the myriad of issues going on with Aircraft X, the attempted pressuring by customer service to get the flight out "on time", we probably should've walked off the aircraft and gone into a quiet planning area to have a thorough discussion (including the Chief Pilot, Dispatch, Maintenance Control, my F/O and myself) and re-evaluated this situation. Bottom line, I think I should have refused this aircraft for an inoperative beacon combined with the manual start requirement, based on the way our manual is currently written. Especially since this was a night flight. What we did was safe but the 'letter' of the manual was not followed. The fact we were tired from the issues of the day, we did not receive our crew meal (hadn't had a chance to eat since breakfast) on the flight to ZZZ due to catering issues with the late unscheduled plane swap, it was getting late in the day and we were unsure about the legality of this combination of deferrals, all should've led me to a refusal. I did not. Our flight to ZZZ1 was uneventful.

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

A319 Flight Crew reported working around conflicting deferred items may have violated the MEL.

Time / Day

Date : 201808

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.MSL.Single Value : 16000

Environment

Weather Elements / Visibility : Turbulence

Weather Elements / Visibility : Rain

Aircraft

Reference : X

ATC / Advisory.Center : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : B767 Undifferentiated or Other Model

Crew Size.Number Of Crew : 3

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Descent

Airspace.Class E : ZZZ

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

Experience.Flight Crew.Total : 18000

Experience.Flight Crew.Last 90 Days : 180

Experience.Flight Crew.Type : 9000

ASRS Report Number.Accession Number : 1565772

Human Factors : Time Pressure

Human Factors : Situational Awareness

Human Factors : Fatigue

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Not Flying
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Instrument
Experience.Flight Crew.Total : 8414
Experience.Flight Crew.Last 90 Days : 255
ASRS Report Number.Accession Number : 1566377
Human Factors : Fatigue

Events

Anomaly.Flight Deck / Cabin / Aircraft Event : Illness
Anomaly.Inflight Event / Encounter : Weather / Turbulence
Detector.Person : Flight Crew
When Detected : In-flight
Result.General : Physical Injury / Incapacitation

Assessments

Contributing Factors / Situations : Weather
Primary Problem : Weather

Narrative: 1

First leg of this trip, delayed departure for ZZZ due to maintenance, aircraft swap, and lightning closing the ramp. Wake up [extremely early] this morning. Both FOs (First Officers) and I seemed surprisingly alert for preflight and departure, but we were all undoubtedly somewhat affected by fatigue by the last hour of this leg, due to the extreme delay on the flight over, and the extremely early wake up today. [Dispatch] noted FCST TSTMS ZZZ AND VCTY AT ETA. TAF included -SHRA with PROB30 -TSRA at arrival time. In my brief to Purser I noted the forecast, and the possibility of descent turbulence, and the likely need to finish service and sit, sooner than normal prior to landing. ZZZ ATIS auto updates indicated 1 mile with heavy rain at destination. We received a reroute from ARTCC, to proceed from ZZZ1 to ZZZ2. Approaching ZZZ1 from the east at FL340, I could see some weather on the distant horizon. I asked [Operations Control] via ACARS message, how the descent rides were into ZZZ. Reply was, PIREPS INDICATE LGT TURBC BETWEEN FL100 and FLO60. I remained leery, and made a PA more than one hour before our FMC eta for destination, prior to initial descent, letting the passengers know that it was their last opportunity to move about the cabin if necessary prior to landing. I also told the FAs (Flight Attendants) to finish their final service early, and to expect possible turbulence in descent. Just prior to top of initial descent, and at the request of one FA who called the IRO (International Relief Officer) on the interphone, we turned on the seat belt sign. As we approached ZZZ1, wx radar showed a good sized cell, and on our route, it was all green with the gain at AUTO, but with a fairly solid yellow spot to the south of our route. We asked ARTCC how the rides were through it, after they had cleared us to descend to 16,000. The arrival says to expect 10 east of ZZZ2 at 16,000, and we were descending appropriately. ARTCC said light chop or turb, with moderate rain. The monitoring FO, returned from rest break 3, and the IRO and I took quick final lav breaks. The rain in the cell was light, and there was almost no turbulence initially. The rain intensity increased, but turbulence remained light. Toward the back end of the cell, descending between 18,000 and 16,000, we hit a sudden patch of what felt to us in the flight deck, was moderate turbulence. IRO made the Flight attendants be seated immediately PA. Monitoring FO made PIREP to ARTCC. [Operations Control] was notified via text of the moderate turbulence in descent approaching ZZZ2 between 18,000 and 16,000. We soon received an interphone call that an FA X had injured her foot, and that it

was possibly broken. We cleared the weather, the ride became smooth, and we made the flight attendants check in PA. The IRO called the cabin again, and suggested someone apply ice to the injured foot. We were then apprised that FA Y stated that his neck had "cracked," and he could move it, but thought he might have whiplash. [Operations Control] was apprised of both injuries. Both injuries occurred in the aft galley. Paramedics and an in-flight supervisor were requested from [Operations Control] and ZZZ ops. IRO called cabin again, and was told the two injured FAs were stabilized. There appeared to be no traffic ahead of us on our arrival, and we did not declare a medical emergency. We landed normally at ZZZ, taxied to gate, where paramedics were standing by. The passengers were asked to remain seated, so the paramedics could board and care for the injured. The IRO immediately went aft, as the other FO and I completed the PARKING checklist. The purser and I remained at the top of the jetway for a number of minutes, until both injured FAs agreed to be transported to the hospital. The Purser, FA X (injured foot) and I, exchanged phone numbers. FA X texted me from the hospital, to let me know that she and FA Y, were both being evaluated and treated.

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

B767 flight crew reported that flight attendants were injured due to turbulence during descent.

Time / Day

Date : 201807

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : IAD.Airport

State Reference : DC

Altitude.MSL.Single Value : 2000

Environment

Flight Conditions : VMC

Aircraft

Reference : X

ATC / Advisory.Tower : IAD

Aircraft Operator : Air Carrier

Make Model Name : Widebody Transport

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : GPS

Nav In Use : FMS Or FMC

Flight Phase : Final Approach

Airspace.Class B : IAD

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

Experience.Flight Crew.Total : 17527

Experience.Flight Crew.Last 90 Days : 195

Experience.Flight Crew.Type : 493

ASRS Report Number.Accession Number : 1561371

Human Factors : Workload

Human Factors : Situational Awareness

Human Factors : Confusion

Human Factors : Fatigue

Events

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Inflight Event / Encounter : Unstabilized Approach

Detector.Person : Flight Crew

When Detected : In-flight
Result.Flight Crew : Became Reoriented

Assessments

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

Narrative: 1

During descent into Dulles new ATIS showed a change from ILS 1R to visual 1R and ILS out of service. We changed the brief to "visual backed up with RNP Y 1R" and reviewed MCP actions ie; LVSAFE for FD guidance on the visual approach. Turning base a few miles outside the FAF I asked to First officer (FO) to "un-park" the ILS; believing I would get ghost GS diamonds to help with intercept of final approach. I soon found this was a mistake. Prior to un-parking ILS we had correct "RNAV RNP Y 1R in top left of PFD; as soon as we un-parked the ILS it became ILS 1R. This confused me and in hopes of bring back guidance I asked the FO to reload the RNP approach. This set off a chain of more problems. I delayed descent while the FO programmed the FMC. The FO was a little overloaded with this request as we were in the turn configuring and sent to the Tower frequency all at the same time. The out of service ILS also gave us a false GS saying were low when were not. I quickly got behind the airplane and was rushing to slow and configure in a tailwind that I did not consider at the time. I did verbalize that if we were not stable at 500 feet we would go around. I believe we missed the 1000 foot call; and at 500 feet were on the PAPI configured and stable. The bottom line was it was a poorly flown approach. We debriefed the event at the gate. The takeaways were that: at 2000 feet outside the FAF when we lost approach guidance there were two better options. I could have turned off all FD's thereby putting the throttles in to SPEED MODE and continued the visual approach. The other option was to stay level at 2000 feet and ask the Tower just to vector us around for another approach. Either of these options would have lessened the workload and kept me from being so far behind the airplane. My decision to continue as I did may not have caused an unwanted aircraft state but it certainly did cause an unwanted crew state. I overloaded the FO and was behind the airplane and not totally situationally aware. The factors involved do include the type of flying we do and all that goes with it (long flight, wrong side of clock, poor sleep), but the bottom line is I made a poor decision to continue in the manner we did.

Synopsis

Air carrier Captain reported high workload led to an unstabilized approach to IAD. Reporter cited fatigue as contributing to the event.

Time / Day

Date : 201807

Environment

Flight Conditions : VMC

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B757-200
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : First Officer
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
Experience.Flight Crew.Total : 6513
Experience.Flight Crew.Type : 4505
ASRS Report Number.Accession Number : 1559742
Human Factors : Physiological - Other
Human Factors : Situational Awareness
Human Factors : Fatigue

Events

Anomaly.Deviation - Procedural : Other / Unknown
Detector.Person : Flight Crew
When Detected : Routine Inspection
Result.General : Physical Injury / Incapacitation
Result.General : Work Refused

Assessments

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

Narrative: 1

I'm writing this report as a follow up to my previous reports regarding the emergency that took place. Since the event, I've experienced some trouble sleeping, irritability, anxiety, and overall fatigue and stress that I don't typically experience. I've also had unresolved questions and concerns pertaining to the flight and the emergency. I believe that these

symptoms are a result of the human need to "process" any major life event. Thankfully this event had a very positive outcome. I've spent the majority of my scheduled days off from work seeking help from various sources in an effort to gain answers and restore my health and wellbeing to what it typically is. My sleep is improving, my questions have been answered, and I'm now able to begin answering the questions my family has regarding the event and my subsequent behavior. What I've learned about myself is that the negative effects of adrenaline take a while to leave the body and that time for this to happen is crucial to my wellbeing and ability to move forward in a constructive, positive way. That said, and the fact that after 5 days I'm still experiencing abnormal fatigue and symptoms, I called in sick for my Recurrent Simulator Training. I strongly believe that after a significant event such as this, a pilot should be afforded a period of time off from work to process the events in a healthy way.

Synopsis

B757-200 First Officer reported calling in sick for their recurrent training.

Time / Day

Date : 201807

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : CAK.Airport

State Reference : OH

Altitude.MSL.Single Value : 4000

Environment

Flight Conditions : VMC

Light : Night

Aircraft

Reference : X

ATC / Advisory.Tower : CAK

Aircraft Operator : Air Carrier

Make Model Name : Medium Transport, Low Wing, 2 Turbojet Eng

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Flight Phase : Initial Approach

Route In Use : Vectors

Airspace.Class C : CAK

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Instrument

ASRS Report Number.Accession Number : 1557710

Human Factors : Situational Awareness

Human Factors : Fatigue

Events

Anomaly.Inflight Event / Encounter : CFTT / CFIT

Detector.Automation : Aircraft Terrain Warning

When Detected : In-flight

Result.Flight Crew : FLC complied w / Automation / Advisory

Result.Flight Crew : Took Evasive Action

Assessments

Contributing Factors / Situations : Aircraft
Primary Problem : Aircraft

Narrative: 1

While enroute to CAK, the aircraft was descending through 4,500 MSL to 3,000 MSL while cleared direct to the CABLE Outer Marker. The aircraft had been cleared for a Visual Approach to a Runway 1 and was in communication with CAK Tower. At approximately 4,000 MSL and six miles from CABLE the PM (pilot monitoring) advised his concern that the aircraft's altitude and current configuration were such that it was unlikely to arrive at CABLE configured to execute a stabilized approach. Simultaneously, CAK Tower contacted the aircraft to determine if it would like vectors to continue its descent and extend its final approach course. The PM accepted this offer and CAK Tower subsequently assigned a right turn to 140. A second vector to 190 was then assigned. During the turn to 190 an EGPWS (Enhanced Ground Proximity Warning System) "Caution Terrain" warning was activated. The PF (pilot flying) disengaged autopilot and executed a climb of approximately 400 feet and the alert ceased. The PM notified the Tower of the alert and the altitude adjustment that was made in response to it. The approach and landing was then completed. It is unclear as to why the alert occurred as the aircraft was on vectors and was well above CAK Tower's Minimum Vectoring Altitude. The timing of this event (10.4 hours into the duty day / Leg 3 / at night) serves to emphasize the importance of being aware of the potential for situational awareness to degrade near the end of long duty days. Pilots should always review of any notes contained in the Station Bulletin that relate to the approach during the approach brief.

Synopsis

Air Carrier pilot reported responding to a questionable "caution terrain" EGPWS warning.

Time / Day

Date : 201806

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : DEN.Airport

State Reference : CO

Altitude.MSL.Single Value : 1100

Environment

Flight Conditions : VMC

Aircraft

Reference : X

ATC / Advisory.TRACON : D01

Aircraft Operator : Air Carrier

Make Model Name : Boeing Company Undifferentiated or Other Model

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Final Approach

Airspace.Class B : DEN

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Instrument

Experience.Flight Crew.Total : 10583

Experience.Flight Crew.Type : 639

ASRS Report Number.Accession Number : 1555874

Human Factors : Fatigue

Human Factors : Situational Awareness

Human Factors : Workload

Events

Anomaly.Deviation - Track / Heading : All Types

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Deviation - Procedural : Clearance

Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Returned To Clearance

Result.Flight Crew : Became Reoriented

Assessments

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Procedure

Primary Problem : Human Factors

Narrative: 1

[Our international flight to] DEN was running about 1 hr+ late. Flight is manned as a 3 man crew and fatigue was noticeable on all of us with only a 2hr 40 min break each. We received 3 different arrivals and the last one was MOLTN 3 RNAV Arrival. We planned and briefed the 34R ILS. It was windy conditions but VFR and field was in sight around 13000 feet. In the descent sometime after RAMMS we were told to expect RNAV (RNP) Z 34R. Several speed assignments were given by approach different than published on the arrival. I was the Pilot Flying (PF) and was busy complying with speed and altitude crossings so the Pilot Monitoring (PM) programmed the FMC. PM entered the required entries and we quickly briefed the RNAV (RNP) Z RWY 34R approach. Unfortunately, we missed that the legs pages wasn't sequenced correctly. The ND displayed the RNAV arc with restrictions but a discontinuity was apparently left from MOLTN 3 on page one. We were cleared for the approach near BABAA. When we crossed HIMOM the airplane didn't start down as anticipated. I manually started down and within seconds we crossed MCMUL. Now the airplane doesn't start the expected turn to follow the arc. At this time I disconnected the autopilot and was flying manually to the KUGLN and BASYN fixes. What seemed like an easy approach deteriorated quickly. We were now in Heading Mode on the MCP instead of LNAV as required. Because of the good weather we decided to continue the approach hand flown and intercept the final visually with Approach Mode armed. The final was intercepted and Approach Mode and Glidepath were captured. Once on final the approach and landing was uneventful. Contributing factors: Fatigue, last minute changes to arrivals, speed, altitudes, and the anticipated approach. Busy environment for PF and PM and correct sequencing was missed. High altitude airport. Visibility was good and outside references made us complacent inside. Neither of us had flown this route recently and got caught with an unexpected approach [that was different from what was] advertised on ATIS.

Synopsis

Air carrier First Officer reported a track deviation occurred on arrival into DEN following multiple ATC changes to the arrival clearance. Fatigue was cited as a contributing factor.

Time / Day

Date : 201806
Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : DSM.Airport
State Reference : IA

Environment

Flight Conditions : VMC
Light : Daylight

Aircraft

Reference : X
ATC / Advisory.TRACON : DSM
Aircraft Operator : Air Carrier
Make Model Name : Regional Jet 900 (CRJ900)
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Nav In Use : FMS Or FMC
Nav In Use : GPS
Flight Phase : Final Approach
Route In Use.Other
Airspace.Class C : DSM

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Pilot Flying
Function.Flight Crew : First Officer
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Instrument
ASRS Report Number.Accession Number : 1548230
Human Factors : Fatigue
Human Factors : Confusion

Events

Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Became Reoriented

Assessments

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

Narrative: 1

We briefed and set up for the RNAV 23 into Des Moines (DSM). Des Moines Approach turned us for final inside of HERKY, (the final approach fix for 23) and high. In a rush to stay ahead of the aircraft, I dialed 1,400 feet for the MDA (as briefed) and selected Vertical Speed down. I spun the wheel but my attention was drawn elsewhere and I spun passed the 700-800 FPM and stopped on 1,400 FPM. This created a steeper than needed descent rate. The Captain caught it and said, "Level off you're four red". Soon after the EGPWS, warning "Glideslope" activated. I had already begun to level off when the warning activated. I continued to hold altitude until two white and two red were seen on the PAPI. I then continued a normal approach and landing.

I had already completed a four-day trip and [had been] called in from short call for the fifth day. I had a satisfactory period of rest but was still tired from the previous four days of working. This created some mental sluggishness, which faced with the "out of the norm" approach into Des Moines, put me behind the "mental power curve".

I reacted appropriately to the Captain's commands and the EGPWS warning and held altitude until a correct glide path was re-established. Suggest continuing to foster a culture where it's okay to say that a landing or take off might be outside of your capabilities. Whether it's because of experience or because a pilot is not on top of his game. Continue to teach (with greater emphasis) to Captains and First Officers that ATC commands are not set in stone and if more time to turn, descend, configure the aircraft, etc., is needed then state that to ATC and request vectors.

Synopsis

CRJ-900 First Officer reported using excessive rate-of-descent and consequently the Captain directed a level off just prior to the crew receiving an EGPWS.

Time / Day

Date : 201805

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZZ.Airport

State Reference : FO

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : B767 Undifferentiated or Other Model

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Taxi

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1546652

Human Factors : Fatigue

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Type : 4227

ASRS Report Number.Accession Number : 1546365

Human Factors : Fatigue

Human Factors : Situational Awareness

Events

Anomaly.Deviation - Procedural : Clearance
Anomaly.Ground Incursion : Taxiway
Detector.Person : Air Traffic Control
When Detected : Taxi
Result.Flight Crew : Returned To Clearance
Result.Flight Crew : Became Reoriented
Result.Air Traffic Control : Provided Assistance

Assessments

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

Narrative: 1

Enroute to ZZZ we received our original gate assignment. We briefed the taxi route during the approach briefing and the Captain (CA) were both very familiar with ZZZ airport and taxi routes as we both come here often. We landed and had a short taxi ahead of us. We exited the runway and contacted ground. We were told [to wait]. I read this back and verbalized it to the CA and mentioned something about a gate change. I also noticed that we had a message from the station about a gate change while completing the after landing checklist (must have been inhibited during approach because we didn't receive the "ACARS" EICAS message until after landing). While taxiing in we taxied past K, we stopped the airplane and told ground that we missed K. They asked us to hold short of L while another aircraft moved, we then were instructed to taxi L, B, K to stand. I'm not sure why we missed K but I think it was a combination of confirmation bias and I fatigue. We had expected a certain route and even though it changed we still executed the original plan. I think we were both extremely tired and I honestly may have had a moment of micro sleep at the moment we taxied past K. This was an un-augmented flight that left ZZZ1 at XR00. By the time we were taxiing in it was XA00 body time with no rest or break. I slept well the night before and had an afternoon nap before the flight and I was still wiped out. Unaugmented flights to [Foreign Countries] are easy and safe when they leave ZZZ1 and land [late] body time. But for some reason the company only runs the late night flights without an IRO.

Narrative: 2

We Landed. Since we briefed taxi-in after landing during our approach briefing, I was taxiing to [the] gate, this was our assigned gate. It had been our gate assignment for hours at this point. Short taxi from Exit. Controller might have said Alpha to Kilo but I'm Taxiing aircraft, visualizing how to get to [the] gate. I realize as we pass Kilo that instructions were Alpha, Kilo to gate, but that makes no sense.

At that point a gate change message comes by ACARS, First Officer (FO) states new gate (this after a busy period of after landing flow). I Bring aircraft to stop for clarification. Alpha, Bravo, kilo to [the other] gate. No conflict with any aircraft or vehicle. Taxi aircraft to gate.

Synopsis

B767 flight crew reported that they taxied past the intended taxiway not realizing there was a gate change and due to fatigue.

Time / Day

Date : 201805

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZZ.Airport

State Reference : FO

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC

Light : Night

Aircraft

Reference : X

ATC / Advisory.Ground : ZZZZ

Aircraft Operator : Air Carrier

Make Model Name : B747-400

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Flight Phase : Parked

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1539385

Human Factors : Situational Awareness

Human Factors : Workload

Human Factors : Distraction

Human Factors : Fatigue

Events

Anomaly.Aircraft Equipment Problem : Less Severe

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Ground Event / Encounter : Other / Unknown

Detector.Person : Ground Personnel

When Detected : Aircraft In Service At Gate

Result.Flight Crew : Took Evasive Action

Assessments

Contributing Factors / Situations : Environment - Non Weather Related

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

I was told by ground personnel that the aircraft was rolling. I immediately put my feet on the brakes and they felt very mushy and nothing was happening. The middle observer and I both reached up to turn the number 4 hydraulics to AUX and the aircraft came to an immediate stop and I set the brakes. It happened so quickly I am not sure if the brakes were set prior to me putting my feet on them. I recall being interrupted during my flow at about the parking brake set portion, but also remember starting there and continuing. At the time of the event we had not run any checklist but were just about to. The ground crew asked to remove the chocks and also asked me twice if the parking brake was set. I remember glancing both times and saying yes, but I believe I was going from my memory of setting them and I don't think I properly looked. After engine start I was still a bit flustered from the event and it was very dark and poorly lighted outside. I initially did not do the best job following the ground crew hand signals until things settled down. Once out of the parking ramp, the remainder of the flight went uneventfully.

I just read the special interest items from safety last week and thought to myself I have good habits, this won't happen to me. Well, it did! Luckily no one was injured and nothing was damaged. The observers on this flight had flown a majority of the previous leg so that we could be well rested for the following late night flight after a 3 hour turn. I laid in the bunk for all my rest period but was unable to sleep. I did feel adequately rested for the flight as I had slept great prior to wake up. I had been flying a lot over the past several days and made two crossings over the Atlantic. I believe after the long duty day and dark hours I could have been susceptible to making errors. I know I was not feeling at my best A game. I have learned the hard way the importance of taking your time and properly ensuring that everything is set the way that it should be and not how you think it is during late hours and a long day. When the ground crew asked me twice if the parking brake was set I should have gotten a second clue to look harder. My only suggestion to the ground crew is to have perhaps have said after the first time that he does not see the brakes on light by the nose gear. That may have given me the clue to look again harder. Sometimes we look and don't see, and that is a very dangerous habit to fall into.

Synopsis

B747-400 Captain reported the aircraft started rolling while at the parking ramp.

Time / Day

Date : 201804

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 3

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase.Other

Person

Reference : 1

Location Of Person : Hangar / Base

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

Experience.Flight Crew.Total : 8981

Experience.Flight Crew.Last 90 Days : 200

Experience.Flight Crew.Type : 2834

ASRS Report Number.Accession Number : 1538375

Human Factors : Fatigue

Events

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Deviation - Procedural : FAR

Detector.Person : Flight Crew

When Detected : Pre-flight

Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Procedure

Primary Problem : Procedure

Narrative: 1

Just wanted to alert you to a heck of a fatigue issue that needs to be addressed. As you may know, the flight has recently undergone a radical shift from a [midday] report/takeoff time to a [late night] report/takeoff. This later start time has a huge impact on crew fatigue and safety because of FAR 117's mandatory 2 hours of rest in the last half of the flight for the Pilot Flying (PF). In order for the PF to get the FAR 117 required rest, the Pilot Flying now has to stay up all night against their normal sleep rhythm (using whatever amounts of caffeine and/or sugar necessary in order to stay awake), then try to sleep when their body clock says they should be awake (fighting whatever amounts of caffeine and/or sugar they had just ingested in order to stay awake), then land the aircraft in any kind of weather/mechanical conditions with a language barrier after bouncing around that no-sleep/sleep cycle. You could not produce a better recipe for fatigue and poor decision making if you tried.

I am now flying ZZZ1 - ZZZ2, so let me give you an example of the problem. Foreseeing this issue, I attempted to contact [the] Captain via company email. This is the first time I have flown with [this] Captain and I gave him my opinion of the rest situation, asking him if he would like to be PF on the way over or PF on the way back. He said he would fly the ZZZ1-ZZZ2 leg, since he was new to the 787 and wanted to land in ZZZ2. I informed [the] Captain I would be taking first break to stay on my normal sleep pattern and, after a short discussion pro/con, he agreed, and I told him I would be calling the IRO's to let them know so they could plan their rest.

Since he was the senior IRO I first called [another] IRO, informed him that I would be taking first break, and since he was the senior IRO he could pick which break he wanted. [The] First Officer (FO) was upset by my call, saying normal procedure was to give 3 days notice of a change in breaks, which, I had never heard of and is impractical, as shown by the other IRO dropping the trip.

Upon arrival in ZZZ1, [the] Captain informed me that [the] FO had instead called him and expressed his strong disagreement with my decision, asked for my side of the story, and asked why I did not want to take second break, as is normally done. I reminded him of our previous conversation that as Pilot Monitoring (PM) I was allowed to take my break at any time I wanted, and that I believed it would be unsafe for both of us to stay awake all night against our normal body clocks and that it would be safer for me to sleep at my normal time, thus my decision to take first break. I informed [the] Captain that I had given the FO 34 hours of notice of my intentions and, unless he told me not to, I intended to stay with my plan of taking first break. [The] Captain and I discussed other options, including split breaks, but ultimately decided to keep the original plan of me taking first break, while [the] Captain took second. Shortly after completing our discussion [the] FO arrived and, attempting to clear the air, I asked if there was anything we need to discuss about the breaks and he said No. We then proceeded to execute the ZZZ1 - ZZZ2 flight.

As planned, I took first break, going to the bunk only a little past my normal domestic bedtime. I woke a little earlier than my normal non-work wakeup but I felt well rested. I relieved [the] FO and was briefed by [the] Captain who informed me that he felt very fatigued after staying up all night against his normal sleep pattern.

Upon returning to the flight deck after his break [the] Captain said he had not been able to get any good rest, which was not unexpected, and showed considerable evidence of fatigue, including sleep inertia, poor comprehension, and attention. The arrival into ZZZ2 was uneventful and despite his fatigue and newness to the aircraft, [the] Captain flew a good approach in VFR conditions.

I believe FAR 117 is wrong mandating that the PF take their 2 hours of rest in the last half of the flight, and the new ZZZ1 - ZZZ2 leg is a perfect example of why there should be some flexibility and allow the pilots to schedule themselves.

Synopsis

Air Carrier First Officer reported a disagreement with the FAR Part 117 requirement for long haul flights as it pertains to required rest breaks.

Time / Day

Date : 201804

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Light : Dusk

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : EMB ERJ 170/175 ER/LR

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Parked

Component

Aircraft Component : Generator Drive

Aircraft Reference : X

Problem : Malfunctioning

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Not Flying

Function.Flight Crew : First Officer

Experience.Flight Crew.Total : 4387

Experience.Flight Crew.Type : 2573

ASRS Report Number.Accession Number : 1535961

Human Factors : Communication Breakdown

Human Factors : Troubleshooting

Human Factors : Fatigue

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Maintenance

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain
Function.Flight Crew : Pilot Flying
ASRS Report Number.Accession Number : 1535962
Human Factors : Troubleshooting
Human Factors : Fatigue
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Maintenance

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : Maintenance
Detector.Automation : Aircraft Other Automation
Detector.Person : Flight Crew
When Detected : Aircraft In Service At Gate
Result.General : Maintenance Action
Result.General : Flight Cancelled / Delayed
Result.Flight Crew : FLC complied w / Automation / Advisory

Assessments

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

Narrative: 1

The inbound flight was delayed about an hour, so time constraints already pushed us to be thorough but quick. We were made aware that the APU Gen was deferred and planned to start an engine at the gate accordingly. Having the APU Gen deferred was already creating an abnormal operation. Once we got clearance to start the engine the captain elected to start engine 2 first. The start occurred normally and it was verified that the engine (IDG 2) had taken the electrical load properly. At that point the captain deselected the GPU, at which point screens shut off and numerous EICAS messages appeared. We concluded there was a possible power transfer issue. Later suspected it to be an IDG 2 fail. At this point we proceeded to contact maintenance control. After a lengthier discussion maintenance control instructed us to start both engines at the gate prior to disconnecting the GPU, in an attempt to eliminate the GPU from the equation of the IDG fail. This seemed abnormal to me but I assumed that because the instruction was from maintenance control, it must be ok. After attempting the dual engine start and before deselecting the GPU button, the IDG 1 failed. It was at this point we finally turned to the MIAC and properly addressed the issue. After following the MIAC we proceeded to call maintenance control and have the issue sorted.

Having known that the day was starting with a delayed inbound flight and a more abnormal MEL, we should have been more cognizant of the possible errors already creeping up. The failure of IDG 2 on the first start up took me by surprise and my first thought was that the GPU had failed before we had a complete power transfer. I didn't realize it was the IDG, and that thought failed to create a mindset to jump into the MIAC, which it should have. Secondly, when maintenance control instructed us to start 2 engines at the gate I should have been more vocal about my suspicions on that procedure. The

failure of IDG 1 was a definitive EICAS message which at that point it became clear what our actions were next.

Narrative: 2

The aircraft arrived at the gate at XC:52 local time (Not the XA:52 as indicated by ZZZ operations at ZZZ in email). The aircraft had a deferred APU Generator. During my review of the logbook I noted an IDG 1 OFF BUS EICAS message had occurred multiple times prior to our flight in the preceding 2 days.

At XD:22 we blocked out and prepped for engine start at the gate. We started the #2 engine for operational purposes, and then after the #2 generator accepted the load sharing, we disconnected the GPU via the button in the overhead panel. We experienced 3 display units turning off and multiple EICAS messages. To preserve the batteries we shut down the engine and contacted MXC. MXC directed a 1 minute power reset at the gate. Subsequently the FO brought an IDG 2 OFF BUS message to my attention, and later realized that this isn't per procedure to power reset, we both wrote reports regarding this inadvertent lack of MIAC use.

During the subsequent start we had a clear indication of an IDG 1 OFF BUS and contacted MXC. We wrote up the discrepancy and handed the aircraft over to local maintenance. About 45 minutes later a local mechanic arrived at the aircraft and began troubleshooting. He took approximately one hour before he told us he wanted to do an engine run at the gate and needed us to assist. We performed an engine run at the gate using a portable GPU and noted no abnormalities. While waiting for the ramp agents to return to the aircraft and while they removed some/all of the passenger bags, I contacted the on duty chief pilot. During the brief discussion we talked about various scenarios/options and how to proceed. The mechanic wanted to do a full 2 engine test, which required pushing back from the gate.

We then coordinated with ground and operations to start one engine at the gate, and then pushback and start the second engine. We did a functional test of the generators. This concluded at approximately XG:40 local time. While the mechanic wrote his conclusion in the logbook, I asked the gate agent if there was an food available at the airport, to which replied no. I then discussed with the chief pilot the results, we reviewed the logbook over the phone in detail so he could understand the full picture. While we didn't disagree with the local mechanic's assessment, there was more to the picture. This call took approximately 30 minutes. After that I discussed with my crew the scenario and addressed our concerns. The first officer and I both took into account the recurring issue, the fact that it's happened >3 times in 2 days and at multiple airports, it was night-time, the lack of diversion airports enroute to [destination], the pressure we received from the gate agent to fly, and the lack of food. I then called the on duty chief pilot back and concluded that I was fatigued. It had been over 8.5 hours since I had last eaten, and there was no food options available at that time. I was tired, had a headache, and I could tell my alertness was degraded as a result of a lack of nourishment. I then contacted crew scheduling to coordinate the fatigue hotel and they said they would coordinate with local operations.

From the time we arrived at the aircraft until I called out fatigued (which was approximately 5 hours), there was only a ~20 minute time period that I wasn't coordinating with dispatch, gate agents, operations, maintenance, or scheduling. At no time was there an intentional delay of the flight.

Synopsis

EMB-175 flight crew reported electrical issues on start up which resulted in a lengthy maintenance procedure. With the addition of time pressure from gate agents, the Captain concluded the event with a fatigue call.

Time / Day

Date : 201804

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : WSSS.Airport

State Reference : FO

Relative Position.Angle.Radial : 023

Relative Position.Distance.Nautical Miles : 2

Altitude.AGL.Single Value : 1500

Environment

Flight Conditions : VMC

Light : Night

Aircraft : 1

Reference : X

ATC / Advisory.Tower : WSSS

Aircraft Operator : Air Carrier

Make Model Name : B767-300 and 300 ER

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Cargo / Freight

Nav In Use : FMS Or FMC

Flight Phase : Initial Climb

Route In Use.SID : VMR 5A

Aircraft : 2

Reference : Y

Make Model Name : Any Unknown or Unlisted Aircraft Manufacturer

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

Experience.Flight Crew.Total : 14900

Experience.Flight Crew.Last 90 Days : 40

Experience.Flight Crew.Type : 5900

ASRS Report Number.Accession Number : 1535684

Human Factors : Workload

Human Factors : Communication Breakdown

Human Factors : Fatigue

Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : ATC
Analyst Callback : Attempted

Person : 2

Reference : 2
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : First Officer
Function.Flight Crew : Pilot Not Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Multiengine
Experience.Flight Crew.Total : 13000
Experience.Flight Crew.Last 90 Days : 100
Experience.Flight Crew.Type : 3000
ASRS Report Number.Accession Number : 1535683
Human Factors : Workload
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : ATC

Events

Anomaly.Deviation - Speed : All Types
Anomaly.Deviation - Track / Heading : All Types
Anomaly.Deviation - Procedural : Clearance
Anomaly.Inflight Event / Encounter : Wake Vortex Encounter
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Returned To Clearance

Assessments

Contributing Factors / Situations : Environment - Non Weather Related
Contributing Factors / Situations : Procedure
Primary Problem : Ambiguous

Narrative: 1

During initial climb through approximately 1,500 feet, we encountered wake turbulence from the preceding aircraft that caused the aircraft to bank approximately 10-15 degrees to the right. I was the Pilot Flying (PF) and first guarded the controls, but the roll seemed like it was going to continue and I decided to not let it go further, so I disengaged the Autopilot (A/P) to correct the flight path. We were very busy at this stage of flight with a clearance and radio call from our initially assigned 3,000 feet to a new clearance to climb 6,000 feet. We were also in the process of cleaning up the flaps to flaps 1 and had a 230 knot speed restriction until above 4000 feet on the WSSS VMR 5A SID. Believing we were clear of the wake turbulence, we tried to reengage the A/P but it disconnected, so I continued to fly. We proceeded to select flaps up on schedule as normal with our airspeed increasing toward clean maneuvering speed of 226 knots, we then encountered wake turbulence a 2nd time.

After it smoothed out, we again tried to reengage the A/P, but it disconnected or didn't

engage, I continued to fly the airplane. We then encountered wake turbulence a third time and a brief stick shaker occurred (1 sec) as we were approximately 10 knots under our clean maneuvering speed of 226 and attempting to accelerate to no greater than 230 knots per the SID. Of course there was also a lot going on with the A/P disconnect warnings sounding twice, but the aircraft was under control, and I did not observe that I was too close to the Pilot Limit Indicator (PLI) until the shaker sounded. In fact, it seemed to me that the PLI disappeared at or near this point in the climb, and came back on simultaneously with the brief shaker - at least that's what I thought I saw. I quickly recovered from the shaker and we waited a bit before reattempting to engage the A/P, which we did successfully.

Aside from the brief warning that occurred while in turbulence and a less than perfect lateral track on the SID, I felt that the aircraft was in control throughout the event. I feel the momentary stick shaker was likely the combination of being 10 knots slower than clean maneuvering speed at a heavier weight, and the wake turbulence causing a sudden change in angle of attack. In retrospect, maintaining flaps 1 until clear of the turbulence might have worked better, but there was a lot going on in the moment, and I thought we were clear of the turbulence after each encounter so I continued to fly the normal flap cleanup profile while mindful to not exceed 230 knots. The 230-knot restriction played a part in my reluctance to accelerate too quickly to 226 and thus may have also played a part in why I was a bit slow as we hit the last wake turbulence. I feel we did the best we could given the complexities of the situation. As a side note to my recollection, the Tower did not advise us we were behind a heavy, and I was not aware given that it was dark as we taxied. Fatigue is always an issue flying international with multiple circadian flips.

Narrative: 2

During initial climb out, we encountered wake turbulence from the preceding aircraft, so the Captain disconnected the autopilot to recover from the induced roll. While recovering the aircraft from the third separate wake turbulence encounter in the initial climb out, we experienced a very brief stick shaker (1 sec) caused by a sudden change of angle of attack (AOA) associated with the wake turbulence. During initial climb through approximately 1,500 feet, we encountered wake turbulence from the preceding aircraft that caused the aircraft to bank approximately 10-15 degrees to the right.

I was the Pilot Monitoring and monitored the Captain, but the roll seemed like it was going to continue and he decided to not let it go further, so he disengaged the autopilot to correct the flight path. We were very busy at this stage of flight with a clearance and radio call from our initially assigned 3,000 feet to a new clearance to climb 6,000 feet. We were also in the process of cleaning up the flaps to flaps 1 and had a 230 knot speed restriction until above 4000 feet on the WSSS VMR 5A SID. Believing we were clear of the wake turbulence, we tried to reengage the Autopilot (A/P) but it disconnected, so the Captain continued to fly.

We proceeded to select flaps up on schedule as normal with our airspeed increasing toward clean maneuvering speed of 226 knots, we then encountered wake turbulence a 2nd time. After it smoothed out, we again tried to reengage the A/P, but it disconnected or didn't engage, the Captain continued to fly the airplane. We then encountered wake turbulence a third time and a brief stick shaker occurred (1 sec) as we were approximately 10 knots under our clean maneuvering speed of 226 and attempting to accelerate to no greater than 230 knots per the SID. Of course there was also a lot going on with the A/P disconnect warnings sounding twice, but the aircraft was under control, and I did not observe that we were too close to the Pilot Limit Indicator (PLI) until the shaker sounded. In fact, it seemed to me that the PLI disappeared at or near this point in the climb, and

came back on simultaneously with the brief shaker - at least that's what I thought I saw.

The Captain quickly recovered from the shaker and we waited a bit before reattempting to engage the A/P, which we did successfully. Aside from the brief warning that occurred while in turbulence and a less than perfect lateral track on the SID, I felt that the aircraft was in control throughout the event. I feel the momentary stick shaker was likely the combination of being 10 knots slower than clean maneuvering speed at a heavier weight, and the wake turbulence causing a sudden change in AOA. In retrospect, maintaining flaps 1 until clear of the turbulence might have worked better, but there was a lot going on in the moment, and I thought we were clear of the turbulence after each encounter so we continued to fly the normal flap cleanup profile while mindful to not exceed 230 knots. The 230 knot restriction played a part in our reluctance to accelerate too quickly to 226 and thus may have also played a part in why we were a bit slow as we hit the last wake turbulence. I feel we did the best we could given the complexities of the situation. As a side note, to my recollection, the Tower did not advise us we were behind a heavy, and I was not aware given that it was dark.

Synopsis

B767-300 flight crew reported speed and track deviations occurred following a wake turbulence encounter departing WSSS.

Time / Day

Date : 201804

Local Time Of Day : 0001-0600

Environment

Light : Dawn

Aircraft

Reference : X

Make Model Name : No Aircraft

Flight Phase : Parked

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1533137

Human Factors : Fatigue

Events

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Deviation - Procedural : FAR

Detector.Person : Flight Crew

When Detected : Pre-flight

Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Procedure

Primary Problem : Procedure

Narrative: 1

I am so exhausted. I am beyond tired. But for fear of denial of a fatigue call I'm going to fly fatigued. I have got minimum rest for 2 nights now [and] haven't been able to sleep at the hotels. I had issues with my hotel last night. I am terrified to call in fatigued because it will be denied and then will count as a sick call and I only have one of those because [my airline] would rather us fly sick and fatigued. I don't know what else to [say].

[Suggestions] Don't penalize crew members for calling in fatigued or sick.

Synopsis

Air Carrier Captain reported he intended to fly even though he was fatigued, due to fear of his airline refusing to accept his fatigue claim.

Time / Day

Date : 201804

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.MSL.Single Value : 2000

Environment

Flight Conditions : IMC

Weather Elements / Visibility.Visibility : 10

Light : Daylight

Ceiling.Single Value : 500

Aircraft

Reference : X

ATC / Advisory.TRACON : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : Regional Jet 900 (CRJ900)

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Nav In Use : GPS

Flight Phase : Initial Approach

Route In Use : Vectors

Airspace.Class D : ZZZ

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Check Pilot

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Multiengine

ASRS Report Number.Accession Number : 1532610

Human Factors : Fatigue

Human Factors : Situational Awareness

Human Factors : Distraction

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Pilot Not Flying
Function.Flight Crew : First Officer
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Instrument
ASRS Report Number.Accession Number : 1532609
Human Factors : Situational Awareness

Events

Anomaly.Deviation - Altitude : Excursion From Assigned Altitude
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : Clearance
Anomaly.Inflight Event / Encounter : CFTT / CFIT
Detector.Person : Flight Crew
Detector.Person : Air Traffic Control
When Detected : In-flight
Result.Flight Crew : Returned To Clearance
Result.Flight Crew : Became Reoriented
Result.Air Traffic Control : Issued Advisory / Alert

Assessments

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

Narrative: 1

We were descending for approach. My Initial Operator Experience (IOE) Captain upgrade student picked up ATIS. Visibility 10 SM and a few clouds at 2,100 ft., which was what had been forecast. I briefed a visual approach to Runway 30 backed up with the RNAV GPS Z Runway 30. (ILS 30 OTS). As we checked in with the final Approach Controller we were told [a new] ATIS was current. [First Officer] picked up [new ATIS] and briefed me that the ceiling had gone down to 500 feet BKN. I quickly briefed the full RNAV approach and [we] were given a vector to the south.

We were eventually given a descent to 3,000 feet and cleared for the approach. As we approached, the snowflake began to descend from the top of the PFD and it was at this point I lost situational awareness and was thinking I would be cleared to descend to 1,600 feet. on the snowflake. I began a descent and didn't realize we were not yet at [the descent point] until descending thru 2,000 feet. I then began a climb back to 3,000 ft. and shortly thereafter were informed by the Approach Controller that he had an altitude alert and told us to confirm [we would cross a waypoint] at 3,000 feet. We acknowledged we were returning to 3,000 feet. and continued the approach.

We ultimately failed to break out at minimums and executed the missed approach. We took vectors back around and on our second attempt, broke out at minimums, and landed.

I can only say that fatigue may have been a factor in doing something so stupid. It was the final leg of a 4-leg day. We had been delayed on maintenance the night before and were reduced to a 10-hour layover with a late show the following day. I only got about 6 hours sleep and had been doing IOE with a different student until [this] flight. Additionally, on the preceding leg, we got a wind shear warning accompanied by moderate to severe

turbulence shortly after takeoff, which may have contributed to still being somewhat distracted.

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

CRJ-900 flight crew reported ATC issued a low altitude alert when they descended below charted altitude on the approach.

Time / Day

Date : 201803
Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.MSL.Single Value : 3000

Environment

Flight Conditions : VMC
Weather Elements / Visibility : Turbulence
Weather Elements / Visibility.Visibility : 5
Light : Daylight
Ceiling.Single Value : 5000

Aircraft

Reference : X
ATC / Advisory.TRACON : ZZZ
Aircraft Operator : Air Carrier
Make Model Name : B767-300 and 300 ER
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Cargo / Freight
Flight Phase : Initial Approach
Airspace.Class B : ZZZ

Component

Aircraft Component : Flap/Slat Indication
Aircraft Reference : X
Problem : Malfunctioning

Person : 1

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
Experience.Flight Crew.Total : 17000
Experience.Flight Crew.Last 90 Days : 40
Experience.Flight Crew.Type : 13500
ASRS Report Number.Accession Number : 1523764
Human Factors : Fatigue
Human Factors : Situational Awareness
Human Factors : Troubleshooting

Human Factors : Workload
Human Factors : Confusion

Person : 2

Reference : 2
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Pilot Not Flying
Function.Flight Crew : First Officer
Qualification.Flight Crew : Air Transport Pilot (ATP)
Experience.Flight Crew.Last 90 Days : 90
ASRS Report Number.Accession Number : 1523765
Human Factors : Workload
Human Factors : Troubleshooting
Human Factors : Fatigue
Human Factors : Confusion
Human Factors : Situational Awareness

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Deviation - Speed : All Types
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : Weather / Turbulence
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Detector.Automation : Air Traffic Control
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
Result.Flight Crew : FLC complied w / Automation / Advisory
Result.Flight Crew : Executed Go Around / Missed Approach
Result.Air Traffic Control : Issued Advisory / Alert
Result.Air Traffic Control : Provided Assistance

Assessments

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

Narrative: 1

Descent and arrival, vectors to final approach. Speed breaks out for speed reduction in light to moderate turbulence. We experienced a momentary stick shaker at the same time flaps were being moved from 20 to 25. This is when we got the master caution for TE Flaps Disagree and LE Slats Disagree. We executed a missed approach, ran the proper checklist and took vectors around for landing. [ATC was advised] at this time also.

I must add that another missed approach was executed from this approach because in the process of the flap checklist, stress and fatigue of the day, we failed to run the landing checklist and missed the gear. That was self-correcting at about 1,000 feet with the GPWS

warning and the Tower calling for go-around/no gear. We went around, took vectors for another approach, and landed without incident.

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

B767-300 flight crew reported that they got the master caution for TE Flaps Disagree and LE Slats Disagree.

Time / Day

Date : 201803

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : IMC

Weather Elements / Visibility : Rain

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : B737 Undifferentiated or Other Model

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Parked

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Total : 20000

Experience.Flight Crew.Last 90 Days : 200

Experience.Flight Crew.Type : 10000

ASRS Report Number.Accession Number : 1523092

Human Factors : Other / Unknown

Human Factors : Fatigue

Events

Anomaly.Aircraft Equipment Problem : Less Severe

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Inflight Event / Encounter : Weather / Turbulence

Detector.Person : Flight Crew

When Detected : Pre-flight

Result.General : Release Refused / Aircraft Not Accepted

Result.General : Work Refused

Assessments

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

Narrative: 1

During preflight planning of the flight plan and the maintenance log, the First Officer and I determined that with the combination of aircraft systems inoperative, complex MEL requirements, fatigue (third flight of the duty period and the late hour of the day), departure, enroute and destination weather and forecast, that it was not safe to continue to operate with this plan and this aircraft. Initially this was met with complete professionalism and concurrence as the PIC had made a final decision. I was then approached by line maintenance requesting my explanation for the aircraft refusal and their reiterating of the MEL and that it was legal to fly. This was followed by Customer Service reminding me that the flight was sold out and all of these people needing to get to their destination. As professional pilots, we always understand the desire for everyone to want to get where they are going and the need for the company to operate all scheduled flights. I am required and expected to make sound decisions based on my three decades of experience to maintain a safe operation. It is a responsibility I enjoy and, at the same time, take very seriously. This was a clear instance of pilot pushing by various entities and contrary to the core of [our company's] operating parameters.

Synopsis

B737NG Captain reported being subjected to "pilot pushing" pressure to depart with an unwanted aircraft.

Time / Day

Date : 201802
Local Time Of Day : 0601-1200

Place

Locale Reference.ATC Facility : T75.TRACON
State Reference : MO
Altitude.MSL.Single Value : 3000

Environment

Flight Conditions : Mixed
Weather Elements / Visibility.Visibility : 10
Light : Daylight
Ceiling.Single Value : 2000

Aircraft : 1

Reference : X
ATC / Advisory.TRACON : T75
Aircraft Operator : Air Carrier
Make Model Name : B737-700
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Mission : Passenger
Flight Phase : Final Approach

Aircraft : 2

Reference : Y
ATC / Advisory.TRACON : T75
Make Model Name : Beechjet 400
Crew Size.Number Of Crew : 2
Flight Phase : Final Approach

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : First Officer
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1521128
Human Factors : Communication Breakdown
Human Factors : Fatigue
Human Factors : Physiological - Other
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Regained Aircraft Control
Result.Flight Crew : Executed Go Around / Missed Approach
Result.Flight Crew : Became Reoriented
Result.Air Traffic Control : Provided Assistance

Assessments

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

Narrative: 1

Our day started with a wakeup for a [early flight]. I did not have anything to eat prior to departure due to the early hour. The first two legs went fine. After the first leg we were notified of an unscheduled aircraft swap. We executed the swap and departed approximately 21 minutes late. The Captain offered me the opportunity to get something to eat, but due to the swap I elected to wait until we arrived at STL. On the arrival into STL we became aware that we were following a Beechjet that was giving ATC some headaches. He was assigned .78 Mach and later admitted to have been flying .72 Mach. As a result we were slowed and given vectors off course during the descent. Once we were vectored to join the ILS we were told to slow to our final approach speed. I called for flaps 30 and we ran the Before Landing Checklist. The autopilot and autothrottles were engaged and I was watching the Beechjet fall within the 2.5 mile arc on the TCAS.

ATC issued go-around instructions. They told us to turn right to a heading of 360 and maintain 3000 feet. I spun the heading knob to 360 and pressed HDG SELECT, but nothing happened. The aircraft remained in the approach mode. Rather than try and deselect approach, I disconnected the automation and manually turned the aircraft to 360. I then asked the Captain to reset the flight directors and, when he could, to give me HDG SELECT and V/S of about 500 fpm climb back to 3000 feet. He complied and at that time prompted me, "Flaps 15?" "Positive rate?" That snapped me back into the Green (or at least Yellowish Green). I realized that even though we were at 3000 feet, we were still fully configured and needed to execute a normal go-around. We finally began to clean up.

The Captain had to say "getting a little slow" once as we transitioned from my botched missed approach to the standard missed approach profile. I don't believe we went below target, but we may have been between target and VREF for a moment. Needless to say I was embarrassed and apologetic. I don't know why it didn't occur to me to just execute a normal missed approach. The Captain asked if I knew the callouts/profile and I do. I can't explain why I didn't execute them as we are trained. Possible contributing factors: 1. Combination of being sleepy from the early wake up and the fact that I hadn't eaten anything. 2. The Captain and I weren't really getting along very well. By the third day of the trip we were really just doing checklists and callouts and were not having any sort of cockpit conversation. I don't know if this could have impacted the way we were working together, but I suppose it's worth mentioning.

Synopsis

B737 First Officer reported incorrectly executing an ATC assigned missed approach due to being fatigued.

Time / Day

Date : 201802

Environment

Light : Night

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : Commercial Fixed Wing
Crew Size.Number Of Crew : 4
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Flight Phase : Cruise

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : First Officer
Function.Flight Crew : Pilot Flying
Function.Flight Crew : Relief Pilot
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
ASRS Report Number.Accession Number : 1516729
Human Factors : Fatigue
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Flight Deck / Cabin / Aircraft Event : Other / Unknown
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Person : Flight Crew
Were Passengers Involved In Event : Y
When Detected : In-flight
Result.General : None Reported / Taken

Assessments

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

Narrative: 1

The crew (all four) had been assigned to this trip for several days. I received no notification from the Captain of a break schedule different than a 50/50 split - as recent guidance has suggested. Normally if I am told that I will have a short 1st break (less than 5 hours) as the Relief First Officer (IRO), I take a nap before the night time departure. In the absence of such notification I did not take a nap.

At operations I became aware that the flying Captain and First Officer (FO) had just arrived shortly before show time and had not taken a nap. During flight planning the Captain did not discuss breaks and left for the airplane saying "he had to make a phone call."

Boarding went quickly and we were pressed to push back early, still hadn't discussed breaks.

During climb out the Captain turned to me and asked if I was figuring out the breaks - he said the relief crew will have a 4 hour break first break. I mentioned that I had no notification of a split break schedule and wasn't prepared for a short break. He said he doesn't do that anymore (notifying the crew). Then he said we should just go back and he would figure the breaks.

It took me awhile to fall asleep and it wasn't a good sleep. I was asleep when the flying pilots woke me up for a crew changeover (approximately 3.5 hours after I had laid down to sleep). I think I may have gotten about 2 hours of sleep.

I felt quite tired when getting back into the cockpit and this did not improve after drinking coffee and getting up for several bathroom breaks. At one point I caught myself doing a "head bob" and looked over to see that the relief Captain's eyes were closed. It was extremely difficult to stay awake for the 7.5 hour shift as the "flying pilots" took their break - with such a short inflight break before resuming duties on the flight deck and a flight in complete darkness/nighttime. Both the relief Captain and I noticed that we were having trouble speaking. The noticeable fatigue became worse with every hour until we were relieved after 7.5 hours on the flight deck.

Synopsis

Air carrier Relief Pilot reported being fatigued enroute due to a short rest period in flight due to a breakdown of CRM.

Time / Day

Date : 201802

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : FNT.Airport

State Reference : MI

Altitude.MSL.Single Value : 3000

Environment

Flight Conditions : VMC

Weather Elements / Visibility : Snow

Weather Elements / Visibility : Turbulence

Light : Night

Aircraft

Reference : X

ATC / Advisory.TRACON : FNT

Aircraft Operator : Air Carrier

Make Model Name : Medium Transport, Low Wing, 2 Turbojet Eng

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Initial Approach

Airspace.Class C : FNT

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1516175

Human Factors : Training / Qualification

Human Factors : Workload

Human Factors : Fatigue

Human Factors : Situational Awareness

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1516179
Human Factors : Situational Awareness
Human Factors : Workload

Events

Anomaly.Deviation - Speed : All Types
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : Weather / Turbulence
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Anomaly.Inflight Event / Encounter : Fuel Issue
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Became Reoriented

Assessments

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

Narrative: 1

On our descent through approximately 8,000 ft we experienced moderate turbulence and windy conditions along with snow. The winds continued to become very gusty and seemed to be worse than advertised. On the final approach an additional 5 kts was added to Vref but airspeed continued to fluctuate. The decision was made to continue due to a late night flight, two aircraft behind us on final, and tower was closing for the night. The weather conditions varied and with lower than planned fuel due to an hour and fifteen minute long wait for de-ice prior to takeoff we just wanted to get the aircraft on the ground at Flint.

The cause was due to turbulent and gusty wind conditions. The winds were the most that the PF had experienced during their time at [Company].

In the future the more experienced pilot should be the one flying. A decision that both pilots need to recognize and make. I would also say that continued exposure to wind shear in sim sessions would help mitigate situations such as this one. We were also not given any extra fuel for the deicing process, thankfully we asked for more once we realized we would be de-icing but I think more contingency fuel should always be added to late night flights to outstations this time of year for unpredictable weather conditions.

Narrative: 2

On approach into FNT it got a little bumpy. It was snowing at our departure airport. I called and added 500 lbs of fuel because of the snow. Our dispatcher had only planned for standard taxi fuel. ACARS was deferred. We sat on the ground for 1hr 15 min before we took off ([approximately] 1hr flight). I was flying with a newer First Officer who had a little more than 100 hrs. I had asked if they had 100hrs due to our company's limitations in the SOP. Snow showers were possible at our time of arrival and runway conditions reported 5/5/5. We departed at a little under initial release fuel 5300 lbs. The First Officer was the pilot flying. On descent we started to get bounced around at 3000-4000 ft. We were given a cleared approach and intercepted our final course inbound. The First Officer called for flaps 8 then 20 and I selected them. Airspeed began to decrease and I called "speed" "speed" we got about 10 knots slow at one point but eventually became stable again. Around a 3 mile final fully configured we were still getting bounced around pretty good. Landing on runway 27, Tower reported wind 220 at 22. I should have just taken controls at that time but didn't have time to calculate the crosswind. There were 2 other planes

getting vectored around for approach. It was snowing. We would be landing with 1800 lbs of fuel. And the wind had dramatically increased from what we had planned. On short final we got a sink rate however the sight picture still looked fine and I think it occurred due to the ride conditions. PAPI was also out of service.

Got the plane under control then received a brief stick shaker. We should have gone around. Our low amount of fuel, and the other aircraft getting vectored behind us detoured me from making a go-around call. Tower and approach were also closing and I did not want to take a further delay getting handed off to center. We landed uneventfully and I had helped get the plane on the ground by adjusting proper rudder correction and helping with my hand on the yoke to counter the crosswind. We taxied back to the gate and debriefed on things we should have and would have done differently and how we successfully got the plane on the ground.

Cause of event: lack of experience and lack of good judgment. Contributing factors: inexperienced flight crew member. Lack of fuel. Strong unforecasted winds. PAPI out of service. First officer's 4th split duty in a row. Night. Tower was closing shortly.

Overall I should have took controls the first time the speed had to be called out. I let my guard down and trusted the abilities of my First officer after seeing the takeoff and climb out. Another contribution may be that I generally fly with more experienced First Officer's. Lately the pilots coming out of the training center seem to not know how to land a plane yet fly a visual approach. All they know is call outs and don't use their brain. This is not the first time I've had to help coach my First Officer on how to land. Last night I learned my lesson by trusting the flying abilities of my First officer. I will be on a heightened awareness on speed and control and be sure to debrief anything negative I see. More than before. Instead of uploading only 500 lbs maybe 1000 lbs would have been best. Or added an alternate. If a go around was initiated we would have landed with minimum to emergency fuel and it just didn't seem like a good idea with the conditions we faced.

Synopsis

Air carrier flight crew reported fuel issues during approach and landing in weather/turbulence that was worse than forecasted.

Time / Day

Date : 201802

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B777-300
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger

Component

Aircraft Component : Aircraft Furnishing
Aircraft Reference : X
Problem : Design

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1515991
Human Factors : Fatigue

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Flight Deck / Cabin / Aircraft Event : Other / Unknown
Detector.Person : Flight Crew
When Detected : In-flight
When Detected : Routine Inspection
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Aircraft
Primary Problem : Aircraft

Narrative: 1

I've now been on the 777 exclusively flying the -300. I think I can say categorically that the bunk, in a word, sucks. It is virtually impossible to get adequate rest for the following reasons:

- 1.)The mattress is as hard as a slab of granite
- 2.)There is no airflow in the sleep pods and the eyeball air is either weak or non-existent
- 3.)The temperature in the sleep pods is uncontrollable. No matter what temperature is set,

the ambient temperature is at least 75deg. If the curtains are completely closed I've had the ambient temperature reach 85deg

4.)The only way to minimally control the temperature is to leave the curtains open, which leads to another problem, you cannot make it completely dark in the bunk room. Even with the area lights off, there is other lighting which remains on and cannot be extinguished or dimmed

Given all of the above I have not received adequate rest on any of my flights. I believe that the bunk on the -300 should NOT be considered a class 1 rest area.

Synopsis

Boeing 777-300ER Captain reported that the crew rest area is inadequate and unacceptable for crew rest.

Time / Day

Date : 201801

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 1000

Environment

Flight Conditions : VMC

Light : Night

Aircraft

Reference : X

ATC / Advisory.Tower : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : B777 Undifferentiated or Other Model

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Final Approach

Airspace.Class B : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Total : 14388

Experience.Flight Crew.Type : 2413

ASRS Report Number.Accession Number : 1512489

Human Factors : Fatigue

Human Factors : Situational Awareness

Events

Anomaly.Inflight Event / Encounter : Unstabilized Approach

Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Executed Go Around / Missed Approach

Assessments

Contributing Factors / Situations : Human Factors

Primary Problem : Human Factors

Narrative: 1

We were vectored abeam the runway on the Northwest side of the field. At approximately midfield the controller vectored us abeam the outer marker. He asked if we had the field. I asked my FO (First Officer) "you have the field" he responded yes, and he cleared us for a visual. At that time my FO started turning the aircraft inside the marker. I had drawn a line without executing the marker showing him the line to the marker.

We were at 2500 ft and 2 miles from the final approach but inside the marker. I then asked are you going to the marker or turning inside. He said inside. I said then we need to dirty up and get down. But he was not descending so we were high and almost on center line. He didn't respond aggressive enough maybe it being [early morning] and him being tired. But I thought we were high and fast, and said this is not going to work. Let's go around. He called missed approach executed a missed approach and we advised tower we wanted to come around for another approach. The second approach was completed successfully and we were on the ground ten minutes later and still on time.

In hind sight I think fatigue played somewhat into the scenario. As we were up all night. It basically was poor execution of the first approach and turning in too early therefore not allowing enough time to descend. There was also hesitation on the descent in the base turn which resulted in him being too high.

All in all we successfully executed a missed approach eliminating the threat and setting the aircraft up for another stable approach. We debriefed as a crew after arriving at the gate and talked about the execution of the approach and what led me to call a missed approach. We all agreed and departed the aircraft knowing we did the right thing.

Synopsis

B777 Captain reported a go-around after an unstable approach.

Time / Day

Date : 201801

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ATL.Airport

State Reference : GA

Relative Position.Distance.Nautical Miles : 2

Altitude.AGL.Single Value : 500

Environment

Light : Daylight

Aircraft : 1

Reference : X

ATC / Advisory.Tower : ATL

Aircraft Operator : Air Carrier

Make Model Name : B737 Next Generation Undifferentiated

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Final Approach

Airspace.Class B : ATL

Aircraft : 2

Reference : Y

ATC / Advisory.Tower : ATL

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Flight Plan : IFR

Flight Phase : Final Approach

Airspace.Class B : ATL

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1511632

Human Factors : Distraction

Human Factors : Fatigue

Human Factors : Situational Awareness

Events

Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : Weather / Turbulence
Anomaly.Inflight Event / Encounter : Wake Vortex Encounter
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Became Reoriented
Result.Air Traffic Control : Issued New Clearance

Assessments

Contributing Factors / Situations : Environment - Non Weather Related
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

We had been operating in the green for the last six legs. During the descent I started reviewing taxi options for landing on 9R and 10 and on arrival I was trying to chair fly all taxi options. We had and reported airport and proceeding traffic in sight on downwind. Once getting vectored on base then to final, twice we were finally cleared for the visual. Close proximity aircraft was at the same altitude on parallel Runway 9R and we hit wake turbulence just as we were cleared for visual. Tower was issuing taxi instructions to Company aircraft and another carrier in front of us while we were continuing down the glideslope. We were stable and made the 1000 call and at 500 we realized flaps were not set from 15 to 30 before 1000 ft above TDZE (Touchdown Zone End) requirement.

Distractions by ATC, anticipation of complex taxi plan, late clearance for visual approach, and back-end of the AM schedule after substandard sleeping conditions all contributed to the missing configuration. We debriefed the event and identified our mistakes. We will be alert at these critical phases in the future. Suggest to other crews to not worry about Ground Operations while in critical phases of flight. Study complex airfield diagram before current leg. Realize ATC distractions and resist attention diversion towards them. Keep situational awareness on profiles and configurations. After debriefing everything, a go-around should have been accomplished.

Synopsis

B737 First Officer reported continuing an unstabilized approach contrary to SOP. Fatigue and distractions were cited as contributing.

Time / Day

Date : 201712

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B767 Undifferentiated or Other Model
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Flight Phase : Cruise
Route In Use : Oceanic

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Crew Rest Area
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
Experience.Flight Crew.Total : 11849
ASRS Report Number.Accession Number : 1507590
Human Factors : Distraction
Human Factors : Fatigue

Events

Anomaly.Flight Deck / Cabin / Aircraft Event : Passenger Misconduct
Anomaly.Deviation - Procedural : Other / Unknown
Detector.Person : Flight Crew
Were Passengers Involved In Event : Y
When Detected : In-flight

Assessments

Contributing Factors / Situations : Environment - Non Weather Related
Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

During my entire break in the crew rest seat I listened to several children including an infant crying and communicating extremely loud right behind the crew rest seat and adjacent to the flight attendant crew rest area. After an hour and a half of crying babies and loud fussy young children I gave up on sleeping and watched the video monitor.

This was the perfect storm of kids versus flight crew rest. Both of my first officers also experienced the same issue as well as did the entire flight attendant crew.

I contacted the [Customer Service] team for passenger compensation because there were

many complaints from most of the [Premium Class] passengers. This flight was 8:40 in length and basically no flight crew member experienced a comfortable rest break at any time during the flight.

Synopsis

B767 Captain reported inadequate rest for a long flight due to loud passengers seated near the crew rest area.

Time / Day

Date : 201712

Local Time Of Day : 0001-0600

Environment

Light : Dawn

Aircraft

Reference : X

Make Model Name : No Aircraft

Flight Phase.Other

Person

Reference : 1

Location Of Person : Hangar / Base

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1506429

Human Factors : Communication Breakdown

Human Factors : Fatigue

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Other

Events

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Deviation - Procedural : FAR

Detector.Person : Flight Crew

Result.General : Flight Cancelled / Delayed

Assessments

Contributing Factors / Situations : Company Policy

Contributing Factors / Situations : Procedure

Primary Problem : Company Policy

Narrative: 1

We were scheduled to operate a flight with a show time [before 5 am]. As we were walking out the door, I received a phone call from scheduling. They stated our show time had been pushed back [6 hours]. They still have us scheduled to complete our trip, which has us scheduled for a 14:27 hour duty day. FAR 117 has us a maximum duty day of 12 hours plus the two hour extension if we agree to it. They are circumnavigating this rule by converting us to short call, which is not reflected on our schedule allowing them to add four hours to the RAP, which brings us to 16 hours of duty. As line holders, this should not be allowed. We were not notified until we were leaving the hotel, which resulted in us being ready to go, and unable to go back to sleep. They knew about this last night and did not contact us. They should not be allowed to do this, the FAR 117 rules exist for a reason.

Converting us from line holders to a RAP of 16 hours when we are awake for the entire portion is not okay.

Synopsis

Air Carrier First Officer pilot reported that after resting and getting ready for an early morning flight, scheduling called and pushed back the show time past the maximum duty day.

Time / Day

Date : 201712

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : PHL.Airport

State Reference : PA

Altitude.AGL.Single Value : 0

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : B757-200

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Not Flying

Function.Ground Personnel : Other / Unknown

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1504566

Human Factors : Fatigue

Events

Anomaly.Deviation - Procedural : Other / Unknown

Detector.Person : Flight Crew

Were Passengers Involved In Event : N

When Detected.Other

Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Staffing

Primary Problem : Staffing

Narrative: 1

During my sequence, I utilized the extension under FAR 117 for the first time. After completion of the sequence I had the chance to re-evaluate the sequence of events and thought I should share them for informational and safety purposes so that they can be improved upon. No known violations or incidents occurred during the sequence.

I was called at Early morning [for a] departure [that would be] terminating after a four hour flight. Upon arrival in PHL, I was reassigned to [a] flight round trip with a scheduled termination of [approximately] eight hours. I arrived on the flight deck, and boarding began shortly after. After boarding, we were told of a catering delay that would be up to 1:30 long. The scheduled round trip was about 8:52 and therefore put us into a position that if continued delays would occur we would be exceeding our duty day limits.

The captain called scheduling and informed them of the delay and they said that currently we appeared "legal" for the trip but would keep their eye on it. After the delay exceeded 2 hours, we were kept on the tarmac under the assumption that we would still be legal to complete the entire pairing. We ended up departing after one hour forty minutes, and did not hear anything from scheduling. On the arrival to destination, we received an ACARS message from dispatch asking for an extension to be legal for the return flight. The Captain and I agreed to do so. I have been in situations in which crew duty was an issue and typically the operations will do all they can to assist in a quick turn. This was not the case; it took over 30 minutes to get paperwork. The turn took about 57 minutes; however, we only had 40 passengers so as soon as we got paperwork they were trying to push us. We flew back to PHL without incident. Upon termination of my pilot duties, I had been awake and active for over 18 hours.

As I said there were no violations or rules broken on this sequence, however I thought I should share my opinion on how an FAR 117 extension works. My opinion is that as soon as you grant the extension the company could care less about how much longer or harder your day will get. The ground staff in our destination did not seem to know of the duty issue. Scheduling did not seem to care about the issue in PHL before we left; only after it became an issue for them did they contact us back. As soon as we gave the extension they got what they needed out of us. At the time I granted the extension, I felt fit for duty and did not want to strand the aircraft or the passengers, therefore I was willing to take the extension. However, after looking back on the sequence of events I regret agreeing to it as I felt it showed that the company is not concerned about the fatigue of the pilots flying the aircraft but only compliance of the regulation. They should be concerned with both.

We should not have been put in this situation to begin with. I did not become fatigued during the sequence, however shortly after on my drive home I did. It made me realize how granting an extension and then flying a 4-hour flight is simply gambling with safety, and should not be done ever. FAR 117 is a good regulation, however the loophole is the extension. I can see very easily after yesterday how an operation can manipulate a pilot to fly into a situation in which they are fatigued and make a grave mistake. Upon review of the regulations, an extension is for unforeseen circumstances. We made the company aware of the issue almost 11 hours before it actually became an issue, this does not constitute an "unforeseen" circumstance.

In a situation like this, where the possibility of the crew duty becoming an issue was noted so long before it became an issue, an extension should not be allowed. The company had plenty of time to utilize their massive resources to avoid this. I blame myself for allowing myself to be put into a situation like this and will not do it again. One obvious recommendation from my experience is that an extension should not be allowed for takeoff for any leg that exceeds 2 hours. We flew almost 4 hours after granting the extension, no one can predict how fit they will feel 4 hours from now. I hope you can use my comments and experience to help prevent fatigue.

Synopsis

B757 Captain accepted the duty time extension available under FAR 117. After the flight, the pilot felt in hindsight that by accepting the extension, crew scheduling had filled their coverage issue, and they were no longer concerned about possible fatigue issues.

Time / Day

Date : 201712
Local Time Of Day : 0601-1200

Place

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

Environment

Light : Daylight

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : B737 Undifferentiated or Other Model
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Flight Phase : Parked

Person : 1

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Qualification.Flight Crew : Air Transport Pilot (ATP)
Experience.Flight Crew.Total : 21000
Experience.Flight Crew.Last 90 Days : 120
Experience.Flight Crew.Type : 15000
ASRS Report Number.Accession Number : 1504384
Human Factors : Communication Breakdown
Human Factors : Fatigue
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Other

Person : 2

Reference : 2
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : First Officer
Qualification.Flight Crew : Air Transport Pilot (ATP)
Experience.Flight Crew.Total : 10400
Experience.Flight Crew.Last 90 Days : 80
Experience.Flight Crew.Type : 1900
ASRS Report Number.Accession Number : 1504846

Events

Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : FAR
Anomaly.Ground Event / Encounter : Other / Unknown
Detector.Person : Flight Crew
When Detected : Aircraft In Service At Gate
Result.General : Flight Cancelled / Delayed

Assessments

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

Narrative: 1

The First Officer and I had our pairing modified on day 4. After a night of reduced rest due to bad weather we flew and the following morning from to ZZZ. Upon arriving at ZZZ the printer showed that we had been reassigned. We were instructed to proceed to a new gate and we would no longer be flying our turn in an hour and thirty minutes but now were to report immediately to fly ZZZ to ZZZZ and back to ZZZ. After arriving at the gate we learned that this flight was delayed by the ZZZZ Airport because they had an inoperative Fire Truck. The original crew was going to time out so we were put in their place. I called the dispatcher on the paperwork and asked what was going on. I was told that they should have heard back from ZZZZ by now but as of yet nothing. I felt this was unsatisfactory and said I needed someone to call and find out what the hell was going on. After a brief period I received a call back from the dispatcher and he advised me that ZZZZ said they would provide an update

Four (4) hours for an update is not satisfactory with the resources available to this airline. To allow people to just sit in the gate area where they still were, why board a plane that probably isn't going for hours if it goes at all is not acceptable. This bothered me if not only for the passengers but for the flight attendants, the FO, and me. Short night and now an exceptionally long day that I'm not certain we would even be legal for is courting disaster. We agreed that calling scheduling and indicating that we would not be able to complete the reassignment because of fatigue was the best move in the interest of safety. In nearly 20 years as a pilot with this airline I have never been late for a show or called in fatigued but I felt like in this situation it was the safety minded thing to do.

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

B737 flight crew reported being unable to depart prior to fatigue setting in due to an equipment problem at the destination airport.

Time / Day

Date : 201712

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Light : Daylight

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : EMB ERJ 170/175 ER/LR

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Parked

Component

Aircraft Component : Safety Instrumentation & Information

Aircraft Reference : X

Problem : Malfunctioning

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1504281

Human Factors : Fatigue

Events

Anomaly.Aircraft Equipment Problem : Less Severe

Anomaly.Deviation - Procedural : Published Material / Policy

Detector.Person : Flight Crew

Were Passengers Involved In Event : N

When Detected : Aircraft In Service At Gate

Result.General : None Reported / Taken

Assessments

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

Narrative: 1

I was advised by the Flight Attendants just prior to push that the passenger prerecorded announcement system was playing. I called Maintenance who sent a local mechanic to check it out and who subsequently deferred the system. In the hustle and bustle of turning a long delayed jet, I neglected to coordinate with the dispatcher to amend the release for the new MEL item. Contributing to this was the fact we were already late and I was being rushed by operations and the agent. Additionally, and more importantly, was the fact that the company had us fly an extended day the day before with long airport sits. Over thirteen hours just from show to finish so in reality a fourteen hour plus day with respect to hotel door to door, which resulted in less than adequate sleep and no opportunity for me to get proper exercise which is every bit as important to me functioning at my highest levels as breathing.

As long as the company continues to push us this hard, I for one will be occasionally filling out [reports] for missing small items because I'm not at my best. Additionally, the most mentally and physically dulling thing you can have me do is sit at airports. There is nothing relaxing or restful about these sits at all. And I absolutely see that dulling effect on everyone I fly with.

Synopsis

EMB-170 Captain reported he forgot to request an amended flight release due to fatigue.

Time / Day

Date : 201712

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : RSW.Airport

State Reference : FL

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC

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

Flight Plan : IFR

Flight Phase : Landing

Route In Use.Other

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Not Flying

Function.Flight Crew : Captain

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1503650

Human Factors : Fatigue

Human Factors : Situational Awareness

Events

Anomaly.Flight Deck / Cabin / Aircraft Event : Other / Unknown

Anomaly.Deviation - 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 : Procedure

Primary Problem : Human Factors

Narrative: 1

While en route, we received an ACARS notification that the aircraft required an auto land. It was the First Officer's leg, and he planned on executing an auto land at our final destination. The weather was VMC and not a factor. We did a normal brief for the arrival and approach. We received vectors to the ILS runway 06 into RSW. After capturing the localizer and glidepath and finishing all checklists we flew the approach. On short final we both commented that the aircraft was lined up right of centerline approximately 40 feet right of centerline. The runway was 150 feet wide. We let the aircraft accomplish the auto land, which was deemed by me as unsuccessful because the aircraft remained right of centerline for the entire approach/landing/rollout. After disconnecting autopilot on rollout, we corrected back to centerline and taxied clear of runway. After logging the unsatisfactory auto land, we entered the comments into the logbook and briefed the mechanic on duty. Upon return to the airport 12 hours later, we discovered that in the airport briefing guide that auto lands to runway 06 were not authorized. I called [the company] while on ground, and explained what transpired the previous [flight] and to please notify maintenance of my erroneous write up. Comments for my performance are that I need to review airport briefing guide better and capture the error prior to commencing the approach. We were both tired after a long night of flying, and this might have been a factor in my missing the note about restricted auto lands in RSW runway 06.

Synopsis

Air carrier flight crew reported completion of an unauthorized autoland after receiving a request from the company.

Time / Day

Date : 201712
Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.MSL.Single Value : 2500

Environment

Flight Conditions : VMC
Weather Elements / Visibility.Visibility : 10
Light : Daylight
Ceiling.Single Value : 2000

Aircraft

Reference : X
ATC / Advisory.TRACON : ZZZ
Aircraft Operator : Air Carrier
Make Model Name : Large Transport, Low Wing, 2 Turbojet Eng
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Cargo / Freight
Nav In Use : FMS Or FMC
Nav In Use : GPS
Flight Phase : Final Approach
Route In Use.Other
Airspace.Class D : ZZZ

Component

Aircraft Component : Approach Coupler
Aircraft Reference : X
Problem : Malfunctioning

Person : 1

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Not Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
Experience.Flight Crew.Total : 20643
Experience.Flight Crew.Last 90 Days : 95
Experience.Flight Crew.Type : 6383
ASRS Report Number.Accession Number : 1503033
Human Factors : Situational Awareness
Human Factors : Fatigue

Person : 2

Reference : 2
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : First Officer
Function.Flight Crew : Pilot Flying
Experience.Flight Crew.Total : 17085
ASRS Report Number.Accession Number : 1503035
Human Factors : Human-Machine Interface
Human Factors : Fatigue

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Deviation - Altitude : Overshoot
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Anomaly.Inflight Event / Encounter : CFTT / CFIT
Detector.Automation : Aircraft Terrain Warning
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Regained Aircraft Control
Result.Flight Crew : Overcame Equipment Problem
Result.Flight Crew : FLC Overrode Automation
Result.Flight Crew : Took Evasive Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Airspace Structure
Primary Problem : Aircraft

Narrative: 1

We were set up for the RNAV 25 approach with V ref (30) +5 speed [and] FAF altitude correctly inserted into the FMC at the FAF. LNAV and VNAV were the active lateral and vertical modes with autopilot and auto throttles engaged. First Officer was the Pilot Flying. We were in VMC conditions at 2500 feet, (estimated cloud bases at 3000 feet during the descent) and had the runway in sight directly ahead. Prior to the FAF, the Pilot Flying dialed the Decision Altitude into the Altitude window and upon reaching the FAF the aircraft pitched down normally to follow the path.

During configuration change to flaps 30 and speed reduction to the final approach speed, the aircraft, for some unknown reason, suddenly pitched down reaching approximately 1500 FPM rate of descent. The Pilot Flying disconnected the autopilot and took over manually to arrest the descent rate, however the GPWS announced "Obstacle" during the recovery. The Pilot Flying leveled the aircraft to re-intercept the VNAV path and the remainder of the approach was stable and uneventful.

I can't remember making the 1000 feet call, but distinctly recall making the 500 feet call and the aircraft stabilized. The remainder of the flight was uneventful. Contributing factors: early report time, extreme cold weather, tail swap in departure airport, pressure to block out on time for the leg, irregular sleep and nutrition during the layover, circadian

flip/flops and cumulative fatigue from previous days on the pairing. In addition, the event occurred on my 10th consecutive day of work.

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

An Air Carrier flight crew reported that after the glideslope was captured some unknown reason the aircraft suddenly pitched down.

Time / Day

Date : 201711

Local Time Of Day : 1201-1800

Place

Locale Reference.ATC Facility : ZZZ.ARTCC

State Reference : US

Altitude.MSL.Single Value : 38000

Environment

Flight Conditions : IMC

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Center : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : Medium Transport, Low Wing, 2 Turbojet Eng

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Cruise

Airspace.Class A : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Type : 1300

ASRS Report Number.Accession Number : 1498775

Human Factors : Fatigue

Human Factors : Physiological - Other

Events

Anomaly.Flight Deck / Cabin / Aircraft Event : Illness

Detector.Person : Flight Crew

When Detected : In-flight

Result.General : Physical Injury / Incapacitation

Result.Flight Crew : Diverted

Assessments

Contributing Factors / Situations : Human Factors

Primary Problem : Human Factors

Narrative: 1

It was the final leg of the duty day and our flight had been delayed due to a late inbound aircraft. I felt slightly more fatigued than normal prior to the start of the flight. Before the inbound aircraft had arrived at the gate I had complained to the crew of some minor cold symptoms, but I thought I was still fit to fly. We decided to proceed with the flight as normal and we accepted the flight release.

After push back there was a lengthy delay in taxi time and it took a great deal of time to reach the runway departure point. Upon reaching the departure point I resolved that I was still feeling good and we proceeded to depart. Everything was normal up until about an hour or so into the flight at cruising altitude. We were cruising at 38,000 feet and getting close to about an hour and 20 minutes left on the flight time. I began to feel cold and grabbed my jacket to cover up and keep warm. As time progressed into the flight I started to break out into a cold sweat along with a warm body temperature. It was at this time I feared that my cold symptoms were worsening and my body temperature was beginning to elevate. To make matters worse I started to feel an elevated heart rate and shallow breathing. At this point I decided to inform the captain that I might be feeling symptoms of hypoxia. The captain immediately checked pressurization of the aircraft and we both crosschecked that the pressurization was normal in the cabin and there was no need to don the oxygen mask. However, as a precautionary measure we decided that I should wear the O2 mask and try breathing normally to see if the symptoms would improve. I tried to take normal breaths from the O2 mask, but my symptoms only worsened gradually. We also asked for a descent to a lower altitude to get to a lower cabin pressure to see if my breathing would improve. This also did not help me.

The captain inquired at this point that I might be getting sick. I agreed with the captain and said to him that if the symptoms worsened I might like to deviate from the planned course for a landing at the nearest airport. We decided to continue on course for what seemed like another 20 minutes until I decided that my symptoms were not getting any better and I was becoming increasingly ill. At this point I became concerned about my ability to safely perform my duties as pilot monitoring and as a side of caution for my fellow crew and passengers I asked that the captain would [advise ATC] and divert to the nearest suitable airport. We utilized CRM and the captain made a precautionary declaration to ATC that we needed to divert. We were cleared and began our course change. The captain contacted the company via ACARs and informed them of my condition. He also got in touch with STAT MD for the required medical information on my physical state and other information. I did my best to perform my job functions and provide the captain with the landing weather ATIS and runway numbers, but my symptoms were getting bad with what seemed like an increasing body temperature and possible fever. I informed the captain of my state of being and from there we requested emergency medical equipment on the ground. There was light snow in ZZZ but the weather conditions were good for a normal CAT I ILS and we were able to get down quickly. We arrived at the planned gate with the emergency equipment standing by. The captain opened his cockpit window and we were greeted by medical staff. They inquired my condition and concluded that I might be dehydrated and that they would perform further tests to see about my condition. At this point the flight was safely terminated and I was escorted into the terminal for a blood and temperature check. It was concluded by medical staff that I was running a high fever of 103 degrees with some dehydration along with it. After further medical care it was determined that I had a cold virus that caused me to have the fever. The fever is what gave me the symptoms of shallow breathing and rapid heart rate. In the interest of safety we did not take these symptoms lightly, and I believe we made the best decision to terminate the flight early. Cold and fatigue symptoms should not be taken lightly. If these

symptoms occur in the future I will call off the trip or ask for a fatigue call. Better communication with the crew and company on my condition prior to departure is also important.

Synopsis

A regional jet pilot reported experiencing multiple physical symptoms resulting in an inability to continue the flight. A diversion to a suitable airport to seek medical help was accomplished.

Time / Day

Date : 201705
Local Time Of Day : 1201-1800

Place

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

Environment

Flight Conditions : VMC
Light : Daylight

Aircraft

Reference : X
ATC / Advisory.Ramp : ZZZ
Aircraft Operator : Air Carrier
Make Model Name : Regional Jet 200 ER/LR (CRJ200)
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Flight Phase : Parked

Component

Aircraft Component : ACARS
Aircraft Reference : X
Problem : Malfunctioning

Person : 1

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Not Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1447721
Human Factors : Communication Breakdown
Human Factors : Fatigue
Human Factors : Situational Awareness
Human Factors : Time Pressure
Human Factors : Workload
Human Factors : Confusion
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew
Communication Breakdown.Party2 : Dispatch

Person : 2

Reference : 2
Location Of Person : Company
Reporter Organization : Air Carrier
Function.Dispatch : Dispatcher
Qualification.Dispatch : Dispatcher
ASRS Report Number.Accession Number : 1447723
Human Factors : Workload
Human Factors : Time Pressure
Human Factors : Communication Breakdown
Human Factors : Confusion
Communication Breakdown.Party1 : Dispatch
Communication Breakdown.Party2 : Flight Crew

Person : 3

Reference : 3
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : First Officer
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1448061
Human Factors : Workload
Human Factors : Time Pressure
Human Factors : Communication Breakdown
Human Factors : Fatigue
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Dispatch

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Deviation - Procedural : Weight And Balance
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Person : Flight Crew
When Detected : In-flight
Result.General : None Reported / Taken

Assessments

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

Narrative: 1

We had a very long day with a very early report time. We had MX issues every leg. The previous 2 issues (APU, R Static heat) were ops checked good. This was our third leg. We had lots of rolling flow delays. Our flow time was moved up to a somewhat close time. We boarded, and decided to wait our flow time out at the gate. It was for about 25 minutes. At this point we noticed the takeoff data was "hanging" and not completing. We double and triple checked the usual problems, passwords, airport and runway numbers, etc. I

called dispatch to see if no in time had recorded from the previous flight. Dispatch said that everything looked good on their end. I then was transferred to MX control. We could not get takeoff data so we deferred the ACARS unit.

While I was doing this, the FO (First Officer) was doing a manual W&B. Our flow time was rapidly approaching. As I finished with MX control, he said "OK, I will put you back in service." I then looked over the W&B and found an error that required re-doing it. We were about 2 hours late at this point, and I really didn't want to miss our flow time. I redid the W&B, reviewed the MEL, looked up the dispatch Radio freq, and closed up. While taxiing out, Ground notified us that our release had timed out, but that he had a new one with no changes except the squawk. We had a new release, because I had talked with several different dispatchers regarding our flow times. The most recent dispatcher had given us a new release with valid weather, a revised time and a new fuel load. I figured this had something to do with ACARS inability to give us any takeoff data. We took off, and headed to our destination, a very short distance away. We received an ACARS msg in flight inquiring if we had received a new release with the MEL. I spoke with dispatch on the ground about it, as we were getting busy with the approach, and the knowledge that I had screwed up was distracting enough.

Flow delays and the fear of missing them are powerful motivators, and can be very distracting. The previous write ups that were fixed and required no action from dispatch were probably sort of lulling me into a pattern of "I have a problem, I call MX, they fix it, I'm done". As a commuter, I rarely work early morning flights. I had just come off of 10 days off. I may be a little rusty. Dispatch now often sends us the amended release via ACARS, requiring no real action from us. With the ACARS being deferred, that isn't going to happen. The statement of "you are back in service" sort of makes you think that you have dealt with the issue and you are good to go. Please don't take that last sentence as blaming MX control, as it was definitely my fault alone, but it sort of leads you to think that the problem is solved.

The real root of the problem was rushing. Trying to meet a flow time can unfortunately cause us to rush. I realize the rush is self-imposed, but it still happens. I try to tell myself to slow down, as nearly every one of these dang things has rushing as a cause, but that whole mission completion thing is tough. When you have been at the gate, listening to peoples woes about missed connections, leading to missed funerals, visits with family etc., it weighs on your mind, even if subliminally. I find this particularly frustrating as I know this has been a focus of the company and the FAA for a while now. Perhaps something in the MEL or DMI card requiring us to get the dispatchers initials? The need for the return to service works great, if ACARS is working.

Narrative: 2

I received a call from MX control prior to departure that the ACARS on the aircraft had been deferred and the crew would be doing a manual manifest. After I hung up I started working up a new amended release with the deferral and called ATC to pull the strip so it could be refilled with an updated time/equipment while the aircraft was out of service. I generated the new release and sent it after the TLR was done.

I was pulling up the captain's phone number to verify that he received the amended release when I was notified by the next dispatcher that they had taken off and the flight had shown up on his [list] showing it hadn't been returned to service. (I usually wait for verification on MEL amendments from the PIC before returning aircraft to service.)

After the flight had reached 10,000 ft I sent an ACARS to the aircraft asking if they had

received the amended release, but probably since it was a short flight and the ACARS was deferred didn't receive a response. I called the captain after they landed and he already realized he had forgotten the amendment and was planning on filling out a [report].

I think the crew got busy working up the manual manifest and was rushing to go since the ground delay was cancelled, so when they got their new clearance they just thought they were good and forgot they were missing the amendment.

Crews should have more responsibility in the amendment process. The [manual] states that it is the responsibility of the dispatcher to ensure the crew has received an amended release, but I have no sure way to stop them departing short of pulling the strip whenever an amendment is required and refiling once the amendment is verified. In the case of added/removed MELs I feel the crews are already or should be aware that an amendment is required without the dispatcher telling them so.

Narrative: 3

[Report narrative contained no additional information.]

Synopsis

CRJ-200 flight crew and Dispatcher reported the hurried crew departed without a new release.