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 .................................................. 27

Date of Update.................................................... January 31, 2018

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

Number of New Records in Report Set ............... 26

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.
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. 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 amplified 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.

Linda J. Connell, 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
<table>
<thead>
<tr>
<th>ACN: 1494572  (1 of 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Synopsis</strong></td>
</tr>
<tr>
<td>A319 Captain reported departure was delayed when an iPad began a download during taxi out that inhibited access to the departure plate.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACN: 1491911  (2 of 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Synopsis</strong></td>
</tr>
<tr>
<td>A Boeing 767 Captain reported that they returned to the gate because the Right Hand side did not have duct pressure, which started a chain of events prior to takeoff.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACN: 1491841  (3 of 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Synopsis</strong></td>
</tr>
<tr>
<td>B737 Captain reported they failed to make a crossing restriction on arrival into SFO. Fatigue and distraction from a wake turbulence encounter were cited as contributing factors.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACN: 1487593  (4 of 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Synopsis</strong></td>
</tr>
<tr>
<td>Air carrier Captain reported issues with scheduling of all night flights which result in fatigued pilots.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACN: 1485403  (5 of 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Synopsis</strong></td>
</tr>
<tr>
<td>B737 flight crew reported an ATC low altitude alert due to an altitude deviation on arrival into ONT. Fatigue and workload were cited as contributing factors.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACN: 1484949  (6 of 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Synopsis</strong></td>
</tr>
<tr>
<td>CRJ-200 First Officer reported descending below charted altitude on approach to BTV citing fatigue as a contributing factor.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACN: 1480496  (7 of 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Synopsis</strong></td>
</tr>
<tr>
<td>A319 Captain and Ramp Marshaller reported the aircraft began to roll back after parking short of gate. Captain inadvertently failed to set parking brake when commanded by ramp personnel. Captain then set parking brake.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACN: 1479226  (8 of 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Synopsis</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Synopsis
CRJ-900 First Officer reported diverting to an alternate after experiencing L BLEED DUCT warning in cruise flight.

ACN: 1477893 (9 of 50)

Synopsis
CRJ900 flight crew reported neglecting to stow the spoilers until shortly before landing.

ACN: 1477738 (10 of 50)

Synopsis
A300 Captain reported a track deviation on arrival into MIA. Chart design and fatigue were cited as contributing.

ACN: 1476000 (11 of 50)

Synopsis
Air carrier flight crew reported getting low while on a visual approach to MCO Runway 36L when VNAV was selected, but it did not engage.

ACN: 1474594 (12 of 50)

Synopsis
Air carrier Captain on approach to GSO Runway 23L reported a low altitude alert from Tower and GPWS alert at 1,000 AGL, but continued to land.

ACN: 1474548 (13 of 50)

Synopsis
B737-700 First Officer reported crew received a GPWS warning on an ILS approach to BWI and encountered IMC conditions close to minimums, did not go around but landed.

ACN: 1472086 (14 of 50)

Synopsis
CRJ-200 First Officer reported a rejected takeoff due to improper flap position.

ACN: 1471726 (15 of 50)

Synopsis
A321 Captain reported executing a go-around after encountering wake turbulence during their landing flare in trail of a B757 to DFW airport.

ACN: 1471308 (16 of 50)
### Synopsis
Air carrier First Officer reported a C90 TRACON Controller issued a 20 degree right turn while on the MDW RNAV Runway 22L Approach which would have placed the aircraft over the city. The crew realized the error, but ATC did not respond to clarify. ATC did finally issue an accurate vector to rejoin the approach.

**ACN: 1468849 (17 of 50)**

### Synopsis
B757-200 Captain reported contacting a tow bar attached to a tug as he parked using an automated parking system in MIA.

**ACN: 1467862 (18 of 50)**

### Synopsis
Air Carrier First Officer reported a hold on the wrong side of FYTTE on the FYTTE 4 arrival to ORD due to fatigue.

**ACN: 1462581 (19 of 50)**

### Synopsis
Air carrier flight crew reported difficulties during a night visual approach to PNS due to the runway lights not being activated via mic clicks. A low altitude alert was issued by ATC and the flight was vectored back around for another attempt.

**ACN: 1460864 (20 of 50)**

### Synopsis
Air carrier Captain reported that incorrect 10-7 chart information on ACARS availability led to rushed manual weight and balance computation resulting in a minor error.

**ACN: 1459500 (21 of 50)**

### Synopsis
A B777 Captain reported programming the FMC incorrectly during preflight and lined up for the parallel runway.

**ACN: 1459495 (22 of 50)**

### Synopsis
Flight crew of a large transport jet reported going below glide path on approach into DCA resulting in a GPWS warning. After correcting the flight landed normally.

**ACN: 1459328 (23 of 50)**

### Synopsis
Air carrier Captain reported receiving pressure from company personnel to accept FAR 117 flight duty period extensions despite reporting a desire not to extend due to fatigue.

**ACN: 1457523 (24 of 50)**

**Synopsis**
Air carrier flight crew reported a ground conflict at EHAM after all three pilots misunderstood the Ground Controller's hold short instructions because of rapid, accented speech.

**ACN: 1453745 (25 of 50)**

**Synopsis**
B777 First Officer reported concern with the FAR requiring the landing pilot to take the last break due to sleep inertia.

**ACN: 1453557 (26 of 50)**

**Synopsis**
Air carrier First Officer reported calling in fatigued for an assignment that followed a six-day trip which included interrupted off-hour sleep and multiple time zone crossings.

**ACN: 1447721 (27 of 50)**

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

**ACN: 1445019 (28 of 50)**

**Synopsis**
Air carrier Captain reported ATC requested 250 KTS approaching KILDE, but after overshooting final, failed to slow and descend sufficiently so executed a go-around.

**ACN: 1444766 (29 of 50)**

**Synopsis**
B737-800 flight crew reported neglecting to set the parking brake after arriving at the gate due to fatigue and distraction.

**ACN: 1441571 (30 of 50)**

**Synopsis**
B737 flight crew reported procedural errors caused by the late callout of a reserve First Officer.
ACN: 1436626 (31 of 50)

Synopsis
The Captain of a Boeing 777 reported that after a long delay and a short turn for the crew, the flight was canceled.

ACN: 1431311 (32 of 50)

Synopsis
CRJ200 Captain reported on a series of frustrating delays that led to a late departure. Once airborne, an unsafe gear indication led to a return and a canceled flight.

ACN: 1428946 (33 of 50)

Synopsis
A321 Captain reported the flying First Officer mistakenly retracted the flaps instead of the speedbrakes on approach. Fatigue was cited as a factor.

ACN: 1428180 (34 of 50)

Synopsis
CRJ-200 First Officer reported diverting for IDG and APU problems. They discovered that a month earlier another crew had a similar experience with the exact same outcome.

ACN: 1425955 (35 of 50)

Synopsis
DHC-8 Captain reported an excursion from a snow covered taxiway.

ACN: 1424221 (36 of 50)

Synopsis
Air carrier flight crew reported they received a low altitude alert from ATC on approach into ASE citing workload, weather, and situational awareness as contributing.

ACN: 1424191 (37 of 50)

Synopsis
B737 flight crew reported they taxied into a gate when they should have called for a tow-in citing fatigue as a factor.

ACN: 1422137 (38 of 50)

Synopsis
Air Carrier flight crew reported attempting to reconfigure their aircraft after receiving and ATC directed go-around, initially climbed into a "monitor vertical speed" TCAS Resolution Advisory.

ACN: 1421894 (39 of 50)

Synopsis
B737-800 flight crew reported missing a crossing restriction on arrival into ORD, citing fatigue, strong tailwinds, and automation dependency as factors.

ACN: 1420514 (40 of 50)

Synopsis
CRJ-900 Captain reported receiving a GPWS warning for improper flap configuration on final approach. The crew selected the correct flap selection and landed safely.

ACN: 1420229 (41 of 50)

Synopsis
An MD-11 International Relief Officer and Captain reported a stick shaker activation while departing Hong Kong when the slats were retracted below slat retraction speed.

ACN: 1419067 (42 of 50)

Synopsis
B737NG flight crew reported multiple distractions along with being late on the last leg of a fatiguing four day trip which resulted in them departing weighing less than what was shown on the release.

ACN: 1418104 (43 of 50)

Synopsis
Air carrier flight crew reported entering a holding pattern on the unprotected side of the hold clearance.

ACN: 1417108 (44 of 50)

Synopsis
Air carrier flight crew reported that the Tower informed them they had not followed their taxi clearance correctly. However, the flight crew believed they followed it as it was assigned by ATC.

ACN: 1417095 (45 of 50)

Synopsis
Air carrier Captain reported setting the incorrect decision altitude in the Radar Altimeter for a CAT II approach to LIT, resulting in two missed approaches. Fatigue was cited as a factor.

ACN: 1414879 (46 of 50)

Synopsis
Air carrier Captain reported fatigue and distractions led to some errors on a go-around from a low visibility approach.

ACN: 1414631 (47 of 50)

Synopsis
CRJ-700 Captain reported flying at a lower than filed altitude due to a previous maintenance issue with the aircraft.

ACN: 1412767 (48 of 50)

Synopsis
A300 flight crew reported experiencing a dual pack failure necessitating an emergency descent. After troubleshooting, the crew discovered the source of the failure and was able to climb back to the planned cruise altitude.

ACN: 1412019 (49 of 50)

Synopsis
CRJ-700 Captain reported a track deviation on departure out of CLT citing fatigue, ATC inconsistencies, and company policies on fatiguing schedules as contributing.

ACN: 1411815 (50 of 50)

Synopsis
CRJ-200 flight crew reported braking action was found to be poor or nil during landing despite good reports and the aircraft could not be taxied to the gate. The aircraft was shut down on a taxiway and the passengers were taken to the terminal in airport vehicles.
Report Narratives
ACN: 1494572 (1 of 50)

Time / Day
Date: 201711
Local Time Of Day: 1801-2400

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

Environment
Light: Night

Aircraft
Reference: X
ATC / Advisory.Ground: ZZZ
Aircraft Operator: Air Carrier
Make Model Name: A319
Crew Size.Number Of Crew: 2
Operating Under FAR Part: Part 121
Flight Plan: IFR
Mission: Passenger
Flight Phase: Taxi

Component
Aircraft Component: Tablet
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 Not Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
Experience.Flight Crew.Type: 1456
ASRS Report Number.Accession Number: 1494572
Human Factors: Time Pressure
Human Factors: Fatigue
Human Factors: Human-Machine Interface

Events
Anomaly.Aircraft Equipment Problem: Less Severe
Anomaly.Deviation - Procedural: Published Material / Policy
Detector.Person: Flight Crew
When Detected: Taxi
Result.General: Flight Cancelled / Delayed
Result.Flight Crew: Overcame Equipment Problem

Assessments
Contributing Factors / Situations: Equipment / Tooling
Primary Problem: Equipment / Tooling

Narrative: 1
I can’t begin to even express the level of frustration experienced last evening, with both engines up and running, in a line-up with a slot and flow control, and a thin margin on reserve fuel when my iPad became a literal boat anchor as it began to auto-download 1. A large JeppFD-Pro update 2. A Pilot mobile update 3. An update to HOT application.

Adding to the stress level, it’s night, unfamiliar airport with already complex departure procedures, thin geographic taxi margins, and rising terrain in all quadrants. Not to mention leg 3 of 4 on an already long day. As the Captain, my plate rapidly became full. I unsuccessfully attempted to stop the download in order to have departure SID, and remembering that we would be down to one iPad (FO), I needed to probably get approval from the [dispatch manager]. The iPad wasn’t broken but it was at 50% capability and the extra flight bag didn’t have a complete set of plates for [departure airport].

We pulled out of the lineup and into the penalty box. I called [dispatch] and quickly related my frustration and pointedly expressed my need for a flight waiver, and I needed it five minutes ago. We received verbal approval and written follow up and we left the box and got back in line. Aside with having to return to the old school approach plate procedures, which felt like wearing borrowed cleats, the remainder of the flight was uneventful.

As a side note, normally I wouldn’t have had the internet up, but I had to use the back panel electrical outlet to recharge my iPad while we did our ground turn. Since I had just downloaded the flight plan forecast package, the iPad was still in the cellular data mode when I plugged in to begin charging, then left the jet to continue my pre-departure tasks.

Synopsis
A319 Captain reported departure was delayed when an iPad began a download during taxi out that inhibited access to the departure plate.
**ACN: 1491911** (2 of 50)

**Time / Day**
- Date: 201710
- Local Time Of Day: 1801-2400

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

**Environment**
- Light: Night

**Aircraft**
- Reference: X
- ATC / Advisory.Ground: ZZZ
- Aircraft Operator: Air Carrier
- Make Model Name: B767-200
- 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: Taxi
- Maintenance Status.Maintenance Deferred: Y

**Component: 1**
- Aircraft Component: Pneumatic Valve/Bleed Valve
- Aircraft Reference: X
- Problem: Malfunctioning

**Component: 2**
- Aircraft Component: APU
- Aircraft Reference: X
- Problem: Failed

**Person**
- 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)
- ASRS Report Number.Accession Number: 1491911
- Human Factors: Fatigue
- Human Factors: Workload
- Human Factors: Time Pressure

**Events**
Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Deviation - Track / Heading : All Types
Anomaly.Deviation - Procedural : Weight And Balance
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Detector.Automation : Aircraft Other Automation
Detector.Person : Flight Crew
When Detected : Taxi
When Detected : In-flight
Result.General : Maintenance Action
Result.Flight Crew : Returned To Gate

Assessments
Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Environment - Non Weather Related
Contributing Factors / Situations : Human Factors
Primary Problem : Aircraft

Narrative: 1

Late push due to being fueled 5000 LBS over request, needing a new weight and balance for accurate fuel, and a live calculation from Dispatch for a requested full thrust takeoff. Pushback and start were normal. Completed after start flow and turned off APU. Just prior to taxi, we noticed both packs indicated PACKS OFF despite being in AUTO. Duct pressure showed zero both sides. We cycled the PACKS controllers, Isolation valves, and engine bleed switches with no effect. Prior to returning to the gate, I called Maintenance control. The DDG (Dispatch Deviations Guide) for the R HI STAGE deferral notes that to clear the message, you need to advance throttles to 80% N1, but the FCOM (Flight Crew Operations Manual) also limits us to 40% N1 for breakaway thrust and FOD concerns. That the right side showed zero duct pressure was expected, but I did not see a reason that the left side would also.

Maintenance control advised following the QRH, but it is designed for in flight and offered no help. This airplane has a history of repeat R HI STAGE deferrals, as well as C HYD DEM PUMP messages. For this flight, a new HP SOV (High Pressure Shut-Off Valve) had been installed on the Right Engine, but for some reason the mechanics [at departure airport] elected not to perform engine runs and sign off the deferral. It would be done [at our destination]. I returned to the gate because we could not determine a reason for the lack of Left duct pressure. Interestingly, at the gate with the APU on, duct pressure returned and operated normally. Mechanics also isolated the center duct and started an engine at the gate - everything worked properly.

We prepared to push back and continue our flight. Just prior to push (I had to call for another live calculation as Runway 9 was now closed), the APU died unexpectedly at the gate. That was deferred and we proceeded to [destination]. All told, I made a dozen calls to Dispatch over deferrals (the HI STAGE deferral wasn't listed and we added the APU later), three calls for the live calculation, one for runway 9, one for 8R and then another for 8R with a deferred APU. To add to the confusion, up until we were ready to push with the APU deferred, we did not know if we were going to [our second leg], as a recovery flight had been launched to [for the second leg]. We were told to fly to [destination] as planned, but be prepared to be rerouted to our [a second destination] enroute. As we are fueled for both legs, it wasn't an issue. We landed [at destination] and the recovery flight
was turned around.

The next leg was normal until landing. I have flown this route for the last two months and I am very familiar with it, but we were hours late and had faced a slew of unexpected changes and challenges. I had slept great prior to the flight and felt sharp but as we approached [the airport] a bit of mental fatigue was setting in, likely due to the adrenaline wearing off. To help minimize potential threats, I elected to brief a CAT I auto-land. Weather was clear and unrestricted, winds 190/10. The airplane overshot LOC intercept due to strong quartering tailwinds, but corrected and was lined up properly. However, on short final, the airplane was increasingly right of centerline. It appeared as if we would touchdown with the left main gear on or right of centerline. Our wheelbase is 30 feet and runway 9 is 150 feet wide, so I knew we would land on the runway, but I was not happy with landing so far to the right. I elected to turn off the autopilot and land manually. I am unsure of my altitude when I disconnected, as I was focused on our lateral track.

This is a challenging run to begin with. Three legs a night is draining and delays remove any chance of a break during our planned 3-hour stop. We typically change planes in [our second destination] and for the two months I've been flying it, it seems that one of the aircraft has issues with repeated write-ups. This flight had an unusual number of distractions, from being over fueled, needed a max thrust takeoff and a live calculation (three times...) , plus the R HI STAGE deferral, which should've been on the release, the unexpected lack of duct pressure with no explanation, and then the APU suddenly dying as we tried to depart again.

As a crew, I felt we dealt well with the constant changes. We have flown together all this month, and my First Officer, although in his first year at [company], flew the 767 at a previous carrier has been a great resource on every leg. The first two legs this night felt like the check ride that wouldn't end. It is becoming a rare relief to get an airplane with no deferrals that behaves as expected. (Thankfully, the last leg of this day was the low-key, good airplane leg we needed after a long night.) Although things went normally once we departed until the landing, we were hours late, which compressed our scheduled turns.

As a crew, we verbalized taking our time and making sure everything was right, without regard to time pressure and pushed back when we were ready. My biggest regret of the evening was the landing [last landing]. I may have turned off the autopilot below 100 AGL, I honestly don't know. I should've gone around and set up for another approach. It was a split second decision that I felt comfortable with because the weather was not a threat, visibility was excellent, and most likely, even letting the airplane auto-land right of centerline probably would have been fine but I did not like the airplane landing much farther to the right than I was expecting. The problem was I had briefed an auto-land, and turning off the autopilot at low altitude wasn't what I had told the First Officer to expect. Certainly I would've gone around under those conditions had weather been any kind of a factor. I was happy with the result, a landing closer to centerline, but not with doing something contrary to what my partner was expecting. The main point of this [report] is the effect repeat write-ups is having on operations. But I do have to recognize the effect the current atmosphere at my airline is having on our behavior out on line. This had no conscious effect on my decision to land manually instead of going around, but lately I have been taking notes on each departure to explain delays, to defend myself in case I am questioned. Certainly, that thought crossed my mind during the gate return. Are they going to question whether this was a legitimate return? Did I miss something? I'm pretty good at compartmentalizing, but that is increasingly becoming a contributing factor.

Synopsis
A Boeing 767 Captain reported that they returned to the gate because the Right Hand side did not have duct pressure, which started a chain of events prior to takeoff.
**Time / Day**

Date: 20171010  
Local Time Of Day: 0601-1200

**Place**

Locale Reference. Airport: SFO. Airport  
State Reference: CA  
Altitude.MSL. Single Value: 25000

**Environment**

Flight Conditions: VMC  
Light: Daylight

**Aircraft : 1**

Reference: X  
ATC / Advisory.Center: ZOA  
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  
Nav In Use: FMS Or FMC  
Flight Phase: Descent  
Route In Use.STAR: DYAMD3  
Airspace.Class A: ZOA

**Aircraft : 2**

Reference: Y  
ATC / Advisory.Center: ZOA  
Aircraft Operator: Air Carrier  
Make Model Name: Widebody Transport  
Crew Size. Number Of Crew: 2  
Operating Under FAR Part: Part 129  
Flight Plan: IFR  
Mission: Passenger  
Nav In Use: FMS Or FMC  
Flight Phase: Descent  
Route In Use.STAR: DYAMD3  
Airspace.Class A: ZOA

**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.Type : 2976
ASRS Report Number.Accession Number : 1491841
Human Factors : Distraction
Human Factors : Fatigue
Human Factors : Situational Awareness
Analyst Callback : Attempted

Events
Anomaly.Deviation - Altitude : Undershoot
Anomaly.Deviation - Altitude : Crossing Restriction Not Met
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : Clearance
Anomaly.Inflight Event / Encounter : Wake Vortex Encounter
Detector.Person : Air Traffic Control
When Detected : In-flight
Result.Flight Crew : Returned To Clearance
Result.Flight Crew : Became Reoriented

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

Narrative: 1

Arrival DYAMD3 briefed and ILS 28R briefed. Verified all altitudes and speed constraints prior to brief. Speed assignment of 250 kts given for traffic. Speed entered into FMC and a discussion of the speed constraints on arrival because the initial two are 280. We opted to leave FMC with input values of 280 instead of changing. Cruise altitude FL360 and given a descent clearance to FL320 and executed by DES NOW prompt in VNAV PATH. A descend via clearance was given and 8000 set in window. Another discussion on setting of airspeed ensued as the FMC would not accept 250 kts over the hard coded 280 kts at LAANE. However, 250 kts was entered at FLOWZ and therefore allowed the FO to enter 250 kts at LAANE. I visually saw the input from the FO on the FMC. During descent on DYAMD3 encountered wake from a heavy which turned the autopilot off. FO re-engaged autopilot shortly afterwards. We were also given the Quiet Bridge routing to RWY 28R. I visually noted the change on the DEP/ARR page that the FO had input, only the approach was changed with transition of ARCHI. I did not check the legs page as I normally do, fatigue, and reverify the route/speed/altitude. NORCAL approach 128.32 queried when we were going to descend from FL250. I visually checked FMC and saw 250/FL250 over FLOWZ and referenced the chart which is FL190 to 14000. Then radar vectors in a box pattern to get to correct altitude. No further problems. We debriefed and could not identify the exact cause of the error to prevent future errors.

Synopsis
B737 Captain reported they failed to make a crossing restriction on arrival into SFO. Fatigue and distraction from a wake turbulence encounter were cited as contributing factors.
ACN: 1487593

Time / Day
Date: 201710
Local Time Of Day: 1801-2400

Place
Altitude.AGL.Single Value: 0

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

Person
Reference: 1
Location Of Person: Company
Reporter Organization: Air Carrier
Function.Flight Crew: Captain
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1487593
Human Factors: Fatigue

Events
Anomaly.Deviation - Procedural: Published Material / Policy
Detector.Person: Flight Crew
When Detected: Pre-flight
Result.General: None Reported / Taken

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

Narrative: 1

Although numerous fatigue reports have been filed regarding this issue, it remains. The issue is fatiguing schedules, with legs and sits prior to a red eye, and flip flops from late night to early morning. This type of schedule is increasing in the bid for [the month]. While the FAA undoubtedly echoes the company line that it is legal, and therefore, acceptable, I would assert that it is the FAA's ethical duty and legal requirement to enforce the preamble to Part 117, which describes the intent and philosophy of 117, i.e., not to have tired pilots flying airplanes. I would also maintain that the [reports] can and must make ameliorative recommendations to the company which recognizes their unsafe practices, even though they are legal.

Operations need to be approached and conducted with caution, and not the abject ignoring of the dangers of bad scheduling and the human factors involved. No leg before red eye, at least 13 hours of rest after and not more than 24 hours unless it is 34 hours of rest to keep circadian rhythms correct.
Synopsis

Air carrier Captain reported issues with scheduling of all night flights which result in fatigued pilots.
**ACN: 1485403 (5 of 50)**

### Time / Day

- **Date:** 201710
- **Local Time Of Day:** 1201-1800

### Place

- **Locale Reference.Airport:** ONT.Airport
- **State Reference:** CA
- **Relative Position.Distance.Nautical Miles:** 20
- **Altitude.MSL.Single Value:** 7300

### Environment

- **Light:** Daylight

### Aircraft

- **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:** Descent
- **Route In Use.STAR:** EAGLZ1
- **Airspace.Class E:** SCT

### 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:** 1485403
- **Human Factors:** Fatigue
- **Human Factors:** Situational Awareness
- **Human Factors:** Workload
- **Communication Breakdown.Party1:** ATC
- **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:** First Officer
Narrative: 1

It was the fourth of five legs on the last day of our trip. We were both a little tired and looking forward to getting home as we descended via the EAGLZ 1 into ONT. The airspace was quiet and SoCal clearly wanted to help us expedite but ended up using far more words than were necessary as he mentioned a Visual Approach more than once. We were told to maintain 8000 ft and proceed direct to either TAKOE or PETIS to acquire the airport for the visual. We didn't have either point in our route and the FO (PF) selected the next point instead. Seeing the error, I went heads down to type in TAKOE. At the same time the FO thought we were cleared for the approach and changed the altitude in the AFCS and started a descent. I did not hear him announce this. ATC queried us as we passed 7300 ft and told us to climb to 7700 ft. We were subsequently cleared for the visual and landed uneventfully on 26R. We clearly had a breakdown in [altitude awareness] and it was completely our fault. Contributing factors were slight fatigue, expectation bias as ATC mentioned a visual approach multiple times and the feeling of being rushed because of our altitude and proximity to the runway.

Communication is the key. We both are very familiar with this airport but neither had flown the EAGLZ 1. A more thorough arrival briefing would have highlighted the fact the arrival does not connect to the runway points. When ATC mentioned the visual so many more times than normal we should have recognized and announced we were in the yellow as we continued to get closer to the airport and above all, we must always announce changes to the [autoflight system] and make sure both pilots are on the same page.

Narrative: 2
As the PF, I should have delayed any descent from our last assigned altitude until I could verify the clearance with my Captain. I allowed myself to feel I needed to rush into a steep descent while in proximity to terrain without allowing the Captain to finish programming our route so his attention could be fully on monitoring our flight path. I allowed an ATC routing instruction to distract me from properly verifying our vertical clearance. There did not seem to be hardly any other air traffic nearby, so a request for vectors to manage the descent would have been easy to get.

Synopsis

B737 flight crew reported an ATC low altitude alert due to an altitude deviation on arrival into ONT. Fatigue and workload were cited as contributing factors.
**Time / Day**
Date: 201709
Local Time Of Day: 1801-2400

**Place**
Locale Reference.Airport: BTV.Airport
State Reference: VT
Altitude.MSL.Single Value: 5500

**Environment**
Flight Conditions: IMC
Light: Night

**Aircraft**
Reference: X
ATC / Advisory.TRACON: BTV
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: GPS
Nav In Use: FMS Or FMC
Flight Phase: Initial Approach
Airspace.Class E: BTV

**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: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1484949
Human Factors: Fatigue
Human Factors: Situational Awareness

**Events**
Anomaly.Deviation - Altitude: Excursion From Assigned Altitude
Anomaly.Deviation - Track / Heading: All Types
Anomaly.Deviation - Procedural: Clearance
Anomaly.Inflight Event / Encounter: CFTT / CFIT
Detector.Person: Air Traffic Control
When Detected: In-flight
Result.Flight Crew: Became Reoriented
Result.Air Traffic Control: Issued New Clearance
Result.Air Traffic Control: Issued Advisory / Alert
Assessments
Contributing Factors / Situations: Human Factors
Primary Problem: Human Factors

Narrative: 1

While heading into BTV we were on vectors to RNAV GPS Z Rwy 33. We were at 5500 feet and on a heading to intercept the final course inbound. While on this heading we were cleared for the approach. We intercepted the inbound course and proceeded with the approach. What I failed to realize is that we were outside NIDUQ. The minimum crossing at NIDUQ is 5400 feet. We were lower than the required 5400 ft and just about to level at HONIB when approach stated that we descended below the required crossing restriction of 5400 feet at NIDUQ. At this point, we had the airport in sight and told approach that we had the airport in sight. He cleared us for the visual and we continued and landed safely without issue.

This was the third night. I was tired as I didn't sleep well the night before and I didn't get enough sleep during the day. I definitely tried to sleep during the day, but only slept about 3 hrs. Once on the ground and parked at the gate. I dug into how I missed the fix. I reloaded the approach with vectors and realized that it doesn't load any fixes past HONIB. I have learned my lesson and will always select an IAF instead of vectors. I was also complacent in thinking that it was going to be a visual approach with the RNAV as a backup.

Synopsis
CRJ-200 First Officer reported descending below charted altitude on approach to BTV citing fatigue as a contributing factor.
**Time / Day**
- Date: 201709
- Local Time Of Day: 0601-1200

**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: A319
- 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: Pilot Flying
- Function.Flight Crew: Captain
- Qualification.Flight Crew: Air Transport Pilot (ATP)
- Experience.Flight Crew.Total: 10514
- Experience.Flight Crew.Type: 8252
- ASRS Report Number.Accession Number: 1480496
- Human Factors: Communication Breakdown
- Human Factors: Distraction
- Human Factors: Fatigue
- Human Factors: Confusion
- Communication Breakdown.Party1: Flight Crew
- Communication Breakdown.Party2: Ground Personnel

**Person : 2**
- Reference: 2
- Location Of Person: Gate / Ramp / Line
- Reporter Organization: Air Carrier
- Function.Ground Personnel: Ramp
- ASRS Report Number.Accession Number: 1480518

**Events**
Anomaly.Flight Deck / Cabin / Aircraft Event : Other / Unknown
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Ground Event / Encounter : Loss Of Aircraft Control
Detector.Person : Ground Personnel
Detector.Person : Flight Crew
Were Passengers Involved In Event : N
When Detected : Aircraft In Service At Gate
Result.Flight Crew : Regained Aircraft Control
Result.Flight Crew : Became Reoriented

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

Narrative: 1

Upon arrival at gate single engine, ran out momentum just prior to parking spot and had to add a little power. Marshall gave stop signal shortly thereafter and stopped normally using toe brakes. For some reason I failed to set parking brake, and the aircraft begin rolling backwards. I stopped the airplane, set the parking brake, and the aircraft was later towed forward into position.

I don't not have an answer for why I failed to set the brake. I believe it was a combination of being tired from four days of flying, a very early wake up, thinking about using a new parking checklist for the first time, but overall, just a lack of concentration and focus. No excuse. All were red flags that should have been heeded and resulted in greater focus and concentration. The flight is not over until the parking checklist is complete and our passengers are off the airplane. We all must remember that. I certainly won't forget it.

It is very easy to become complacent in this business of repetitive flights to the same stations, multiple legs each day, etc. We absolutely cannot let this happen as it will bite us when we least expect it, such as this, the last event of the last leg of the last day of a four day trip. "It ain't over until it's over" Good advice from a wise former baseball player. I certainly won't forget it.

Narrative: 2

I was parking this plane. Once I had it parked, I went to grab the chocks for the nose gear. When I turned around the plane was rolling back.

Synopsis

A319 Captain and Ramp Marshall reported the aircraft began to roll back after parking short of gate. Captain inadvertently failed to set parking brake when commanded by ramp personnel. Captain then set parking brake.
**Time / Day**

Date: 201708
Local Time Of Day: 1201-1800

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

**Environment**
Weather Elements / Visibility: Icing
Light: Daylight

**Aircraft**
Reference: X
ATC / Advisory.Center: 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
Flight Phase: Cruise
Airspace.Class A: ZZZ

**Component**
Aircraft Component: Engine Air Pneumatic Ducting
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: First Officer
Function.Flight Crew: Pilot Not Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1479226
Human Factors: Communication Breakdown
Human Factors: Fatigue
Communication Breakdown.Party1: Flight Crew
Communication Breakdown.Party2: Dispatch

**Events**
Anomaly.Aircraft Equipment Problem: Less Severe
Anomaly.Inflight Event / Encounter: Weather / Turbulence
Detector.Person: Flight Crew
When Detected: In-flight
Result.General : Maintenance Action
Result.General : Flight Cancelled / Delayed
Result.Flight Crew : Landed As Precaution
Result.Flight Crew : Diverted

Assessments
Contributing Factors / Situations : Aircraft
Primary Problem : Aircraft

Narrative: 1

[We were] originally scheduled through icing while single PACK. We were cruising along at FL240 on schedule and around 30 minutes into the flight L BLEED DUCT Warning. The Captain immediately assumed controls and radio responsibilities (he was PF) and called for the BLEED DUCT Warning QRH checklist. We proceeded to descend to 10,000 feet after [notifying ATC] and picked an appropriate [alternate] destination as it was right in front of us and we knew it had sufficient runway distances.

After, we ACARSeed Dispatch to inform him of the event and planned destination, we never heard back and relied on ATC for updated weather and NOTAMS. We successfully fully completed the QRH checklist and had a successful/uneventful landing.

The Captain decided we would deplane and allow the passengers inside as this mechanical issue could take significant time to fix. We sat around the airport running maintenance checks with the outstation maintenance for a couple of hours, it was [late at night] at this time and scheduling was trying to extend us until [early morning hours] to complete the flight on the same aircraft. We decided we did not feel comfortable working the flight until those early hours on an extension after the stress we just went through but the chief pilot said that was not a "valid excuse" to cancel the flight, so the Captain called in fatigued and the flight ended up getting canceled.

Synopsis

CRJ-900 First Officer reported diverting to an alternate after experiencing L BLEED DUCT warning in cruise flight.
Time / Day
Date: 201708
Local Time Of Day: 1801-2400

Place
Locale Reference.Airport: ZZZ.Airport
State Reference: US
Altitude.AGL.Single Value: 100

Environment
Flight Conditions: Marginal
Weather Elements / Visibility: Rain
Light: Night

Aircraft
Reference: X
ATC / Advisory.CTAF: 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
Flight Phase: Final Approach
Airspace.Class G: ZZZ

Component
Aircraft Component: Spoiler System
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: Captain
Function.Flight Crew: Pilot Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1477893
Human Factors: Situational Awareness
Human Factors: Workload
Human Factors: Confusion
Human Factors: Fatigue

Person: 2
Reference: 2
Location Of Person.Aircraft: X
Narrative: 1

While on Approach to RWY 35 we had just come through the overcast and were maintaining 6,000 ft. We were cleared for the Approach almost 20 miles out. We elected not to cancel IFR as there was a scattered cloud layer around the airport. However we were told to maintain 6,000 ft till established inbound on the localizer. Maintaining this altitude brings you in above the glideslope. To be able to get down fast enough to catch the glideslope while still slowing to achieve Vref spoilers had to be used. I had to click the autopilot off and hand fly in order to catch the glidepath. I remember the FO struggling with the CTAF frequency even though we had it preprogrammed into the #2 comm. This led to a little bit of confusion. We reached the proper glidepath and inside 1,000 ft we received the spoilers caution message. At that point the FO reached over to retract the spoilers. Landing was made soon after and taxied into the gate without incident.

During the flight, items happen very fast with such short flight time. Weather was not good and workload was high. A HUGE contributing factor was exhaustion. A 4 leg flying day, going into a mountain surrounded airport at night with marginal weather and a low experience FO caused a high workload environment. Our approach was stable, and on the glidpath. But I do not remember at all hearing the FO call 1,000 ft. With our new CA flows to check spoilers I believe not hearing that call kept me focused on the approach since I was hand flying at the time. But being beyond tired and trying to keep with the FO duties lead to missing the spoilers call and flow. Completely my fault not just as the CA but as the pilot flying.

Narrative: 2

We were on the approach. It was dark, raining lightly, a few clouds, but pretty good visibility. It was at night, past my bedtime, and the tower was closed. The captain was the pilot flying, I was the pilot monitoring. We were using the ILS as a backup. The captain
used the flight spoilers during the descent, and then forgot that they were still out. We got rather busy during the transition to the approach, we had a little difficulty getting the runway in sight. I had a little confusion on finding the correct frequency to turn on the runway lights. The aircraft was stabilized by 1000 feet, however I forgot to make the 1000 foot call out, and neither of us realized that the flight spoilers were still out. I did make the 500 foot call out. At about 100 feet AGL I realized that the spoilers were out, and I reached over and pushed the spoiler lever forward. We landed without further incident.

Caused by fatigue, lack of alertness, late time of day, getting behind the aircraft during the transition to approach phase.

**Synopsis**

CRJ900 flight crew reported neglecting to stow the spoilers until shortly before landing.
ACN: 1477738 (10 of 50)

Time / Day
Date: 201708
Local Time Of Day: 0601-1200

Place
Locale Reference.Airport: MIA.Airport
State Reference: FL

Environment
Flight Conditions: VMC
Light: Daylight

Aircraft
Reference: X
ATC / Advisory.TRACON: MIA
Aircraft Operator: Air Carrier
Make Model Name: A300
Crew Size.Number Of Crew: 2
Operating Under FAR Part: Part 121
Flight Plan: IFR
Mission: Cargo / Freight
Flight Phase: Initial Approach
Route In Use.STAR: HILEY6
Route In Use.Other
Airspace.Class B: MIA

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: 1477738
Human Factors: Fatigue
Human Factors: Situational Awareness

Events
Anomaly.Deviation - Track / Heading: All Types
Anomaly.Deviation - Procedural: Published Material / Policy
Anomaly.Deviation - Procedural: Clearance
Detector.Person: Air Traffic Control
When Detected: In-flight
Result.Flight Crew: Became Reoriented
Result.Air Traffic Control: Issued New Clearance
Result.Air Traffic Control: Issued Advisory / Alert

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

Narrative: 1

On arrival into MIA landing 26R we were told to expect the RNAV 26R. We mistakenly edited the HILEY6 arrival with the instructions on the procedure that were listed in the Lost Comm Box for landing west operations. After waypoint HILEY we proceeded to HOXIL. After we turned to HOXIL, Approach Control asked us if he had given us a heading. We responded that he had not but we were following the landing west procedure. We said that we were incorrect and that crews often make this same mistake. He told us not to worry about it and cleared us direct to NAYIB for the RNAV 26R. We landed, taxied, and shutdown uneventfully.

Fatigue was a big factor for us. This was the second leg of [a day that included] holding and heavy storms. Many planes were delayed inbound and or required to divert due to low fuel. The presentation of the arrival chart also added to our misinterpretation, as well as other prior crews apparently. This chart was especially confusing and counter intuitive during landing west ops in MIA. More careful review of the arrival and more effective awareness of our state of fatigue.

Synopsis

A300 Captain reported a track deviation on arrival into MIA. Chart design and fatigue were cited as contributing.
ACN: 1476000 (11 of 50)

Time / Day
Date: 201708
Local Time Of Day: 1201-1800

Place
Locale Reference.Airport: MCO.Airport
State Reference: FL
Altitude.MSL.Single Value: 1600

Environment
Flight Conditions: VMC
Light: Daylight

Aircraft
Reference: X
ATC / Advisory.Tower: MCO
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
Nav In Use: FMS Or FMC
Flight Phase: Final Approach
Route In Use: Visual Approach
Airspace.Class B: MCO

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: 1476000
Human Factors: Workload
Human Factors: Confusion
Human Factors: Fatigue
Human Factors: Human-Machine Interface
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
We were assigned the PIGLT Four RNAV Arrival to land Runway 36L. 36L only has an RNAV approach so that's what I set up for even though the conditions were VFR. On the downwind leg of the PIGLT arrival we were given clearance to descend to 1600 ft and turn to a heading for an intercept to the final approach course 36L. When we reported the runway in sight we were cleared for the visual 36L. I set the VNAV for the RNAV approach and shortly after the captain noted that it might've just been easier to go direct to BERDY (the outer fix). I checked to make sure that the course line was going to intercept the extended centerline which it did. As we rolled onto final the captain asked "why are we still descending?" At that point I realize that even though I had selected VNAV it had not engaged. I disconnected the autopilot, applied power, and initiated a climb. While I was in the process of this procedure the tower announced an altitude alert for us. When we leveled off, due to the fact that we were in VFR conditions, no other traffic around, and in clear view of the runway I elected to continue the approach visually.

We continued to configure the aircraft for landing but before I could call for flaps 30 (final flap configuration) the aircraft announced 1000 feet. At that point, we were on the extended centerline, on the visual glidepath, configured, and on airspeed. I elected to continue the approach and made a normal landing.

At the point of this event we were on day four of a four-day trip. All of our sign ins had been late with long overnights. However, the night before this event we were scheduled to have a 10:35 overnight which got reduced to 10 hours as we were running late. We were three hours out of Home Base Time, getting up early in the morning. In hindsight, and after a good night's sleep, I can't believe that I didn't execute a go around at the first sign of trouble. Obviously, I was more fatigued than I realized at the time.

**Narrative: 2**

[Report narrative contained no additional information.]
Synopsis
Air carrier flight crew reported getting low while on a visual approach to MCO Runway 36L when VNAV was selected, but it did not engage.
**Time / Day**
Date: 201708
Local Time Of Day: 1801-2400

**Place**
Locale Reference.Airport: GSO.Airport
State Reference: NC
Altitude.MSL.Single Value: 3000

**Environment**
Flight Conditions: VMC
Light: Night

**Aircraft**
Reference: X
ATC / Advisory.TRACON: GSO
Aircraft Operator: Air Carrier
Make Model Name: Medium 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
Route In Use: Visual Approach
Airspace.Class C: GSO

**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: 1474594
Human Factors: Fatigue
Human Factors: Workload

**Events**
Anomaly.ATC Issue: All Types
Anomaly.Deviation - Altitude: Overshoot
Anomaly.Inflight Event / Encounter: Unstabilized Approach
Detector.Person: Flight Crew
Detector.Person: Air Traffic Control
When Detected: In-flight

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

Narrative: 1

Descending into GSO we were being given vectors for the Visual 23L. We were given a 360 heading and a descent to 3000 ft. This put us on a fairly direct course to BRANT (FAF for 23L). ATC asked us if we had the field. We were approximately 8 miles east of the field when I called the field in sight. ATC cleared us for the visual approach and told us to keep our turn inside BRANT. This would put us at about a 5 mile final so we accepted. The FO was configuring the aircraft in an appropriate time frame but was a little late initiating a descent. This was then compounded when instead of squaring the turn to final, he cut the corner a bit. These things combined with a delayed decision to disconnect the autopilot put us behind in the final configuring and descent to the runway. As he descended to get back on glide path, I mentioned we needed to be stable by just above 1,900 ft. He began to transition the descent rate to 1,000 FPM. I got busy with bugging the reference speed and completing the Before Landing Checklist. At roughly the 1,000 foot AGL call, we got a low altitude alert warning from tower combined with a 'glide slope' call from the GPWS. Apparently, his transition to the proper descent rate did not happen as quickly as I had expected it would. As best I remember we were about a dot to dot and a half below glide slope but on speed. He promptly corrected back and we continued the approach to an uneventful landing as the safety and outcome of the flight were never in doubt. With the quick succession of events, I was uncertain at the time whether we were truly in a fully stable approach but decided it was close enough to continue. However, after landing and further evaluation I determined the correct decision should have been to go around and do it again. This was a combination of an ATC alert as well as a GPWS alert.

I believe that the cause of this was due to a couple factors. The set up to the approach became hurried with the ATC instruction to keep it in a little tight. This combined with a degree of breakdown in crew coordination resulted in the altitude alert (i.e. I should have been more vocal earlier when I saw the potential for us to get behind). Additionally, the decision to continue with an unstable approach was a poor judgement call on my part due in part to my indecision in the moment as well as my desire to complete the flight due to starting to feel tired.

A positive pitch correction was initiated immediately and the aircraft was returned to the proper glide path.

Synopsis

Air carrier Captain on approach to GSO Runway 23L reported a low altitude alert from Tower and GPWS alert at 1,000 AGL, but continued to land.
ACN: 1474548 (13 of 50)

Time / Day
Date: 201708
Local Time Of Day: 0601-1200

Place
Locale Reference.Airport: BWI.Airport
State Reference: MD
Altitude.MSL.Single Value: 1000

Environment
Flight Conditions: Mixed
Weather Elements / Visibility. Visibility: 7
Light: Dawn
Ceiling. Single Value: 200

Aircraft
Reference: X
ATC / Advisory.Tower: BWI
Aircraft Operator: Air Carrier
Make Model Name: B737-700
Crew Size.Number Of Crew: 2
Operating Under FAR Part: Part 121
Flight Plan: IFR
Mission: Passenger
Flight Phase: Initial Approach
Airspace.Class B: BWI

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)
ASRS Report Number. Accession Number: 1474548
Human Factors: Fatigue

Events
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

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

**Narrative: 1**

Approaching BWI we were being vectored for the visual 33L. We were left high on the arrival due to a short flight. We were assigned the RAVNN 6 THHMP transition, but we were limited to 16,000 ft due to an MEL for the number 2 IDG (Integrated Drive Generator) so the altitudes were not flown as assigned on the arrival. Weather was dawn with 7SM visibility and some scattered clouds. We were expecting the visual and on a heading direct GRAFE, the FAF.

Approximately one to two miles from GRAFE, ATC asked if we would prefer the ILS. We still didn't have the airport in sight so we elected to take the ILS. We briefed it only as a backup to the visual so everything was setup except for minimums. The PF (Pilot Flying) was busy trying to slow when we were cleared immediately for the ILS. Our course had us headed to GRAFE at approximately 2000 ft. The aircraft intercepted the Localizer over GRAFE and the PF was busy trying to configure and slow. I had stated the aircraft was not descending yet upon crossing and we were at 2000 ft; all the while in VMC conditions but with the airport not in sight.

The VNAV showed us about 500 ft high on the path but correcting. I missed the 1000 ft call due to the rushed conditions but caught up and stated one at 800 ft. The PF was still correcting on the glideslope. We had a Pull Up (I think, it was a GPWS warning but I could be wrong on the exact verbal warning) as the PF was still correcting. We went IMC approximately 400 ft AGL and I called approaching minimums at 100 ft above. I had to reference the Approach plate as we didn't have the minimums set. PF had the correct responses and I called minimums and we landed uneventfully although slightly above REF speed.

ATC asked us if the shallow layer was an issue when landing and we stated it was at minimums. The first we were told of any cloud layers. As the PM (Pilot Monitoring), I didn't do my duties when I stayed quiet about a go-around. Everything happened so fast and I had no doubt the PF wouldn't get it stabilized, but it was too late in the approach when it did stabilize. Upon the GPWS call an immediate go-around is required and neither one of us called for it.

**Synopsis**

B737-700 First Officer reported crew received a GPWS warning on an ILS approach to BWI and encountered IMC conditions close to minimums, did not go around but landed.
**Time / Day**
Date: 201708
Local Time Of Day: 1201-1800

**Place**
Locale Reference.Airport: ORD.Airport
State Reference: IL
Altitude.AGL.Single Value: 0

**Environment**
Flight Conditions: VMC
Light: Daylight

**Aircraft**
Reference: X
ATC / Advisory.Tower: ORD
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: 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: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1472086
Human Factors: Fatigue
Human Factors: Situational Awareness
Human Factors: Time Pressure

**Events**
Anomaly.Flight Deck / Cabin / Aircraft Event: Other / Unknown
Anomaly.Deviation - Procedural: Published Material / Policy
Detector.Person: Flight Crew
When Detected: In-flight
Result.Flight Crew: Rejected Takeoff

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

**Narrative: 1**
EVENT: Rejected Takeoff (RTO) due to configuration warning.

FLIGHT CREW DUTIES: CA: PM; FO: PF.

EVENT DESCRIPTION: Upon lining up on runway 28R at taxiway November 5, FO advanced throttles for takeoff. Nearly instantly, crew received a configuration warning due to improper flap position. FO maintained aircraft control, retarded the throttles and applied the brakes to perform the RTO. CA advised ATC, took control of the aircraft and exited the runway, per ATC instructions. No other warnings or cautions were observed. All brake indicators were at 2 or below. Crew was resequenced for takeoff and performed the rest of the trip without incident.

BACKGROUND:
Prior to this incident, crew executed two legs aboard another aircraft. On each of these legs the aircraft APU was deferred. Each of the legs were notably delayed due to issues on the ground. Upon arrival back at ORD, the crew swapped airplanes and rushed to the new gate to board the incident aircraft. The crew expeditiously prepared the new aircraft for pushback and taxi in an attempt to get back on schedule. During pushback, the FO's before taxi flow was interrupted briefly and flaps were not lowered to the proper position, even though all other flow items were accomplished correctly. The taxi checklist was performed. Crew received clearance and taxied to runway 28R/N5 and while in the number 4 position for takeoff the crew performed the, Before Takeoff Checklist, to the line. Crew was cleared into position and read the, Before Takeoff Checklist, below the line and shortly thereafter, the incident occurred.

While the aircraft system logic provided the most immediate and direct solution to preventing a departure with an improper flap setting, both the CA and the FO remarked to each other how neither had ever attempted a takeoff with an improper flap setting before this incident and, during a crew debrief, identified their being dehydrated, rushed, undernourished and tired as possible contributing factors that while apparent afterward, were not necessarily apparent in the time leading up to the incident.

In arriving at his particular thought, the crew considered the following:

1) Both of the previous legs were notably delayed due to issues on the ground at ORD. Ground crew's slow acquisition of "start-cart" for ground air start. 
2) Ramp congestion resulting in 10-15 minute sit at the gate.
3) Taxi to out-of-the-way area, away from gate (at ORD) to perform cross-bleed start.
4) As the delay time increased, so did the temperature on the flight deck due to the inoperative APU.
5) By the time the crew departed the flight deck was exceedingly hot and the crew noted the possibility of heat related impairment as a threat during the takeoff brief and while on the approach to next airport.
6) Ground ops at next airport were rushed and the crew turned the aircraft as fast as conditions would allow.
7) The temperature in the cockpit was still exceedingly hot and the crew, again, mentioned heat related impairment as a possible and very real threat as they prepared to depart.
8) As stated above, upon arrival at ORD, the crew swapped airplanes and rushed to the new gate to board and prep the incident aircraft.
9) The crew expeditiously prepared the new aircraft for pushback and taxi in an attempt to get back on schedule however, as the crew later realized, they were now dehydrated, rushing and starting to feel the effects of a lack of nourishment.
10) Additionally, prior to the incident, the FO had flown 16 legs over the past 3 and a half days and the CA was a commuter. Both had remarked how they were feeling the effects of
a tough schedule.
11) In realizing all of this the crew concluded, even though they performed the appropriate checklists, they, "saw what they wanted to see," when they looked to confirm the flap setting and noted their physical condition as a definite contributing factor.

RECOMMENDATION: If a crew finds that it must, for whatever reason, fly an aircraft with a non-functioning APU, the crew MUST ensure each member is THOROUGHLY hydrated and nourished. In so doing, the crew can not only mitigate the brutal effects of an inoperative APU during a hot summer day but also mitigate the effects of being slightly tired while operating at a heightened operational tempo.

Synopsis

CRJ-200 First Officer reported a rejected takeoff due to improper flap position.
ACN: 1471726 (15 of 50)

**Time / Day**
- Date: 201708
- Local Time Of Day: 0001-0600

**Place**
- Locale Reference.Airport: DFW.Airport
- State Reference: TX
- Altitude.AGL.Single Value: 50

**Environment**
- Flight Conditions: Mixed
- Light: Night
- Ceiling.Single Value: 1500

**Aircraft : 1**
- Reference: X
- ATC / Advisory.Tower: DFW
- 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.Localizer/Glideslope/ILS: Runway 35C
- Flight Phase: Landing
- Airspace.Class B: DFW

**Aircraft : 2**
- Reference: Y
- ATC / Advisory.Ground: DFW
- 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: Taxi

**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: 1471726
- Human Factors: Fatigue
- Analyst Callback: Attempted
**Events**

Anomaly.ATC Issue : All Types  
Anomaly.Inflight Event / Encounter : Wake Vortex Encounter  
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 : Procedure  
Primary Problem : Procedure

**Narrative: 1**

In the flare after an ILS approach to Runway 35C at DFW I initiated a go-around due to wake turbulence from the preceding arrival. On glide path at about the 50 ft radio altimeter call out the wings started rocking. I attempted to slightly flatten out the descent angle to rise above the turbulence but the oscillation continued for another cycle. At around 20-30 feet and nowhere near stable due to the buffeting I initiated an autopilot-off go-around. We followed ATC instructions and returned to land uneventfully on runway 35R.

In my opinion the event occurred due to poor spacing by the DFW approach facility. We had followed this aircraft on the arrival and in fact were kept 1000 ft higher than normal at SILER due to our tight lateral separation. The ATIS had advertised visual approaches with a 1500 ft reported ceiling but were told to expect the ILS by the Controller. As we joined final we were instructed to maintain 170 knots to a five mile final. The next transmission we received informed us that we had a 40 knot overtake on the aircraft in front of us yet there was no amendment to our previous speed assignment by the Controller. Based on that information I put the gear down with landing flaps and asked the FO to query the Controller whether he still wanted that 170 knots given our closure rate. Of course I knew the answer but when the FO finally got the question out the Controller responded by telling us to reduce to final approach speed, which I was already doing. Basically what happened is the Controller treated us like we were a visual instead of an ILS, even though we were IMC until after passing the FAF. We were never informed what type of aircraft we were following. At some point in the radio exchanges subsequent to our go-around the FO was able to glean that the preceding aircraft whose wake we hit was a B757. By the way this was the return leg of an all-nighter, the second consecutive night in a row for me.

It would have helped to have known the type aircraft whose heels we were nipping on final approach. The "170 to five mile final" instruction was unrealistic given our separation and the weather. Not exactly how you want to end an all-night duty period.

**Synopsis**

A321 Captain reported executing a go-around after encountering wake turbulence during their landing flare in trail of a B757 to DFW airport.
Time / Day

Date: 201708
Local Time Of Day: 1801-2400

Place

Locale Reference. Airport: MDW.Airport
State Reference: IL
Relative Position. Distance. Nautical Miles: 15
Altitude. MSL. Single Value: 3000

Environment

Light: Night

Aircraft

Reference: X
ATC / Advisory. TRACON: C90
Aircraft Operator: Air Carrier
Make Model Name: Medium Large 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
Nav In Use: GPS
Flight Phase: Initial Approach
Route In Use. Other
Airspace. Class B: MDW

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: 1471308
Human Factors: Confusion
Human Factors: Fatigue
Human Factors: Time Pressure
Human Factors: Workload
Human Factors: Communication Breakdown
Communication Breakdown. Party1: ATC
Communication Breakdown. Party2: Flight Crew

Events

Anomaly. ATC Issue: All Types
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 :Requested ATC Assistance / Clarification  
Result. Flight Crew :Became Reoriented  
Result. Air Traffic Control : Issued New Clearance

**Assessments**

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

**Narrative: 1**

We were proceeding direct to SAILZ on the RNAV Y 22L. ATC told us to turn right 20 degrees and "join the final." I turned right 20 degrees and Captain went to FMS to put in an intercept to the final approach segment which begins at YACHT. Quickly realized this did not make sense as intercepting the extended centerline of the runway would take us over downtown/inconsistent with this type of approach. Had ATC meant left 20 which would have us join the centerline of the runway south of downtown? Had ATC meant right 20 to join the INTERMEDIATE segment of the approach, a clearance I had never heard before in 10,000 hours of flying? Captain attempted to clarify but could not get a response. ATC then advised we were right of the intended course. They issued a heading to rejoin the approach which would have taken us head on into arriving traffic. We rejoined approach on our own and landed without incident.

Recommend a speed adjustment instead of heading if the intent was to adjust spacing. No "heading to join" when you're basically already on the published approach. I should have clarified before starting the turn. Unfamiliarity with the approach and approaching almost eight hours of block, I caught the confusion after I turned.

**Synopsis**

Air carrier First Officer reported a C90 TRACON Controller issued a 20 degree right turn while on the MDW RNAV Runway 22L Approach which would have placed the aircraft over the city. The crew realized the error, but ATC did not respond to clarify. ATC did finally issue an accurate vector to rejoin the approach.
**ACN: 1468849 (17 of 50)**

**Time / Day**
- Date: 201707
- Local Time Of Day: 1201-1800

**Place**
- Locale Reference.Airport: MIA.Airport
- State Reference: FL
- Altitude.AGL.Single Value: 0

**Environment**
- Light: Daylight

**Aircraft**
- Reference: X
- ATC / Advisory.Ramp: MIA
- 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
- Flight Phase: Taxi

**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)
- ASRS Report Number.Accession Number: 1468849
- Human Factors: Distraction
- Human Factors: Fatigue

**Events**
- Anomaly.Deviation - Procedural: Published Material / Policy
- Anomaly.Ground Event / Encounter: Object
- Detector.Person: Flight Crew
- When Detected: Taxi
- Result.General: Maintenance Action
- Result.Aircraft: Aircraft Damaged

**Assessments**
- Contributing Factors / Situations: Company Policy
- Contributing Factors / Situations: Human Factors
- Primary Problem: Human Factors

**Narrative: 1**
Whilst approaching the gate in Miami, at the culmination of the flight, the area appeared to be clear. I called clear on the left and the first officer responded clear on the right. I saw from the automatic guidance that L2 was displayed, so I asked the first officer to advise the purser that L2 was being used. On the left side of the gate approach area there was an air conditioning cart parked in the safe area, close to but outside the line. I noticed that the air conditioning ducting did not appear to be secured on the cart so as a precaution against it possibly being blown into the left engine by jet wash, I instructed the first officer to shut down the left engine and we continued the last few yards to the gate on the right engine. As I followed the automatic guidance, we failed to notice that the tug and tow bar were positioned incorrectly and as we were coming to a stop, the tow bar contacted the left nose gear tire causing a cut in the tire. We called maintenance and requested a nose gear inspection and made an entry in the AML. I then notified dispatch. A tire change was completed and the aircraft departed as scheduled.

This event was a direct result of poor ramp management in Miami. Two traps were set for the incoming aircraft at this gate. The cart with the unsecured AC ducting in close proximity to the safety zone and the tug/tow bar protruding into the safety zone. The automatic parking guidance system was turned on without anyone first checking that the safety zone was safe. The threat of the cart with the unsecured air conditioning hose parked in close proximity diverted our full attention causing us to miss the threat that the tug/tow bar was protruding into the safety zone, something that we should easily have caught if that had been the only issue. We had a [early morning] wake up that morning and though we both felt we were adequately rested, some level of fatigue may have affected our alertness. A misguided level of confidence in the automatic parking guidance system. In the past it has given a stop command when a significant obstacle is detected in the safety zone. Not having someone standing in front of the aircraft actively monitoring our progress with the ability to signal a stop if a safety issue is observed Ramp control/operations has camera views of the gate area. There was only one other aircraft movement at the time of our arrival and they were holding for us. Could an alert ramp controller have been another layer of safety in preventing this incident? The agent on the jet bridge said she saw the tow bar was an issue but had no way to alert us in time. Is there a communication channel input to the parking guidance system that would facilitate a STOP input to the guidance display from the jet bridge and ramp? Maybe hand held VHF communication set to the ramp frequency for urgent safety communication only. I accept full responsibility for the safety of my aircraft, crew and passengers but my job is made much more difficult by poor ramp training and Control which set the trap for this incident. I often feel that the pilots are the sole safety layer in the Miami ramp area instead of being the final layer.

[Suggest] having a person actively monitoring an aircraft being guided in by the automatic guidance system, positioned where a stop signal can easily be seen by the captain. If there is even the slightest distraction during the parking process, stopping until the issue is resolved or stop and get towed to the gate. Over 25 years of flying, I have never once had to stop to have someone clear an obstacle in the safety zone. Arriving in Miami on the other hand, it is a regular occurrence. We regularly have had to stop and gesticulate to ramp personnel about an obvious object in the safety zone. It points to a lack of training, management and accountability for safe ramp operations. Having ramp personnel not park, stop or place any equipment in the safety zone except when servicing an aircraft at the gate. Before the aircraft is pushed back, the safety area should once again be cleared until the arrival of the next aircraft. A zero tolerance policy should be adopted. Whoever turns the automatic gate parking guidance system on should be responsible for the safety zone being clear before turning the system on and a log should be placed next to the switch where a name, employee number, time and initial has to be entered, accepting
responsibility for the area being safe for an aircraft to enter the gate area before turning the automatic guidance system on. I also believe that better ramp control of the alley between concourses could improve safety and on time performance. On numerous occasions, I have had to hold while an aircraft is pushed back and disconnected in front of my gate when more proactive controlling could have had them instruct the crews to push further back or pull forward to a clear area before disconnecting to avoid unnecessary delays. This causes frustration for the crews with the associated negative impact on safety. The agent at the jet bridge waiting for an aircraft arrival could be another safety layer, inspecting the safety area from the jet bridge and alerting someone if a safety issue is noticed. An accountability program being put in place. Inbound aircraft noticing a safety issue could for example say "snapshot gate #" on ramp control and the event is documented and an immediate call is made to the crew chief or implicated party requesting a reason for the safety issue. It could be tracked by a simple program.

A program of the gate camera system being used to scan the safety area prior to each aircraft arrival and immediate notification to a crew chief or a mobile safety monitor to resolve an issue before the aircraft even enters the ramp area. Random safety audits by a ramp supervisor of gate areas prior to aircraft arrival. Too much burden is being placed on cockpit crews dealing with these unnecessary safety distractions. The crews have often had long and often stressful days due to weather, terrain, passenger, technical challenges and they should never be placed in jeopardy situations by completely avoidable situations caused by poor ramp control and management.

**Synopsis**

B757-200 Captain reported contacting a tow bar attached to a tug as he parked using an automated parking system in MIA.
Time / Day
Date: 201707
Local Time Of Day: 0601-1200

Place
Locale Reference.Airport: ORD.Airport
State Reference: IL
Altitude.MSL.Single Value: 10700

Environment
Light: Daylight

Aircraft
Reference: X
ATC / Advisory.TRACON: C90
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
Nav In Use: FMS Or FMC
Flight Phase: Cruise
Route In Use.STAR: FYTTE4
Airspace.Class E: C90

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)
ASRS Report Number.Accession Number: 1467862
Human Factors: Fatigue

Events
Anomaly.ATC Issue: All Types
Anomaly.Deviation - Altitude: Excursion From Assigned Altitude
Anomaly.Deviation - Track / Heading: All Types
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

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

**Narrative: 1**

My Captain and I were operating our 2nd redeye in a row. Our flight was delayed more than 2 hours and it was [very early morning] when we finally left [the departure airport]. About an hour before arrival we started receiving reroutes and altitude changes for thunderstorms in ORD. At some point ATC cleared us "to FYTTE, via the FYTTE 4 arrival, hold at FYTTE as published, 10 mile legs ok". The captain inserted the hold from the database and I said it looked good. As he finished and looked at the Navigation Display he seemed shocked and told me to tell ATC we would be high at a certain waypoint. I was very confused because I did not think we were given a descent clearance and did not confirm a lower altitude was set in the FCU. The captain started down as I told the controller we were a little high and her response was "you were not cleared to descend via the arrival but just cross FYTTE at 11,000." We had deviated about 300 feet. We continued our descent down and started our hold at FYTTE. On our outbound leg the controller asked us to verify we were holding as published. The Captain told me to ask her where it was published and another pilot came on the radio and said it was at the bottom of the chart. We both looked at the chart and realized the hold is published with left turns but the database had right turns, so we were holding on the wrong side of FYTTE. I told the controller we would fix it on the next turn. We continued holding for 5 minutes and were cleared direct to FYTTE to resume the arrival and began our approach to 10C. We landed without further incident.

Fatigue was the major contributor to these deviations. I had only slept 4.5 hours the day prior because a maid had knocked on my door to clean my room even though I had the Do Not Disturb sign on my door. Operating another flight plus a delayed redeye with that little of sleep was poor judgement on my part and I will call in fatigued next time.

**Synopsis**

Air Carrier First Officer reported a hold on the wrong side of FYTTE on the FYTTE 4 arrival to ORD due to fatigue.
**ACN: 1462581 (19 of 50)**

**Time / Day**
- Date: 201707
- Local Time Of Day: 0001-0600

**Place**
- Locale Reference.Airport: PNS.Airport
- State Reference: FL
- Altitude.MSL.Single Value: 1700

**Environment**
- Flight Conditions: VMC
- Light: Night

**Aircraft**
- Reference: X
- ATC / Advisory.TRACON: P31
- Aircraft Operator: Air Carrier
- Make Model Name: Medium 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
- Route In Use: Visual Approach
- Airspace.Class C: PNS

**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: 1462581
- Human Factors: Distraction
- 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: First Officer
- Function.Flight Crew: Pilot Flying
- Qualification.Flight Crew: Air Transport Pilot (ATP)
- Experience.Flight Crew.Total: 1700
Events

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

Assessments

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

Narrative: 1

Expecting a visual to 17 we were 20 miles out and direct to PNS. A scattered layer at 2000 MSL was obstructing our view so I asked approach control for direct to BRENT. Approach control gave us direct BRENT and descend to 1700 MSL. On a right base direct BRENT the FO said he spotted a beacon, but I still couldn't see it thinking the layer was the reason. I had listened to the ASOS and noted pilot controlled lighting was on CTAF but forgot to click the lights on using COMM2. We were slowed to 160 kts with Flaps 3 and gear down as we approached 3 miles from BRENT. Approach told us field at 2 o'clock, I replied still searching. Approach gave us a 140 heading to join. This had us going inside BRENT at 1700 MSL. The FO stated, "Oh, the runway lights are off". I scrambled to click the lights on with COMM2 but had 119.1 tuned in. The FO disengaged the AP pitched the nose down to remain on glide path while I was doing this. We were not cleared for an approach however. We lost 150 to 200 feet of altitude. Approach control told us, "Low altitude alert" and gave us a left turn heading 090. We corrected back to 1700 MSL. We were vectored back around for the ILS but by now had the lights on and the runway in sight.

Both the FO and I remarked during the descent that we could feel the lateness of the night and were fighting to remain alert. We think this contributed to the event. ATC turning us inside final while holding 1700 ft MSL was not a help. The FO's reaction was to start descending to capture the glide path because he knew otherwise we would be too high. But because we were neither cleared for a visual or the ILS, we should have remained at 1700. I had my focus on the box correcting a frequency and clicking on lights when I should have accomplished that a while ago so I could maintain situational awareness at a critical time. Taking the initiative to activate runway lights early on instead of waiting to see the airport beacon would have given us the visual in time. Also asking for a vector to join outside of the FAF would buy more time to see the airport and control the lighting.

Narrative: 2

After thinking about the events the causes were the runway lights being off and my failure to recognize a slight descent. The pilot monitoring thought she was clicking them on but the frequency was off by one digit. Also, I should have left the autopilot on until we were cleared the approach to assure we didn't drift down. Task saturation as well as trying to find the runway (eyes outside) probably led me to not noticing a loss of altitude prior to being cleared the visual. Both crew members noted prior to descent that we were
beginning to feel the effects of a long day with multiple weather delays and deviations. Finally the turn inside the final approach fix only exacerbated the situation by giving us less time.

In the future this situation can be mitigated by a more detailed brief describing the additional actions necessary for a closed runway, also if I had left the autopilot on the plane would not have drifted down. I also would not have accepted the heading that cut us inside the final approach fix and instead asked for a vector away. ATC informed us on our vectors to the ILS that he could see that the lights were not on. It would have been nice to have been told this information sooner considering he knew we were having trouble finding the runway and we thought we were clicking the lights on.

**Synopsis**

Air carrier flight crew reported difficulties during a night visual approach to PNS due to the runway lights not being activated via mic clicks. A low altitude alert was issued by ATC and the flight was vectored back around for another attempt.
Time / Day
Date: 201706
Local Time Of Day: 1201-1800

Place
Locale Reference.Airport: DRO.Airport
State Reference: CO
Altitude.AGL.Single Value: 0

Environment
Flight Conditions: VMC
Light: Daylight

Aircraft
Reference: X
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: Parked

Component
Aircraft Component: Aero Charts
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
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1460864
Human Factors: Fatigue
Human Factors: Workload
Human Factors: Time Pressure

Events
Anomaly.Deviation - Procedural: Weight And Balance
Anomaly.Deviation - Procedural: Published Material / Policy
Detector.Person: Ground Personnel
When Detected: Aircraft In Service At Gate
Result.General: None Reported / Taken

Assessments
Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Airport
Contributing Factors / Situations : Chart Or Publication
Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Human Factors
Primary Problem : Chart Or Publication

**Narrative: 1**

The Jeppesen 10-7 for DRO shows ACARS available. Late in the loading and W&B computation process, the Ramp Agent alerted us that [our aircraft type] did not have ACARS access and we then verified that to be the case and began an expedited process to complete a manual manifest by dividing the task between the two pilots. In so doing we did not notice the omission of the 25-pound pet enclosure weight and so that weight was not included in the manual manifest.

[There was] a small amount of fatigue after a demanding arrival and approach to DRO, followed by a sizable and unexpected add on task at the last minute. If the 10-7 for DRO was to accurately reflect the non-availability of ACARS for [our aircraft type], then advance preparation for a manual manifest would be provided and crews would prepare for it in a timely manner.

**Synopsis**

Air carrier Captain reported that incorrect 10-7 chart information on ACARS availability led to rushed manual weight and balance computation resulting in a minor error.
ACN: 1459500 (21 of 50)

Time / Day
Date: 201706
Local Time Of Day: 1801-2400

Place
Locale Reference.Airport: EGLL.Airport
State Reference: FO

Environment
Flight Conditions: Marginal
Weather Elements / Visibility: Turbulence
Light: Dusk

Aircraft
Reference: X
ATC / Advisory.TRACON: EGLL
Aircraft Operator: Air Carrier
Make Model Name: B777 Undifferentiated or Other Model
Crew Size.Number Of Crew: 3
Operating Under FAR Part: Part 121
Flight Plan: IFR
Mission: Passenger
Nav In Use: FMS Or FMC
Nav In Use: GPS
Nav In Use.Localizer/Glideslope/ILS: Runway 27R
Flight Phase: Initial Approach

Component
Aircraft Component: Navigational Equipment and Processing
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: Captain
Function.Flight Crew: Pilot Not Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
Experience.Flight Crew.Total: 21500
ASRS Report Number.Accession Number: 1459500
Human Factors: Fatigue
Human Factors: Situational Awareness
Human Factors: Time Pressure
Human Factors: Workload
Human Factors: Confusion

Events
London Final Approach has our aircraft on a vector, base leg for Runway 27R. Approach for 27R had been selected and briefed and instead of the usual holding pattern at Ockham, the controller put us on a heading and descent for the approach without delay. On base leg controller gave us a 300 degree heading to intercept the localizer and once on the LOC descend on the glideslope. Aircraft displayed LOC Capture and began turning to intercept the final course 27L. ILS ERROR came up on the FMC. We noted aloud the Aircraft was aligning on the wrong runway. Approach reminded us we were cleared for 27R. We acknowledged we had a NAV anomaly, we resumed 300 degrees using raw data while I manually typed in the proper ILS frequency for 27R. Localizer and glideslope were intercepted, approach continued and landing was successfully achieved without incident. At no time was a break out required nor was any evasive maneuver required during the anomaly. FMC NAV Error was recorded in Maintenance Logbook for follow-up investigation upon flight termination.

The FMC locked into the frequency for the ILS to 27L when it was selected on the ground during the FMC preflight programming of the entire route. The ILS Identifier is in the upper left quadrant of the PFD. Our normal cadence for preparation was thrown off slightly when we transitioned from expecting a hold at OCK to being cleared right into Heathrow. This expeditious handling got us saturated into configuration (speed slow down, descent profile for the CDA profile) and the ILS Frequencies was omitted out of our cross check. It wasn't until the aircraft actually turned to the parallel runway did we notice the discrepancy along with the ILS ERROR message on the FMC.

I suggest ALWAYS cross check that the ILS Frequency for your Selected Approach is in the upper left of your PFD. Don't assume the aircraft will ALWAYS automatically select the proper frequency despite that being on this aircraft [for a while] this anomaly has never happened to me. Just because the Map display is correct, doesn't mean the Navaids have followed.

Synopsis
A B777 Captain reported programming the FMC incorrectly during preflight and lined up for the parallel runway.
Time / Day
Date: 201706
Local Time Of Day: 0001-0600

Place
Locale Reference.Airport: DCA.Airport
State Reference: DC
Altitude.AGL.Single Value: 1000

Environment
Flight Conditions: VMC
Light: Night

Aircraft
Reference: X
ATC / Advisory.Tower: DCA
Aircraft Operator: Air Carrier
Make Model Name: Large Transport
Crew Size.Number Of Crew: 2
Operating Under FAR Part: Part 121
Flight Plan: IFR
Mission: Passenger
Flight Phase: Final Approach
Flight Phase: Initial Approach
Route In Use: Visual Approach
Airspace.Class B: DCA

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: 11583
ASRS Report Number.Accession Number: 1459495
Human Factors: Troubleshooting
Human Factors: Distraction
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
ASRS Report Number.Accession Number: 1459508
Human Factors: Workload
Human Factors: Fatigue
Human Factors: Distraction
Human Factors: Situational Awareness

Events

Anomaly. Inflight Event / Encounter: CFTT / CFIT
Detector. Person: Flight Crew
When Detected: In-flight
Result. Flight Crew: Became Reoriented
Result. Flight Crew: Took Evasive Action

Assessments

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

Narrative: 1

I was pilot monitoring. We were cleared for River Visual Approach to runway 19 at DCA. FO had visual on the river and began the approach. Aircraft was on the path. Told to contact tower and I went heads down to switch over and get landing clearance. When I looked back up we were below the path and descending. Just as I directed a correction we got a GPWS terrain warning. FO disconnected the autopilot and started correcting back to the descent path. I also directed a turn to the left to continue following the river. We configured the aircraft and he was slightly below the path at 1000 ft and correcting. At 500 ft he was stable and following the VASI guidance. Landing was uneventful.

Narrative: 2

I was flying the aircraft, the Captain Pilot monitoring (PM). Was given the River Visual 19, which I had flown many times. Given descent to 3000 prior to FERGI LVL CHG, no problem reaching 3000 feet prior to FERGI ALT HOLD, was gear down flaps15 prior to FERGI and fully configured by GREYZ. CLEARED for RIVER VISUAL, Captain set 600 ft in altitude window and started down on visual (10 miles vis). Our descent rate got a little high on way point after SETOC which set off the TERRAIN ALERT, Approach called us at almost the same exact time with a TERRAIN ALERT. Added power (disconnected auto pilot) immediately and climbed turning slightly away from RESTRICTED AREAS P-56A/B until a safe altitude to re-established on PAPIs landing uneventful.

I didn't feel that tired, but fatigue had to have been a player landing at midnight, last two nights were short and all late flights. I had only received about 6.5 to 7 hours of sleep woke twice, once someone at my door. Should have called in FATIGUE. Inside outside scan broke down a bit after SETOC got a little low setting off TERRAIN ALERT because of sky scrapers.

Get proper amount of sleep and call in FATIGUED when you don't get it.

Synopsis

Flight crew of a large transport jet reported going below glide path on approach into DCA resulting in a GPWS warning. After correcting the flight landed normally.
As part of my responsibilities under SMS (Safety Management System) I feel it necessary to report an identified hazard that could lead to an accident or injury/harm to personnel. In this case the hazard relates to FAR 117.5(b) and the joint responsibility which requires that no certificate holder may assign and no flight crew member may accept an assignment to a FDP (Flight Duty Period) if the flight crew member has reported for a FDP
too fatigued to safely perform his or her assigned duties.

[Company] delivered an unequivocal message to the pilot group to increase the acceptance rate of FDP extensions. Further operational pressure has also been reported to me monthly by pilots in the recurrent training classes I am responsible for teaching as well as line pilots I fly with. I have brought these concerns about operational pressure negatively impacting the fatigue program and operational safety to my supervisor in an effort to address them, but his response was to either toe the company line or remain silent when the company's operational pressuring tactics are raised by pilots in class.

During the day and flight segment specific to this report, I witnessed firsthand the operational pressure exerted by the company when I was reassigned to operate a flight that would require me to extend my FAR 117 duty day. On this day I attempted to provide the company with sufficient time to address any operational issues associated with my inability to accept an FDP extension, and these were ignored or forgotten about. Over the course of the day [I] reported to several different company employees, several times that I would be unable to accept the flight assignment that would require an extension beyond my 117 limits and each time I did I received operational pressure from the crew scheduler and the duty pilot I spoke to. This included questioning my fit for duty assessment by characterizing me as "unwilling", implying that the length of time of the extension was not substantial, drawing attention to the lack of other crewmembers available for the flight segment in question, as well as consequences to the operation if I did not accept, re-iterating that it would only extend my duty period that "everyone wins, we don’t take a cancellation and you get to go on your days off and go on vacation." Under threat of disciplinary action I was forced to accept a flight segment I knew would result in the rolling of my day off.

Once at the outstation in ZZZ I had to call crew scheduling again, telling them I would be unable to operate the flight back. Instead of immediately terminating the FDP there was further questioning of my fit for duty assessment thereby delaying the operational response and delaying my rest opportunity. By continuing the FDP after multiple notifications the company was in violation of 117.5 (2) "immediately terminate a flight crew member's FDP if the flight crew member does not affirmatively state before beginning a flight segment that he/she is fit to safely perform the assigned duties." In addition the operational pressure exerted on myself and other crewmembers by front line crew schedulers, supervisors, duty pilots, chief pilots, and senior management, runs contrary to the stated language of 117 II 1. C. ii whereby the FAA strongly encourages certificate holders to voluntarily terminate the FDPs of flight crew members who are showing signs of fatigue.

The operational pressure from the company by crew schedulers, supervisors, duty pilots, chief pilots, and senior management, that might have influenced my decision and many other pilot's decisions to accept a flight segment when they are not fit for duty, [could] lead to an incident or accident because of fatigue. Whenever a pilot reports they are unable to accept a 117 extension any questions or conversation from the company should only be related to the safety of the flight segment in question and whether or not the crewmember is fit for duty. Any other questioning or conversation can only be interpreted as coercion through operational pressure. At the first notification of an inability to extend the company should comply with 117 and reassign the flight segment to another crewmember rather than hope the pilot will go against his better judgement and fly in a fatigued state in order to solve operational problems caused by insufficient staffing by the company.
Synopsis

Air carrier Captain reported receiving pressure from company personnel to accept FAR 117 flight duty period extensions despite reporting a desire not to extend due to fatigue.
ACN: 1457523

Time / Day
Date: 201706
Local Time Of Day: 0601-1200

Place
Locale Reference.Airport: EHAM.Airport
State Reference: FO
Altitude.AGL.Single Value: 0

Environment
Flight Conditions: VMC
Light: Daylight

Aircraft
Reference: X
ATC / Advisory.Tower: EHAM
Aircraft Operator: Air Carrier
Make Model Name: Large Transport, Low Wing, 2 Turbojet Eng
Crew Size.Number Of Crew: 3
Operating Under FAR Part: Part 121
Flight Plan: IFR
Mission: Passenger
Nav In Use: FMS Or FMC
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
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1457523
Human Factors: Communication Breakdown
Human Factors: Distraction
Human Factors: Fatigue
Human Factors: Situational Awareness
Human Factors: Confusion
Communication Breakdown.Party1: Flight Crew
Communication Breakdown.Party2: ATC

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: 1459216
Narrative: 1

After landing and receiving taxi instructions which were difficult to clearly understand due to the ground controllers accent and rapid speech rate. We proceeded to taxi according to what we read back to ground control. An aircraft after landing behind us took a reverse high speed taxiway and was difficult to see due to it coming behind us at a diagonal, taxied in front of us forced us to stop abruptly then ground controller proceed to chastise us about that we were supposed to have stopped and held for aircraft.

Strong accent and rapid talking rate from controller with fatigue from all nighter on our part. Double question controllers.

Narrative: 2
Landed 36C in EHAM cleared at W3. Contacted ground control, he spoke very fast, I had to ask 3 times for him to repeat the instructions - Bravo-Quebec, hold short Quebec 1. We taxied down Delta (Delta turns into Bravo) I was looking for the hold short point on the taxi chart. At this point an RJ had cleared 36C at W6 a reverse high speed. We were just about to W6 when Ground control asked if we saw the RJ. I had not seen them because of them coming down the reverse high speed and due the size of the aircraft. They were taxing at pretty fair speed. Ground control then told us to stop and give way. Ground then told us that we should have given way on our own. The ground controller could have been much clearer with the instructions and should have said to give way at W6 or to hold short of W6 if it was going be an issue.

**Narrative: 3**

This was my first time in EHAM. The FO had been there several times recently. The CA had limited experience at this airport. When the taxi clearance was given, I was looking at my 10-9 chart. We had briefed possible taxi instruction during approach briefing. We got cleared according to what we had briefed. Approaching taxiway W6, ground controller gets upset with us because he says he told us to hold short of W6. I don't recall any such instruction. Being in a depleted state of mental alertness due to long overnight flight, I suppose its possible there was such an instruction but none of us heard it. Controller's English was not what we are accustomed to.

**Synopsis**

Air carrier flight crew reported a ground conflict at EHAM after all three pilots misunderstood the Ground Controller's hold short instructions because of rapid, accented speech.
This [report] has nothing to do with this particular flight. It has to do with every flight in which the FAA (as I understand it) requires the landing pilot to take the last break. I fly mostly [relief pilot position], but on occasion fly as [flying First Officer]. There is one CA [I fly with] that requires the First Officer if he is to land, to take the last break. He is not popular. The vast majority of landing pilots take the second break, because for most
pilots, coming to the cockpit on an all-night flight with sleep inertia prior to landing is unsafe. Beyond that, there is no pilot I know who does not think this FAA directive intrusive and silly. How can anyone external to the person in question know when and how that pilot needs rest to be best prepared for landing during an all-nighter, or any flight? This rule is a perfect example of the tail wagging the dog, and is corrosive because it pits pilots' good judgment against a regulation. Thank heavens most pilots opt to do what is right and reasonable for their bodies and passenger safety.

The FAA directive needs to be rescinded.

Synopsis

B777 First Officer reported concern with the FAR requiring the landing pilot to take the last break due to sleep inertia.
I commute and took a flight to SFO. I had a full night's rest. On the flight to ZZZZ I slept in the bunk for about 1-2 hours, which is about normal. The breaks were split 3 ways at around 3 hours each. We arrived very late in the day. I did not sleep during my nap due to air conditioning not keeping the room cool at all. It was a very hot day. I thought it would work better at night, and I tried to sleep with the windows open but it was still too hot and extremely noisy. Our rooms are at the back of the hotel and face the courtyard and side street where they unload trucks, load large buses (with engines running most of the time), take the trash, and do maintenance on who knows. Flight to and from ZZZ, no sleep in the bunk due to the very short breaks. Had very adequate rest at the Hotel, which is a lovely
hotel and I always ask for a room in the front or the other side and their response is always they do not put pilots in the front rooms. I could only sleep for about 2 hours during my nap due to the heat in the room and about 6 hours sleep that night. Could not keep the windows open due to the early bed time required (still light out!) and all the noise in the back of the hotel. We had a very early get up for the flight back to SFO, and I slept for about an hour in the bunk. There was turbulence for the first bit and then just couldn't sleep any more even though I was tired.

I eat very healthy and walked 4-8 miles per day on all 3 layovers. Obviously on day 1 and 6 the only exercise available is walking the terminals. A six day trip is very hard on the body. Your circadian rhythm is really out of whack. Fatigue builds up and becomes chronic and the recovery time is more than for a regular 3 or 4 day 2 segment international trip, which is what I usually fly. I knew that 2 days off between these trips would not be enough recovery time. In the first two nights at home my body clock was definitely not back on [home] time. I would fall asleep early in the evening, wake up in the middle of the night and be up for hours, then when I did sleep it was fitfully. I did try to mitigate fatigue by taking naps during the day and exercising but still felt like a zombie, which is normal for recovery time. The third night, I slept more regularly but was nowhere near Fit for Duty for the early departure. This is my first fatigue call, and it was not an easy call to make. I tried to trade out of the trip, move it back one day, drop it, asked for trades but the trip trade system (outside of the normal trades) would not allow any of it, and there were plenty of trips open.

**Synopsis**

Air carrier First Officer reported calling in fatigued for an assignment that followed a six-day trip which included interrupted off-hour sleep and multiple time zone crossings.
**ACN: 1447721 (27 of 50)**

**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: Dispatch

**Person: 2**
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.
### Time / Day

Date: 201704  
Local Time Of Day: 1801-2400

### Place

Locale Reference. Airport: SJC.Airport  
State Reference: CA  
Altitude. MSL. Single Value: 4200

### Aircraft

Reference: X  
ATC / Advisory. TRACON: NCT  
Aircraft Operator: Air Carrier  
Make Model Name: Medium Large 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  
Nav In Use: GPS  
Nav In Use. Localizer/Glideslope/ILS: Runway 30L  
Flight Phase: Initial Approach  
Route In Use. STAR: SILCN4  
Airspace. Class C: SJC

### 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: 1445019  
Human Factors: Fatigue  
Human Factors: Situational Awareness  
Human Factors: Time Pressure  
Human Factors: Training / Qualification  
Human Factors: Workload  
Human Factors: Distraction

### Events

Anomaly. ATC Issue: All Types  
Anomaly. Deviation - Speed: All Types  
Anomaly. Deviation - Track / Heading: All Types  
Anomaly. Inflight Event / Encounter: Unstabilized Approach  
Detector. Person: Flight Crew  
When Detected: In-flight  
Result. Flight Crew: Took Evasive Action
Result. Flight Crew: Executed Go Around / Missed Approach  
Result. Air Traffic Control: Issued New Clearance

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

Narrative: 1

We were slowing to be at 230 at KILDE (SILCN4 arrival/IF RNAV Y 30L SJC) Norcal approach asked us to cross KLIDE at 5000 and keep 250 knots until KLIDE/ then slow to 210. Then cleared for the approach at KLIDE. I increased the speed to oblige. I overshot final approach course and so GP was not captured. (I had selected 'vector to final' and failed to eliminate the discontinuity between KLIDE and HIVAK.) This was promptly corrected but it compounded the issue because it delayed pulling the speed back to 210 and delayed the descent when we could not afford both. At 245 knots I called for gear down in an initial attempt to slow down/ get down but after a few seconds, I realized this wasn't going to work as we were not even flaps 1 and 1500' high (at ~4200') 3-4 miles from FAF HIVAK (2700') we had a slight tailwind also. I told the FO of my intention to go-around and asked him to bring the gear up he then asked 'did you hit TOGA?' I knew I had not (and didn't intend to at that point in time, but I doubted my plan given that we don't do soft go-arounds at this airline.)

The decision to go-around was absolutely correct, but if ever there was a time to do a soft go-around; this would have been it. I immediately second-guessed what I was doing and selected GA (after having a moment and accidentally deselecting/reselecting the auto throttle). We were ~4000' and given runway heading and 3000, so we now also had a descent. Between the descent and selecting GA we were up to 260 knots beneath the edge of the SFO Bravo shelf. We should have been at 200. ATC gave us a right turn to the northeast and a climb to 6000 to re-sequence us for another RNAV Y to 30L. This helped get the speed under control and gave us time to complete all announcements/ checklists and we subsequently made an uneventful landing. This debacle was unfortunate because although ATC put us in an undesirable position at KLIDE (high and fast) 1). I should never have made that error loading the approach and 2) I failed to fly the plane despite knowing that GA would put us in a bad position. There was no rush; I should have continued to slow and taken a moment to brief the best way to manage this particular situation. Both fatigue and emotional state were absolutely contributing factors in my errors as I received this assignment at the very end of 5 days of sitting reserve under the new regime and having an argument with scheduling over this assignment. It seems contradictory to say; but at the same time I also feel that a lack of flight hours in recent months has also degraded my performance as I have been only averaged 35 hrs/month over the past year.

Synopsis

Air carrier Captain reported ATC requested 250 KTS approaching KILDE, but after overshooting final, failed to slow and descend sufficiently so executed a go-around.
**Time / Day**

Date: 201704  
Local Time Of Day: 1801-2400

**Place**

Locale Reference: Airport: ZZZZ.Airport  
State Reference: FO  
Altitude: AGL.Single Value: 0

**Aircraft**

Reference: X  
Aircraft Operator: Air Carrier  
Make Model Name: B737-800  
Crew Size.Number Of Crew: 2  
Operating Under FAR Part: Part 121  
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: Captain  
Qualification: Flight Crew: Air Transport Pilot (ATP)  
ASRS Report Number: Accession Number: 1444766  
Human Factors: Distraction  
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  
Qualification: Flight Crew: Air Transport Pilot (ATP)  
ASRS Report Number: Accession Number: 1444760  
Human Factors: Distraction

**Events**

Anomaly: Flight Deck / Cabin / Aircraft Event: Other / Unknown  
Anomaly: Deviation - Procedural: Published Material / Policy  
Anomaly: Ground Event / Encounter: Other / Unknown  
Detector: Person: Flight Crew  
When Detected: Aircraft In Service At Gate  
Result: Flight Crew: Overcame Equipment Problem

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

**Narrative: 1**

This was the second flight of the day for the crew. We were delayed due to winds and a runway change pushing our flying time past 8 hours for the day. After a challenging arrival and approach we taxied to Gate X which is a short taxi and requires engine cool down prior to shutdown. I hacked the clock clearing the runway. As we stopped at the gate I thought I had set the parking brake but was also concerned about the cool down period and after a short discussion, mentioned to FO then we had a few more seconds to go as I referenced the clock. I did not visually confirm the parking brake light was on at this time. After a few more seconds I turned off the fasten belts sign and checked the APU was on the buses. When the cool down time expired I called for the engines to be shut down and the parking checklist.

Before we could start the checklist the ground crew flashed a light at the FO to get his attention and he recognized we were moving backwards. He called it out and we both pushed the brake pedals to stop the plane. I looked down to see the parking brake light was not on and the parking brake was not properly set. The ground crew hooked up a tug and towed us back to position. The passengers deplaned normally and the flight attendants reported no injuries. The ground crew came to the cockpit and confirmed no injuries to ground personnel or damage to the plane. The longer than normal flight day combined with challenging approach procedures with difficult weather conditions added a level of fatigue that probably contributed to this incident.

Additionally I allowed the non-standard shutdown procedure to interfere with the normal parking flow and did not prioritize confirming that I had properly completed checklist items prior to worrying about the cool down clock. Staying focused and prioritizing what is most important especially as you get tired. Slow down enough to confirm each step and follow the checklist first, then take care of non-standard things. Don't allow distractions to break the flow or habit patterns. For this particular airport, anytime you land on runway X there will be a cool down period so it could be briefed ahead of time to alleviate any discussion or confusion at the gate. For me personally, perhaps verbalizing the first items of the checklist as they are completed will keep the focus where it needs to be. If a first officer gets used to hearing me mention each item out loud then on one leg doesn't hear an item that may be enough to catch an error.

**Narrative: 2**

[Report narrative contained no additional information.]

**Synopsis**

B737-800 flight crew reported neglecting to set the parking brake after arriving at the gate due to fatigue and distraction.
**ACN: 1441571 (30 of 50)**

**Time / Day**
- Date: 201704
- Local Time Of Day: 0001-0600

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

**Environment**
- Light: Dawn

**Aircraft**
- Reference: X
- ATC / Advisory.Ground: ZZZ
- Aircraft Operator: Air Carrier
- Make Model Name: B737-700
- 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)
- Experience.Flight Crew.Last 90 Days: 169
- ASRS Report Number.Accession Number: 1441571
- Human Factors: Communication Breakdown
- Human Factors: Confusion
- Human Factors: Fatigue
- Human Factors: Situational Awareness
- Human Factors: Time Pressure
- Human Factors: Workload
- Human Factors: Distraction
- Communication Breakdown.Party1: Flight Crew

**Person : 2**
- Reference: 2
- 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: Last 90 Days: 85
ASRS Report Number: Accession Number: 1441832
Human Factors: Workload
Human Factors: Time Pressure
Human Factors: Situational Awareness
Human Factors: Confusion
Human Factors: Communication Breakdown
Human Factors: Distraction
Communication Breakdown: Party 1: Flight Crew
Communication Breakdown: Party 2: Flight Crew

Events
Anomaly: Deviation - Procedural: Published Material / Policy
Detector: Person: Flight Crew
When Detected: Taxi
Result: General: Flight Cancelled / Delayed
Result: Flight Crew: Became Reoriented

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

Narrative: 1
I acknowledged a reserve trip the evening before and went to bed. I was then woken by a two hour call-out for a different trip that pushed in less than two hours. I arrived at the gate to find the aircraft boarded and the Captain completing the walk around. He started the ACARS and FMC duties as I settled in and ran my flows. We [reviewed] the route and briefed the departure and other normal items and pushed back.

As I did the After Start Flow, I noticed the transponder had no code in it. We had no clearance. I had not done it myself and we did brief the route. I called for the clearance; we reviewed it and started the taxi. At that point there was no [Set Takeoff Flaps] call and no prompt for the Before Taxi Checklist. We moved a very short distance when I noticed the mistake and began corrections. We set the brakes at the hold short line, ran the checklists, called for departure, and completed the rest of the flight normally.

Don't board aircraft without Crew Members present. It creates pressure on all to perform extra to help out. Unfortunately it leaves gaps in the duties, and items can get skipped.

Narrative: 2
First Officer was called out on reserve for early morning push. Scheduling woke him up and moved up his report time two hours. He arrived five to ten minutes prior to push. I had tried to complete all of his tasks. He briefed the departure which I interpreted as the clearance. We pushed back and realized as the Push Crew was departing that we did not have a clearance. First Officer got clearance and we called for taxi. Within about 100 ft, we realized that the flaps were not set. Set flaps, did all checklists. No conflicts or problems.

Scheduling should not move an assignment up earlier in the early morning for a reserve. That puts both of us in a bad spot. This forced me to do two jobs and forced him to rush to
work after being woken up two hours sooner than his alarm. Although I emphasized that we were not going to hurry, we still missed the clearance which led to missing putting the flaps out at the correct time.

**Synopsis**

B737 flight crew reported procedural errors caused by the late callout of a reserve First Officer.
Time / Day
Date: 201704

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

Environment
Light: Night

Aircraft
Reference: X
Aircraft Operator: Air Carrier
Make Model Name: B777 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
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1436626
Human Factors: Communication Breakdown
Human Factors: Fatigue
Communication Breakdown.Party1: Flight Attendant
Communication Breakdown.Party1: Flight Crew
Communication Breakdown.Party2: Ground Personnel
Communication Breakdown.Party2: Maintenance
Communication Breakdown.Party2: Dispatch

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.General: Flight Cancelled / Delayed
Result.Flight Crew: Returned To Gate

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

Narrative: 1

Was on a short call; crew desk called [in the early morning] and assigned [this flight], and please get to the airport ASAP, the aircraft had been a double gate return; I was at the airport [a half hour later]; no flight officers present; called dispatch as no flight plan; my name was not yet on the flight so I could not see that she had release 5 and was having problems getting it to work; [company software] nor iPad app would allow me to declare fit for duty for some time; eventually was able to see release 5 but it had a much lower fuel request than agreed upon; meanwhile she conferenced me with [maintenance control] re: "partially open engine anti-ice valve": (there was no reference in the MEL to flight into known icing conditions and the dispatcher, maintenance tech, nor myself had never seen this before, so we read through everything carefully to make sure that there would be adequate engine anti-ice capability with a partially open valve- I suggest a re-write of this MEL item to clarify); I called the [duty manager] as I was disconnected from dispatch and unable to get past a voicemail prompt; He informed me that she was working on it but that the proper flight plan was release 4, which I was not able to see; finally found the flying first officer who had been at the aircraft struggling with loading the FMC who told me about a looming flight attendant duty expiration and that the aircraft was boarded already. He also was unable to see his assignment nor the flight plan on the iPad app; I proceeded to the aircraft to ascertain the flight attendant situation, as we still did not have our relief pilot, and briefed the customers and flight attendants and CSR's as to our progress; finally received release 4 and printed the package as the relief First Officer arrived; all went to the aircraft and proceeded to preflight and load; still big problems loading the flight plans, winds, etc., plus we were still not showing as the pilots of record in ACARS; multiple calls to dispatch and the [duty manager] for help; finally pushed, but revised clearance from ATC came across and we loaded it, an entirely new route and track; push crew was unable for a reported tug or tow bar issue to push us to the spot ramp control wanted us, but ramp control said we would be fine; after disconnect and salute, I called dispatch to clarify what was going on with the route as we were indicating insufficient fuel; She determined that the re-route was the original release from earlier in the evening and refilled; meanwhile we were blocking the alley for multiple aircraft; by this time, with a messed up FMC route and release verification (we still weren't showing as the pilots of record in ACARS) I was resistant to start and move the aircraft and burn down our fuel until we at least had a valid flight plan that matched ours, dispatch's, and ATC; enduring repeated badgering by other pilots waiting for access to the alley and the ramp controller, we finally decided to start, do our checklists as best we could considering the conflicted information we had, and head for the box to figure things out; taxiing, and the resultant distracting multiple taxi plan changes was probably a mistake, as it only heightened the confusion; meanwhile, whenever we were stopped, I had multiple calls from the back by flight attendants who are very fatigued and not wanting to depart (they decided they wanted to proceed after all, citing fear of reprisals, as while they were obviously very, very tired, they were technically legal) while also juggling calls to the [duty manager], Dispatch, ATC and ramp control; At this point, the flying first officer announced that he had had enough, and called fatigue- he felt exhausted and was making mistakes and was completely confused with the route and FMC (we all were- by this time, ATC had two flight plans on file and wondered which one we wanted). All this in our weakest circadian low. After a brief discussion we all agreed to return to the gate. Thanks to the supervisors who met us at the gate. Valiant efforts by the crew, the [duty manager], dispatcher, CSR's, fueler, and push crew to get the job done.
Synopsis

The Captain of a Boeing 777 reported that after a long delay and a short turn for the crew, the flight was canceled.
ACN: 1431311 (32 of 50)

Time / Day
Date: 201703
Local Time Of Day: 1801-2400

Place
Locale Reference.Airport: ZZZ.Airport
State Reference: US
Altitude.MSL.Single Value: 18000

Environment
Flight Conditions: VMC
Light: Night

Aircraft
Reference: X
ATC / Advisory.Center: 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: Climb
Airspace.Class A: ZZZ

Component
Aircraft Component: Landing Gear
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: 1431311
Human Factors: Fatigue
Human Factors: Time Pressure
Human Factors: Workload

Events
Anomaly.Aircraft Equipment Problem: Less Severe
Anomaly.Conflict: Ground Conflict, Less Severe
Anomaly.Deviation - Procedural: Published Material / Policy
Detector.Person: Flight Crew
Assessments

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

Narrative: 1

Flight was delayed 20 minutes. The FO and I met the plane after the passengers deplaned. The exiting CA informed us that he wrote up the CA-side-yoke-map-light. Maintenance arrived and deferred the item and a new MEL was generated and a Release 1 was issued. This delayed the flight even more. Our FA arrived after us and upon completion of the boarding, just prior to removal of the jet-bridge she informed us that a latch in the galley would not move appropriately to secure a catering container. Her concern was that the container would fall out during climb-out. I went and tried to move the latch with no effect. We called maintenance and they could not move the latch either, and removed the catering container. I called dispatch and let them know about the situation, and was told by maintenance that no log book entry was needed. Dispatch and maintenance mentioned that the empty catering container weighed less than 2 pounds and would not affect the weight and balance of the aircraft and that the numbers we received for takeoff would not be affected. This situation delayed the flight even more. We were cleared by maintenance and dispatch, and were ready to depart. We did not have a ramp crew to push the plane. The jet-bridge was moved with the help of the maintenance person and another gate agent on the jet-bridge. We were able to close the main cabin door and we tested the anti-skid system with the parking break momentarily off and then placed back on. We conducted the appropriate pre-flight and push-back checklists and waited for a ramp crew to push the plane. We initiated 3 calls to Operations and after waiting more than 20 minutes we had a crew to push back the plane. I made 3 announcements to the Passengers during this time to inform them about the wait for pushing back the plane, and I thanked them for their patience.

Once the ramp crew arrived we were informed that the headset being used did not have a working microphone, but the crew could hear us. I mentioned to them that we would use hand-signals and delay the start of the engines until the push back was completed. He acknowledged by thumbs up, and gave me a sign to release the breaks. I released the brakes and mentioned to him that we would call for the push. When getting the clearance to push back the ramp control mentioned to us to contact metering prior to taxi. I mentioned to the push back driver that we were cleared to push and as we started to push back I noticed that the nose wheel steering was not in the off position. Before any turns were made I moved the nose wheel steering to the off position. The push back driver stopped the push abruptly as a van raced behind us as we were pushing back and if he would not have stopped we would have hit the van going to the aircraft next to us. The push back was resumed, and immediately stopped again once a turn was initiated as he ran over the headset cord. Upon completion of the push-back we initiated the engine start sequence and both engines were started. The FO was concerned about not having experience contacting Metering before, and I said that I would make the call and she could listen. We called metering and there was no answer, we contacted ramp control to verify
and they gave us a new frequency, then metering said contact ramp for taxi, we contacted ramp and they informed us that we needed to start to taxi as two aircraft were waiting for us to move to get into the ramp area.

We started to move and I realized that the nose wheel steering was not armed due to the distractions we encountered that were out of the ordinary during and after the push back. I stopped the aircraft and a steering inop caution message appeared. I turned on and then off and then on the nose wheel steering, and the system was reset and we were able to taxi out of the ramp area. As we proceeded to taxi clear of other aircraft we were able to complete an after start checklist and a taxi check up to the point of CA control check. Once we stopped as we waited in line for takeoff we were number 7 and had the opportunity to set the parking brake and perform the rudder check. As we taxied we noticed the nose gear making a whining noise like a squeaky brake, but thought this to be somewhat normal as the weather was cold outside and it disappeared prior to us being number 3 for Takeoff. All of the remaining checklists were completed as normal.

The Takeoff was normal and I was the pilot flying. We performed all of the normal calls and followed ATC instructions on departure. We leveled off at lower altitudes as we climbed to our cruise altitude of FL180. Upon reaching FL180 the FO said look at our gear indications. She then said, I thought I heard a thump noise. The gear indication lights were white, then the nose turned yellow slashes and then turned to red slashes, and we got a gear disagree warning message. We canceled the warning and the indications went back to yellow, then white and then disappeared. Then within seconds it came back again in the same sequence as before. The FO asked about the QRH for the gear disagree, and I said yes lets run the checklist. As she was looking for the checklist, I pulled up the hydraulics synoptic page and all of the indications were green and normal levels were indicating on all systems. At this time the gear disagree indications disappeared and we continued with the checklist anyway. We complied with all of the checklist items including the last item of "land at the nearest suitable airport". It was decided to return to the departure airport by both the FO and me. We notified ATC and informed them of our situation for an air return. We did not declare an emergency, and were given a new clearance back. I transferred controls of the aircraft and ATC to the FO. I made an ACARS message to dispatch regarding gear disagree and problem rectified. Precautionary return all systems normal. Then I called the FA and informed her. Then I made an announcement to the passengers letting them know the situation and the precautionary nature of our return with all systems normal.

I returned to the pilot flying role and asked for a longer final and slowed to place the gear down farther out than normal to ensure proper operation. All was indicating normal and tower was informed that we were indicating all systems normal. They informed us that the ARFF trucks were standing by as a precaution. We landed normally, and taxied into the ramp area uneventfully. Upon arriving at the gate, we experienced a wait of over 20 minutes for a ramp crew to park us. Initially operations answered us to give us a gate location, but once we arrived at gate parking area the operations frequency had no reply. We contacted ramp to have them help us coordinate a parking crew. We contacted maintenance operations to inform them that we were at the gate, and could use help with ramp coordination. We contacted maintenance over 3 times and were monitoring the frequency when Dispatch contacted us on the maintenance frequency, and let us know that they were trying to get us help to park the aircraft. I thanked them, and told them that I would call them on the phone once we were parked. We finally were informed by maintenance personnel that they sent someone to the ramp and were able to locate a crew to help us park. After we parked and set the break and turned the seat belt sign off, we were never given a chocks-in signal. We were motioning to the gate agent on the jet
bridge to notify ramp personnel that we needed a chocks-in sign. We finally got this signal, and I notified the flight attendant "doors for arrival." She called me and mentioned that the ground personnel opened the door from the outside, and someone was waiting at the cockpit door waiting to talk with us. We then had someone banging on the cockpit door. I told the FO to slow down and complete the parking checklist, and then we would open the door.

Once the checklist was completed we opened the door and started getting questioned by someone. I said wait, who are you and then I introduced myself. He was a maintenance person, and at that moment we heard banging on the FO side of the plane. Another individual was outside making hand signals to the FO. She was confused and said what does that mean; he wants us to shut down the APU... #3 engine?? I immediately said, wait, don't touch anything. Everyone needs to slow down and take a chill pill! We don't have hand signals for these things like hydraulic systems etc. Maintenance is here and they have radios to communicate. Let's relax and think clearly or someone could get injured. At that time the gate agent entered the cockpit area and wanted to know about the passengers. I let him know that the passengers should deplane and wait in the gate area. The maintenance person agreed that this plane was not going to leave tonight and that there were other planes available. The first officer mentioned that she was not interested in going back to ZZZ with lower weather and at such a late hour with the idea that we would be returning almost immediately with no time in the hotel for the rest we were expecting. I mentioned that we would work this out with dispatch. I then called dispatch on the phone. He explained that the weather was forecasted to decrease to 3/4 mile visibility with snow, and that we could not use the exemption for a high mins CA and high mins FO were the operating crew. Based on this information and the fact that it was already late, and by the time we would get another plane and get to ZZZ we would have no time for an expected rest in the hotel. Fatigue was starting to set in, and based on the situation we just experienced, and were continuing to experience, the FO and I decided that it would be an issue of safety of flight if we accepted the new assignment to take another aircraft to ZZZ.

I informed dispatch and the Dispatcher said he would transfer me to a supervisor. A supervisor answered and we were able to discuss logically the situation, and being in agreement we decided to remove us from the flight. I did ask to be connected to the Chief Pilot on duty to discuss the situation. The supervisor placed me on hold and to call the Chief Pilot. He returned to the line and said that a message was left for the Chief Pilot and they would call me back when both were on the line. I agreed, and at that time the FA entered and said that passengers were asking for an update. I asked, we still have passengers on board, I thought I told the [gate agent] that the passengers should deplane. The [gate agent] entered and mentioned that he just offered for them to deplane if they wanted. We still had the majority of the passengers on board. I said that I would make an announcement from the FA PA system and look the Passengers in the eye and give the information from me. I let them know that the plane needed to be inspected and that they should deplane and take all of their belongings with them. One woman asked me if they would get to ZZZ tonight. I replied that I did not know that information yet. As I was making the announcement my phone was ringing in my pocket, and I realized operations was calling me back. I re-entered the cockpit and answered another phone call from Operations. The Chief Pilot was on the line and everyone agreed that we should not take the flight to ZZZ this evening based on all of the issues, the late hour of the evening, the Warning Message situation, the ZZZ Weather, the Delay, and the expected return from ZZZ. The Chief Pilot agreed and so did Operations. We then called Crew Scheduling and they wanted us to say that we were Fatigued. We complied and they issued us a hotel.
After about 20 minutes on hold they issued us a hotel and gave us a number. The number was called and it was the hotel in ZZZ. We called back and placed on hold for another 10 minutes, got another number and called a hotel where we were. We waited over 50 minutes for a van and made 3 calls to confirm the specific hotel. Once the shuttle arrived it was full of the passengers from our flight that was delayed until the morning. Upon arrival at the hotel our names were nowhere to be found. All of the passengers were placed into rooms and we were still waiting as we called back Crew Scheduling, and were on hold for another 10 to 15 minutes. We finally entered our rooms at little while later.

Synopsis

CRJ200 Captain reported on a series of frustrating delays that led to a late departure. Once airborne, an unsafe gear indication led to a return and a canceled flight.
**Narrative: 1**

First officer was hand flying and trying to slow the aircraft on a visual approach after being kept fast on arrival by ATC. Aircraft was at flaps 2, gear down and speed brakes out. First Officer went to retract speed brakes and mistakenly grabbed the flap handle bringing the flaps back up to 0. First thing I noticed as pilot monitoring was the aircraft speeding up and the VLS (lowest selectable speed) (hook) raising rapidly. That’s when I said "your
speed brakes are still out” and brought the handle up. At that time he realized the mistake and said "I brought the flaps up by mistake." When I looked over the flap indicator appeared to be at 0, we got a quick "over speed" annunciation and I believe the airspeed was accelerating from 180 to approximately 210 (just at the bottom of the barber pole). Aircraft was reconfigured and remaining approach/landing was normal.

It's an unusual occurrence, but it can happen. We both were tired as this was a 2 day trip and after waking up on the east coast and now landing on the west coast it was [late] for us. Although we are all comfortable where things are in the cockpit, a visual look before moving a handle or switch is a good idea.

**Synopsis**

A321 Captain reported the flying First Officer mistakenly retracted the flaps instead of the speedbrakes on approach. Fatigue was cited as a factor.
ACN: 1428180 (34 of 50)

Time / Day
Date: 201702
Local Time Of Day: 1801-2400

Place
Locale Reference.Airport: ZZZ.Airport
State Reference: US
Altitude.MSL.Single Value: 24000

Environment
Flight Conditions: VMC
Light: Night

Aircraft
Reference: X
ATC / Advisory.Center: 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: Ferry
Nav In Use: GPS
Nav In Use: FMS Or FMC
Flight Phase: Cruise
Airspace.Class A: ZZZ

Component: 1
Aircraft Component: AC Generation
Aircraft Reference: X
Problem: Malfunctioning

Component: 2
Aircraft Component: APU
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: First Officer
Function.Flight Crew: Pilot Not Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accepion Number: 1428180
Human Factors: Distraction
Human Factors: Fatigue
Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : Maintenance
Anomaly.Deviation - Procedural : Weight And Balance
Detector.Automation : Aircraft Other Automation
Detector.Person : Flight Crew
When Detected : Pre-flight
When Detected : In-flight
Result.General : Work Refused
Result.General : Maintenance Action
Result.Flight Crew : Diverted
Result.Flight Crew : Landed As Precaution
Result.Flight Crew : FLC complied w / Automation / Advisory

Assessments

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

Narrative: 1

This narrative is the First Officer's sequence of events occurring during a two day period. The events leading up to this flight operation are discussed in my previous report and involved separate maintenance discrepancies. At the conclusion of my previous report, all pertinent maintenance discrepancies were resolved.

The Captain and I reported for duty mid-morning. We departed and proceeded on course. Our planned cruise altitude was FL240, due to MEL 21-51-XX-XX RH Air Conditioning Pack. Approximately 5-10 minutes after reaching cruise, we received multiple EICAS master caution messages. I was pilot monitoring (PM) and the Captain was pilot flying (PF). The first EICAS message I observed was "GEN 2 OFF" master caution, followed by the autopilot disconnect chime and a flash of our PFD and MFD screens. Within 5-10 seconds after that message, the second EICAS message I observed was IDG 2. This IDG 2 message posted and cleared several times, then became steady. I looked on the overhead panel and observed that the IDG 2 switch-light indicated "FAULT." The Captain took the controls and began hand-flying, and asked me what the problem was. I explained to the Captain that GEN 2 had switched off, and we had an IDG 2 fault. I told the Captain I felt that the IDG malfunction most likely tripped the generator offline. We also had several other EICAS messages, including STAB/MACH TRIM and R WSHLD and R WINDOW HEAT messages. We then re-engaged the autopilot.

The Captain called for the IDG 2 QRH checklist. I completed the checklist, which directed me set GEN 2 to RESET/OFF, to confirm and disconnect IDG 2, and then to start the APU and turn on the APU GEN. I completed the checklist and reported the pertinent checklist notes to the Captain. At this point, we then ran the QRH checklists for trim and window/windshield heat messages, which all were resolved (I felt these messages all came
from the momentary power interruption when the IDG/GEN failed). The Captain and I then discussed the scenario and felt we had completed all of the QRH checklists properly. The QRH did not advise any flight deviations, so we decided it was safe to continue our flight to our filed destination. We were in the process of contacting dispatch to ensure we could account for the APU fuel burn when we were interrupted. Approximately 5 minutes after the IDG event, we received an APU OIL TEMP master caution message. The Captain called for the APU OIL TEMP QRH checklist. I ran the checklist, which first directed me to transfer the packs (one was deferred) to the engines (which had already been accomplished during climb, per the MEL procedure). The QRH then asked if the APU was required. I answered "YES" to this question, as our APU GEN was required to be operating per the IDG 2 QRH checklist. The Captain agreed with this. I followed the QRH, which directed us to monitor the APU indications and land at the nearest suitable airport. I discussed this with the Captain, and we both acknowledged that if the APU failed, we would be down to one operating electric generator.

The Captain told me we would divert, and we began to split up duties in the flight deck. The Captain asked if I knew of any nearby airports, and I quickly referenced my EFB and the "AIRPORTS" option of the FMS MFD display. I observed an airport directly east, within 5-10 miles, of the aircraft. The Captain quickly made a search of all airports within our nearest airport cone. We checked the distance to our departure airport and noted it was approximately 75 miles. Thus, the Captain made the decision that the nearby airport would be our best diversion point. He began to coordinate with ATC, and I completed all necessary diversion tasks. I obtained the ATIS, conducted a landing distance assessment, modified our FMS destination and flight plan, and loaded/briefed the instrument approach. The Captain continued flying and coordinated with ATC. The Captain also momentarily asked me to help him send an ACARS to our Dispatcher, in which we said the aircraft had multiple maintenance problems and we were diverting. The dispatcher replied and agreed, and she amended our dispatch release to reflect the diversion. The Captain and I then briefed the landing, discussed any additional threats and our mitigation plan, and finally completed the normal checklists and flows. The remainder of the flight was operated without incident and within all our company procedures. Due to time constraints, I did not make a PA to the cabin, but we did give our passengers the 10,000 ft sterile cockpit bells. Please note the only passengers on-board were a company flight attendant and two company mechanics. Thus, we felt that they would be adequately understanding of the situation, and that our flight attendant would ensure the cabin was ready for landing. The Captain and I did discuss declaring an emergency, but we felt the flight conditions were safe and under control. We did agree that if the APU and APU GEN failed, we would declare an emergency. Upon landing, we coordinated with ATC and another air carrier's station and obtained a parking location. We also sent our dispatcher another ACARS message detailing the problems. Once we parked the aircraft at the gate, the Captain and I shut the aircraft down and completed all relevant checklists. The Captain made a telephone call to dispatch, and I walked back into the cabin and explained the situation to our flight attendant and mechanics.

The Captain made two logbook entries: "IDG 2 master caution in cruise flight. Complied with QRH." and "APU OIL TEMP master caution while on one [engine] generator due to IDG 2 caution. Complied with QRH." The mechanics consulted with Maintenance Control and began inspecting the aircraft on the ramp. One of the mechanics relayed to me the status of the aircraft when I walked out to observe their work. He said the IDG on the right engine "was most likely shot" and pointed out the oil filter was in pressure bypass mode. He said he felt it would be unsafe to try and service the IDG, but rather that it needed to be replaced. There was no oil leak observed by myself or the mechanics inside the engine cowling. The mechanic then reported to me that he checked the APU oil level,
and that it was "very low." The mechanic reported there were no oil leaks observed inside the APU's titanium box. Upon further questioning by myself of how the low oil level occurred, the mechanic said he did not know. He remarked that APU oil levels should be regularly checked during CRJ-200 line/service checks. Ultimately, the mechanics deferred the IDG 2 and serviced and leak-checked the APU oil as the corrective actions for the two maintenance log entries. When I returned to the cockpit, the Captain informed me that Dispatch and Crew Scheduling had requested for us to take an FAR 117 flight duty period extension to complete the flight segment into our filed destination, to avoid it being cancelled. The Captain and I both agreed we were tired, and after a long sit at the previous airport and subsequent diversion, did not feel safe operating past the FDP limits. Thus, we rejected the extension. Crew Scheduling then provided all five of us (pilots, flight attendant, and mechanics) with hotel rooms. We were released from duty very late at night.

Day Two

The Captain and I reported for duty at mid-morning. We proceeded to the aircraft and began our pre-flight preparations. Two MELs had been applied - the IDG 2 (MEL 24-11-XX-XX) and APU OIL CHECK (related to IDG 2). The mechanics inspected the APU oil level and made an entry in the logbook. The Captain and I were satisfied with these entries and corrective actions, and the preflight inspection revealed no further abnormalities. We did also have an unrelated MEL - RH Air Conditioning Pack (MEL 21-51-XX-XX), which was also satisfactory. I was pilot flying (PF) for this leg, so I conducted the departure briefing. At the conclusion of the briefing, I read through each MEL with the Captain and discussed operational restrictions. I observed that we were limited to a minimum flight weight of 38,500 LBS per MEL 24-11-XX-XX. Since our aircraft was very light (3 passengers, 2 pilots), I told the Captain that we may have an issue with this limitation. We reviewed our weight numbers and confirmed that we would be landing well below this minimum flight weight for landing, as planned in our dispatch release. The Captain remarked this was a "good catch," and he made a phone call to Dispatch. Our dispatcher decided to add approximately 4,000 LBS of fuel, which would have us landing at just over 39,000 LBS. We found this to be an acceptable solution. We uplifted the additional fuel, and safely conducted the flight without incident and within all company SOPs.

I believe the biggest threat in this situation was the cascade of multiple system EICAS messages in a confined period of time. I feel that the Captain and I did a great job properly managing the workload and addressing the situation in a timely manner. Further, the Captain was quick to divide duties on the flight deck and ensure that one pilot was flying the aircraft and monitoring ATC, while the other pilot was able to perform troubleshooting and QRH duties. After the fact, I again reviewed the logbook for our aircraft. I was very surprised to find two entries a month earlier, which described almost word for word the scenario that we encountered. "In climb IDG DISC status message on number 2 engine." "After APU start - APU OIL TEMP caution." The aircraft appeared to have diverted following these issues, as both pages stated "ZZZ" as the station. The corrective action for the IDG 2 DISC message was a reset/could not duplicate, while the corrective action for the APU OIL TEMP message was adding 3/4 qt of oil to the APU. Of note, the next logbook described a replacement of the IDG 2 with a new unit. Thus, it appears that this aircraft encountered a very similar event less than a month ago. The IDG 2 was replaced, but it seems the corrective action for the APU being low on oil was simply to fill up the oil and sign off the logbook. Again, this is indicative of a "keep the airplane moving" mentality across our company. Given our APU was again low on oil, most likely there is a bigger problem with the APU on this specific aircraft that was never identified or purposefully ignored by our maintenance. Lastly, after the MEL 24-11-XX-XX was applied,
there appears to be no "check" in our system for dispatch to comply with the minimum flight weight of 38,500 LBS. If the Captain and I had not caught this error, we would have most likely been dispatched in a condition contrary to the MEL. Perhaps our Operations and dispatch need to develop some kind of performance check to ensure this limitation is automatically flagged on dispatch releases in the future.

I think the biggest thing to learn from this event is that it is imperative for a Captain and First Officer to develop a positive working synergy on the flight deck. I feel that the Captain's CRM allowed for us to work together extremely well, and we quickly and easily completed the diversion. Further, I believe this report again shows the negative safety culture of "keep the airplane moving" and "controllable completion factor" at our carrier. I believe for a write-up like this, there needs to be some kind of "big picture" troubleshooting, or at least a more comprehensive monitoring of the parts involved. If the APU had been placed on an oil watch, maintenance may have established why it was 3-4 qts low on oil a month earlier, and we would have never needed to go through the situation of diverting.

**Synopsis**

CRJ-200 First Officer reported diverting for IDG and APU problems. They discovered that a month earlier another crew had a similar experience with the exact same outcome.
Time / Day
Date: 201702
Local Time Of Day: 1201-1800

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

Environment
Flight Conditions: VMC
Visibility: Snow
Visibility: 1.5
Light: Daylight

Aircraft
Reference: X
Aircraft Operator: Air Carrier
Make Model Name: Dash 8 Series 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
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: 22310
Experience.Flight Crew.Last 90 Days: 145
Experience.Flight Crew.Type: 7700
ASRS Report Number.Accession Number: 1425955
Human Factors: Fatigue

Events
Ground Excursion: Taxiway
Inflight Event / Encounter: Weather / Turbulence
Detector.Person: Flight Crew
When Detected: Taxi

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

Narrative: 1

The airport was covered by approximately 2-4 inches of fresh snow. The runway was plowed. Braking action was good. Landed Runway XY, exited onto H. Tower cleared us to taxi A, F, across ZA to park. I noticed that the taxiways were not plowed. The centerline and edges obscured. I referenced the taxiway reflectors (raised) to steer. A difficult task as the reflectors are set a good distance from the taxiway edges, and the taxiways are narrow. Nosewheel steering seemed effective. Low light also reduced visual detail. It was overcast at 600 ft. ½ miles in mist. Taxi A angles 30 degrees left onto F. I began steering left, and started the after landing flow (only a few items). I might have also tried to reference the airport chart. I then found the aircraft, possibly, too far left. I applied the tiller to steer right. The left main dropped off the taxiway into the soggy grass. I idled. Maintenance suggested power. It only slid the nose gently into the grass. I shut down the engines. Ground transport took the passenger to the terminal. No injuries, orderly.

Causal factors: fatigue due to short sleep the night before, therefore I
1) Didn't recall we require taxiways plowed.
2) didn't fully gauge the level of fatigue
3) didn't stop the aircraft to either
a. have taxiways plowed
b. at least deliberately evaluate situation
c. bus pax to terminal
4) Multitasked when full attention should have been on taxiing.

I mitigated the possibility of fatigue with caffeine earlier, but, as this situation occurred, I was feeling the effects of the previous night's short sleep.

Secondary causal factors.
Complacency/comfort with conditions. We'd been operating in snow for 2 months, so it did not raise my concern as much as it might have 2 months earlier.

Solutions:
1) Quantify a minimum amount of sleep.
2) More deliberate and continuous evaluation of alertness.
3) Re-evaluate sleep conditions.

Synopsis

DHC-8 Captain reported an excursion from a snow covered taxiway.
**ACN: 1424221** (36 of 50)

**Time / Day**
- Date: 201702
- Local Time Of Day: 1201-1800

**Place**
- Locale Reference.Airport: ASE.Airport
- State Reference: CO
- Altitude.MSL.Single Value: 12600

**Environment**
- Flight Conditions: Marginal
- Weather Elements / Visibility: Fog
- Light: Daylight

**Aircraft**
- Reference: X
- ATC / Advisory.TRACON: ASE
- Make Model Name: Commercial Fixed Wing
- Crew Size.Number Of Crew: 2
- Operating Under FAR Part: Part 121
- Flight Plan: IFR
- Mission: Passenger
- Nav In Use.Localizer/Glideslope/ILS: Runway 15
- Flight Phase: Initial Approach
- Airspace.Class E: ASE

**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: 1424221
- Human Factors: Fatigue
- Human Factors: Situational Awareness
- Human Factors: Workload

**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)
- ASRS Report Number.Accession Number: 1424214
Events

Anomaly.Deviation - Altitude : Overshoot  
Anomaly.Deviation - Procedural : Published Material / Policy  
Anomaly.Deviation - Procedural : Clearance  
Anomaly.Inflight Event / Encounter : CFTT / CFIT  
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 had just went missed into ASE and we were in the process of asking for another approach. We were on the published missed and ATC had told us to expect the approach over LIFTT. I was trying to get the FMS set back up for the approach. The FO had been really behind on the first approach and the missed. I decided to take control over the FMS. In the process the FO had already started to execute some changes and the aircraft had started a turn. I told the FO to get a vector. Knowing that ASE airspace is rather tight with EGE I knew we needed to be quick. I reloaded the FMS and then tried to clean up the box as ATC told us to turn direct LIFTT and cleared for the approach. No altitude or heading was given. Things would not cleaned up correctly and I just went to green needles to intercept the LOC.

At that point the FO noticed the FMS was on page 2 and went ahead and cleaned up the FMS. The LOC captured and were at 14,200. At this point I looked up to make sure we were headed in the correct direction and the entire valley was now covered in fog. I was a little disoriented as only 5 mins earlier we could see airport with a few low level clouds. I noticed a few key terrain features and knew we were headed in the correct direction. The FO was still a little task saturated and I set a lower altitude to start down and I begin to call for flaps and get the aircraft configured for landing. In the process I confused where we were on the approach and set 12,300 instead of 13,600 to cross LIFTT. About 3 miles from LIFTT ATC gave a low alt alert and told us cross LIFTT at 13,000. I immediately turned off the autopilot and climbed the aircraft back to 13,000. At that point we were at 12,600.

Going missed in ASE is a complex procedure and trying to get the FMS reprogrammed for another approach is not easy. ASE has very limited airspace and this really brings down the time you have to properly set things up. The FO is rather [junior] and the first approach he was rather behind and that led me to have to worry about more things and become task saturated. When we left the ramp, I noticed a strange MX issue with the flaps/slats indicator and we had to pull back into the ramp and have MX reset a few things. After the MX issue was taken care of we left only to be told that we had a ground stop into ASE. Was waited 45 mins to depart. I had also not flown in almost 3 weeks due to not being used on reserve and days off. I had also not slept well the night before and felt a little tired. I should have slowed things down to help bring the FO back into the game and
given us more time to set up and brief the approach again. I know ASE pretty well and I feel proficient flying in there. I was rushed with the airspace and I should have asked for more vectors for more time. I should have transferred the controls to the FO while I took care of the FMS and briefed the approach.

**Narrative: 2**

We had already experienced a number of issues on this flight. The slats were MELed for half speed. During taxi, we had an issue relating to proper slat position indication which required a maintenance troubleshoot. After the problem was resolved, we departed for Aspen. Conditions in Aspen were marginal with many aircraft going missed, requiring multiple approach attempts and in some cases diversions. Aspen was calling above minimums with good visibility however they were experiencing intermittent low clouds/fog. Prior to departure we briefed the approach/missed approach/balked landing procedures and discussed what we would do in the event of a missed. We had enough fuel for at least two approach attempts if we deemed it safe. We shot the LOC DME 15 approach, we had the runway in sight at approximately LIFTT but we could see a cloud on the approach end of the runway. Unfortunately, the cloud was exactly over CEYAG at the MDA which required a missed approach. While tracking outbound on the IPKN to LINDZ we told Aspen approach that we would like to try again. We were told to expect the LOC DME 15 from AJAXX. This required a modification of our previous approach in order to not have to completely reload the approach and all the intermediate fixes/altitudes.

We asked and were given a vector so that we could accomplish the task and the captain began to manipulate the FMS. As he was working on the changes, approach gave us a base turn and asked to keep it tight. This caused the captain to become task saturated. I asked if I could manipulate the FMS and free him to focus on flying the aircraft to which he agreed. While I was reloading the approach the controller cleared us direct LIFTT and for the LOC DME 15. I read back the clearance however in my distraction I did not notice if he gave us a crossing altitude at LIFTT nor did I read one back. I was able to execute the direct to LIFTT and returned to monitoring our progress. We were VMC in a descent and almost at LIFTT when the controller instructed us to maintain 13000 until crossing LIFTT. At that time, I looked and saw that we were at 12,600. We began to correct the altitude when the controller gave as a low altitude alert. We were VMC with adequate terrain separation, we corrected and continued the approach. Unfortunately the fog bank had completely recovered the airport and surrounding area. We went missed again and diverted.

It was a challenging day at a very challenging airport. We allowed ourselves to be rushed us into a second attempt at an approach without enough time to adequately prepare. In the rush, PF attempted to manipulate the FMS during a critical phase of flight and lost situational awareness. When the PM took over FMS load responsibilities, he was rushed and also lost situational awareness. While the PM was loading the FMS, the PF mistakenly started a descent for 12,300, the published altitude after LIFTT, without making proper challenge/response of altitude selection. As a result, the PM was unaware of the selected altitude change. To avoid recurrence, the flight crew need to follow SOP guidance, requiring PM to make all FMS changes during critical phases of flight, and requiring the PF to confirm all altitude changes in Alt Pre select with the PM. Above all, the crew must be more assertive in communicating with ATC their need to set up between approaches with such tight geographic and airspace constraints.

**Synopsis**
Air carrier flight crew reported they received a low altitude alert from ATC on approach into ASE citing workload, weather, and situational awareness as contributing.
Time / Day
Date: 201702
Local Time Of Day: 1801-2400

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

Environment
Light: Night

Aircraft
Reference: X
ATC / Advisory.Ramp: ZZZ
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: Taxi

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)
ASRS Report Number.Accession Number: 1424191
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: First Officer
Function.Flight Crew: Pilot Not Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1424193
Human Factors: Fatigue
Human Factors: Situational Awareness

Events
Anomaly.Conflict : Ground Conflict, Less Severe
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Person : Flight Crew
When Detected : Taxi
Result.Flight Crew : Became Reoriented

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

Narrative: 1
On day six of two back-to-back three day pairings, we landed at LAX and taxied to [the] gate. It was [late] at night and I approached [the] gate cautiously. I couldn't see the aircraft parking outline very well and saw a left wing walker and individual standing on the centerline. I began my turn and noticed the wheels of one baggage cart was inside the parking lines and stopped the aircraft. Simultaneously, I discovered that the individual I thought was the guide man had walked away. At this point I realized we did not have a guide man and directed the FO to notify Ops of the need for a parking crew. After about a 10 minute wait, a crew showed up. The guide man began motioning me to taxi into the gate, however, we had several items inside the parking lines needing to be moved. We had to open both windows and forcibly direct each wing walker to move all of the items, which was quite frustrating.

Finally, the baggage cart, cones and extra chocks were moved and we could follow the guide man's instructions to park. The parking was uneventful. [Later], while sitting in another aircraft being pushed by a tug, it occurred to me that I had made a mistake. I looked at my iPad and realized at that point that I should have shut the engines down and demanded a tow into [the] gate.

It was night and the FO and I were fatigued from six continuous days of flying. [The gate] had multiple items inside the parking lines, but we could not tell for certain until I began the turn. Finally, I became fixated on looking for items inside the parking lines that I mistook the individual standing on centerline as the guide man. While waiting several minutes for the parking crew our frustration grew and then was exacerbated attempting to direct each wing walker to move equipment out of the parking lines. All the while, the guideman was motioning me to continue to park. Being slightly fatigued and extremely frustrated, I parked the aircraft completely forgetting the tow-in procedure.

Narrative: 2
After a long 5 days of work, I was tired. Forgot all about to shut down the engines and wait for the rampers to come out and tow us in after we made the initial turn towards the gate.

Synopsis
B737 flight crew reported they taxied into a gate when they should have called for a tow-in citing fatigue as a factor.
**Time / Day**
- Date: 201702
- Local Time Of Day: 1201-1800

**Place**
- Locale Reference.Airport: LAX.Airport
- State Reference: CA
- Altitude.MSL.Single Value: 2000

**Aircraft**
- Reference: X
- ATC / Advisory.Tower: LAX
- 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.Localizer/Glideslope/ILS: Runway 24R
- Flight Phase: Landing
- Airspace.Class B: LAX

**Component**
- Aircraft Reference: X

**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: 1422137
- Human Factors: Confusion
- Human Factors: Fatigue
- Human Factors: Workload
- Human Factors: Communication Breakdown
- Communication Breakdown.Party1: ATC

**Events**
- Anomaly.ATC Issue: All Types
- Anomaly.Conflict: Airborne Conflict
- Anomaly.Deviation - Altitude: Excursion From Assigned Altitude
- Anomaly.Deviation - Speed: All Types
- Detector.Person: Flight Crew
- Were Passengers Involved In Event: N
- When Detected: In-flight
Result. Flight Crew: Executed Go Around / Missed Approach
Result. Air Traffic Control: Issued New Clearance

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

Narrative: 1
In this event we had been cleared for the LAX ILS 24R. When we turned onto the localizer we had adequate separation from the aircraft in front of us. At some point that separation was lost. At about 2300 feet MSL, and near the final approach fix, Tower asked us if we had visual contact with the traffic in front of us and told us to slow to approach speed. We did not as the traffic appeared to go into a scattered cloud layer. I reported that, and right away Tower came back and told us to cancel approach clearance and maintain 2000.

At this point in the approach, we were both unsure if they wanted to continue the approach, or execute a go around. We ended up doing a sort of "half go around." That left the airplane in a confused state of speed, automation and control. Shortly thereafter Tower finally officially gave us a go around instruction.

At this point we were trying to get the airplane into a stable state and that's when the RA happened. The autopilot was disconnected. The RA instruction was to monitor vertical speed. By this time we were both pretty far behind the airplane with no automation and ended up climbing into the RA, maybe 100 feet. We had the traffic in sight for the duration of the event.

The RA was resolved, and we got the aircraft into a desired configuration and went on to land without incident. Most of us, myself included, could probably be better at briefing missed approach procedures and develop possible plans for a "soft go around."

Contributing factors were the ambiguous or not expected instructions from ATC and task saturation as a result. Also, we were pretty worn out after a day in and out of [another airport] with several lengthy delays.

Synopsis
Air Carrier flight crew reported attempting to reconfigure their aircraft after receiving and ATC directed go-around, initially climbed into a "monitor vertical speed" TCAS Resolution Advisory.
ACN: 1421894 (39 of 50)

Time / Day

Date: 201702
Local Time Of Day: 0001-0600

Place

Locale Reference. ATC Facility: C90.TRACON
State Reference: IL
Altitude. MSL. Single Value: 13000

Aircraft

Reference: X
ATC / Advisory. TRACON: C90
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: GPS
Nav In Use: INS
Flight Phase: Initial Approach
Route In Use. STAR: BENKY 4
Airspace. Class E: C90

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)
ASRS Report Number. Accession Number: 1421894
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: First Officer
Function. Flight Crew: Pilot Not Flying
Qualification. Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number. Accession Number: 1421908
Human Factors: Fatigue
Human Factors: Situational Awareness

Events
Anomaly.Deviation - Altitude : Undershoot
Anomaly.Deviation - Altitude : Crossing Restriction Not Met
Anomaly.Deviation - Speed : All Types
Anomaly.Deviation - Procedural : Clearance
Anomaly.Inflight Event / Encounter : Weather / Turbulence
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Became Reoriented

Assessments

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

Narrative: 1

We were on descent into ORD, cleared for the BENKY 4 RNAV STAR arrival. Vnav descent winds were inserted prior to descent (approximately 100 tailwinds). ORD had a high altimeter setting about 30.39. We then received a clearance to cross BENKY intersection at 12000 ft. & 300kts. It is also possible we "might have" received an earlier clearance to fly direct to BENKY. This was an "all nighter", so I'm using best recall.

We had 12000 ft selected into the altitude mode control panel & had -Vnav Path- displayed on my PFD. & we had BENKY 12000 ft. & 300 kts inserted in the legs page. Everything looked normal. While my First officer (FO) was briefing the approach, and I noticed the speed was suddenly increasing to 320-325 knots. But still in Vnav Path & "right on" the vertical descent path display. I then deployed max (flight) speed brakes -to slow it down back to 300 kts. The plane was not slowing down, very much, at all - so I briefly pushed "level change" mode to attempt to slow it down, further- to 300 kts @ BENKY intersection. (I still had full speed brakes deployed) near BENKY intersection, the Vnav Path began to show our vertical path "high" & we crossed BENKY around 13000 ft & just above 300 kts. ATC never commented on our "high crossing" altitude at BENKY intersection & there was no further incident.

High tailwinds, on descent & a "direct clearance" reduced the distance to descend to cross 12000 ft clearance at BENKY intersection.

More proactive monitoring on descent and notifying ATC that we might not make the crossing restriction assigned- if it looks difficult to comply with.

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

B737-800 flight crew reported missing a crossing restriction on arrival into ORD, citing fatigue, strong tailwinds, and automation dependency as factors.
ACN: 1420514 (40 of 50)

**Time / Day**
- Date: 201701
- Local Time Of Day: 1801-2400

**Place**
- Locale Reference.Airport: ZZZ.Airport
- State Reference: US
- Altitude.AGL.Single Value: 500

**Environment**
- Flight Conditions: VMC
- Light: Night

**Aircraft**
- Reference: X
- ATC / Advisory.Tower: 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
- 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: Pilot Not Flying
- Function.Flight Crew: Captain
- Qualification.Flight Crew: Air Transport Pilot (ATP)
- ASRS Report Number.Accession Number: 1420514
- Human Factors: Fatigue
- Human Factors: Situational Awareness

**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**
Writing has always been a challenge for me but that isn't why this report is so late. I find writing a report particularly hard. While it appears to be a great idea and I whole heartedly endorse it, it remains very difficult to confess a failure in performance. I wonder if there is a way to make the report more inviting and less intimidating. Even if the only thing that can be done is for all who read these, keep the fact that confession is a very difficult thing to do and to exercise the awareness of that particular human component. What follows is my confession. It seems one mistake often leads to others. That certainly happened this last flight of a four-day trip. I was blessed with a good crew. Two flight attendants that are both competent and pleasant to work with. My first officer has been with the company for a year and is everything an airline could hope for. His work ethic, knowledge, communication skills and relationship with the aircraft are top notch. He is more than a pilot, he's a student of aviation. Still, we managed to forget to go from flaps 30 to flaps 45 on final approach and once the error was discovered, we failed to go around. We landed without a problem but that doesn't excuse such mistakes. I was alerted to the problem by the GPWS saying, "Too low, terrain. Too low, terrain." This didn't make sense to either one of us since we had the runway in sight at 12 o'clock with the PAPI showing two white and two red. The localizer and glide slope also indicated that everything was fine. I wish it had said, "Too low, flaps." That was why it went off and that would have pointed our minds in the direction of the actual problem rather than worrying about running into something or GPS problems. We were at the threshold and very close to the flare before I figured out we had flaps 30 and announced it. My FO said, "Flaps 45" and I selected it. I did consider a go around but opted to continue the landing since we were so close to the flare on a runway that is very long.

I don't wish to rationalize bad behavior as that's a slippery slope to building bad habits. But that decision to land might have been preferable to going around. As I said, we were very close to landing. A go around at that moment might have involved greater risk not because we were so low, we train to go around at the last second like that in the simulator. Rather, I think the earlier mistake indicated a new found ability to make errors. I can't speak for my FO but I was starting to feel a little run down and I think he might have been too. I'll return to this later but first I'd like to look at how we got into this mess in the first place. I’d gotten the ATIS and we had briefed a visual backed up by the ILS to a different runway when we were told to descend via the STAR to that runway. I’d mentioned during the brief that it was quiet and that we might be offered a longer runway. My FO agreed to accept that if it was offered. It had been rainy for a few days but the air was clear and clean as we descended. ATIS advised a very light wind out of the southeast. Aloft it was a different story, the wind was quite strong out of the south and the autopilot had to hold a wind correction of 5 to 10 degrees to track the course. As hoped for, we were offered the longer runway. We were cleared direct to the IAF and instructed to cross at or above 4000 and to maintain 210 knots to a 10 mile final. We were already doing 210 so my FO selected 4000 while I put the runway in the FMS and selected direct IAF. As we approached the IAF he selected heading sync, heading mode, green needles and approach mode. I think the combination of a very shallow intercept angle and a decreasing crosswind as we descended caused us to parallel the approach course without LOC2 becoming active. I told him you need to use the heading bug to make a small left turn to get on the localizer. He did and LOC2 became active. Unfortunately, we were slightly above the glide slope. My FO started a descent at a rate between 1500 and 2000 feet per minute to catch the glide slope from above. That can take a while as the glide slope is "falling away" from the plane as you descend to catch it. He called for gear down to get ready to land and presumably to increase drag. We were going too fast to select flaps 30 and he didn't call for that. I'm not certain but I think he had the thrust levers about 1/2 inch to 1 inch above flight idle. I believe that's a common error when trying to go down and slow down. We had been instructed to maintain 170 knots or greater to a 5 mile final
which took care of itself in our descent to the glide slope. As we caught the glide slope we slowed and flaps 30 was called for and selected. During all this we were handed off to Tower and cleared to land. I don't know how we skipped the flaps 45 on the Before Landing Checklist callout or the Stable at 1000 ft but we did. We had a lot going on in a short period of time and skipped the things we've done every flight for many years.

There are a number of things that lead to this event. I can't speak for my FO but I think we were both running a little low on energy. Combining that with the instruction to "keep your speed up" and the runway change, created the opportunity for the unthinkable. It's been very difficult for me to confess this in this very public forum. It feels like I am opening myself up to some severe repercussions. I do, however, have a few ideas to reduce the risk of this happening in the future. First, calling for the gear without calling for flaps 30 makes the call for flaps 30 in the near future feel like you've accomplished flaps 45. That is the action that normally happens a short time after calling for gear down. Perhaps a policy of saying, "Gear down, flaps 30, bug 165" (as if it were one word) only when the speed allows the extension of flaps 30 would help. We use the gear to slow down sometimes and I hesitate to recommend taking that tool out of the toolkit but it should be considered. Second, I think we've gotten away from making standard callouts to get configured. This might be a result of operating in the real world. ATC often asks pilots to keep the speed up. We were instructed to maintain 210 to a 10 mile final and 170 to a 5 mile final. While this can be an engaging challenge when you're operating at 100%, if anything goes even slightly wrong like getting above the glide slope, or if it's late at night and your energy level is starting to wind down, meeting the challenge to keep the speed up can lead to trouble. I also see a lot of FO's bugging 165 while doing 190 to 200, then slowing to flaps 30 speed and calling for flaps 30. This might be a result of bugging Vt when flaps 20 is selected. Perhaps bugging 180 at the extension of flaps 20 would help. 180 mirrors the "flaps 30, bug 165" call in that it's 5 knots below the next flap speed and, it is a safe change to make since 180 is greater than the minimum maneuvering speed for the maximum landing weight at flaps 20. Ultimately, rededicating ourselves to sticking to the 'script' spelled out in the CFM can only help. Third, fatigue is a tough problem. Sometimes you know you're getting tired but often fatigue sneaks up on you with little warning. I think the FAA has given us good rules to keep fatigue from being a problem and that the airline has implemented policies and programs that go above and beyond the regulations. Still, it sneaks into the cockpit occasionally and when it does, it seems to be at busy times. I wouldn't say that I was fatigued when this happened nor when we shut down the aircraft and went home. But, it was late in the day and the end of a four day trip. I don't know how to prevent this but continuing efforts on this front will be important.

**Synopsis**

CRJ-900 Captain reported receiving a GPWS warning for improper flap configuration on final approach. The crew selected the correct flap selection and landed safely.
**Time / Day**

Date: 201701
Local Time Of Day: 0601-1200

**Place**

Locale Reference.Airport: VHHH.Airport
State Reference: FO
Relative Position.Distance.Nautical Miles: 10
Altitude.MSL.Single Value: 5000

**Environment**

Flight Conditions: VMC
Light: Daylight

**Aircraft**

Reference: X
ATC / Advisory.Center: VHHK
Aircraft Operator: Air Carrier
Make Model Name: MD-11
Crew Size.Number Of Crew: 3
Operating Under FAR Part: Part 121
Flight Plan: IFR
Mission: Cargo / Freight
Nav In Use: FMS Or FMC
Nav In Use: GPS
Flight Phase: Initial Climb
Route In Use.SID: PECAN1A

**Person: 1**

Reference: 1
Location Of Person.Aircraft: X
Location In Aircraft: Flight Deck
Reporter Organization: Air Carrier
Function.Flight Crew: Relief Pilot
Qualification.Flight Crew: Air Transport Pilot (ATP)
Experience.Flight Crew.Total: 11623
Experience.Flight Crew.Last 90 Days: 150
Experience.Flight Crew.Type: 3118
ASRS Report Number.Accession Number: 1420229
Human Factors: Distraction
Human Factors: Human-Machine Interface
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: Captain
Function: Flight Crew: Relief Pilot
Function: Flight Crew: Pilot Flying
Qualification: Flight Crew: Air Transport Pilot (ATP)
Experience: Flight Crew: Total: 20000
Experience: Flight Crew: Last 90 Days: 130
Experience: Flight Crew: Type: 9000
ASRS Report Number: Accession Number: 1420870
Human Factors: Situational Awareness
Human Factors: Fatigue
Human Factors: Distraction
Human Factors: Human-Machine Interface

Events

Anomaly. Deviation - Altitude: Excursion From Assigned Altitude
Anomaly. Deviation - Speed: All Types
Anomaly. Deviation - Procedural: Published Material / Policy
Detector. Person: Flight Crew
When Detected: In-flight
Result. Flight Crew: Returned To Clearance
Result. Flight Crew: Became Reoriented

Assessments

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

Narrative: 1

During the Pecan 1A departure from Hong Kong, just after we rolled out of the turn to RAMEN at 220 knots, the Captain (pilot flying) called for slats retract. The first officer (Pilot Monitoring) repeated the command and moved the flap/slat handle to the slats retract position. As soon as the handle was moved the stick shaker activated. The Captain called "slats extend", the first officer extended the slats and the stick shaker stopped. We lost several hundred feet of altitude during the recovery. I was the International Relief Officer (IRO) on this flight. I had been focusing on our ground track as the mandatory overflight of PORPA resulted in going a bit wide of the FMS generated ground track during the departure turn from PORPA to RAMEN. As we rolled out and I saw that we were correcting to track, I looked down at the SID depiction on my [Electronic Flight Bag (EFB)]. When I heard the slats retract call, I immediately looked up and saw that we were still several miles short of RAMEN with a 220 knot speed restriction there. I then looked at the airspeed indicator (thinking that maybe I missed a "high speed approved" call from ATC). We were still at 220 knots. The green slat retract (SR) on the airspeed indicator was obscured by the Gear Extend (GE) indication superimposed over it as the two speeds were almost identical. By the time I had processed this information and realized that we were still nearly 30 knots below slat retract speed (maybe 2 or 3 seconds), it was too late. The handle had been moved and the shaker was activated. Recommendations: First and foremost, this event illustrates the importance of the pilot monitoring verifying the limiting speed on the airspeed indicator before moving the flap/slat handle. This should continue to be discussed during recurring training. It is often said that the IRO has the best seat in the house when it comes to threat detection and mitigation as the IRO can devote 100% of his/her time to this activity. Obviously, I picked an unfortunate time to look down at my
[EFB]. That being said, could I have processed the position and airspeed information more quickly and possibly avoided this incident? Perhaps. At this point I should mention that this duty day followed two near minimum crew rests (for both me and the Captain). An international rest of 12 or 13 hours is simply not enough time to travel from the airport to (an often distant) hotel and back, check in and out of the hotel, eat at least once--often twice, plug in our required electronics (iPads and phones), sync our iPads, check our email for scheduling advisories, shower, shave and sleep eight hours. Something has to be sacrificed and it's almost always sleep. When you factor in the inevitable transportation issues (late bus, traffic congestion, etc.) and hotel issues (room key doesn't work, room smells like cigarette smoke, etc) even more sleep is lost. While sleeping only six or six and a half hours may not necessitate calling in fatigued, it definitely resulted in me performing at less than 100%. [The company] needs to do their part in the fatigue mitigation process. Minimum or near-minimum rest periods (less than 15 hours) should be minimized and back to back minimum or near-minimum rest periods should be prohibited.

**Narrative: 2**

This was a 630,000 LBS takeoff 07R out of Hong Kong. We got stick shaker activation at 5000 feet and 220 knots while flying straight and level to RAMEN. We briefed stick shaker threat twice and it still happened. It felt like we were doing straight and level slow flight for no reason and Slat Retract symbol was not in view, so slats retract was called for by Captain (Pilot Flying). First Officer retracted slats and we got stick shaker activation and recovered lost about 500 feet in recovery. This happened with three sets of eyes watching! A mitigation strategy was briefed that I would speed up before slats retract. We all debriefed ourselves after the event we agreed the threat was briefed thoroughly but our mitigation strategy could have been briefed better. Mitigation strategy we had 2 options request high speed which is a normal for us or brief we will retract slats until after RAMEN. Max speed into RAMEN was 220 knots. IRO at last moment noticed SR was covered by GE.

**Synopsis**

An MD-11 International Relief Officer and Captain reported a stick shaker activation while departing Hong Kong when the slats were retracted below slat retraction speed.
Time / Day
Date : 201701
Local Time Of Day : 1801-2400

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

Environment
Flight Conditions : Mixed
Weather Elements / Visibility.Visibility : 10
Light : Night
Ceiling.Single Value : 5000

Aircraft
Reference : X
ATC / Advisory.Tower : ZZZ
Aircraft Operator : Air Carrier
Make Model Name : B737 Next Generation Undifferentiated
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Mission : Passenger
Nav In Use : FMS Or FMC
Flight Phase : Takeoff
Airspace.Class B : 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 Not Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
Experience.Flight Crew.Last 90 Days : 183
ASRS Report Number.Accession Number : 1419067
Human Factors : Time Pressure
Human Factors : Distraction
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
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1419373
Human Factors : Distraction
Human Factors : Fatigue

Events

Anomaly.Deviation - Procedural : Weight And Balance
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
Contributing Factors / Situations : Weather
Primary Problem : Human Factors

Narrative: 1

It was the last leg of a four day trip. We were late. Bad weather the entire four day, and both the First Officer (FO) and I were getting tired. We had an inoperative APU which was a further distraction as we had to talk to the Ground Crew and ensure the correct ground start procedure was followed, and also figure out where the cross bleed start would be accomplished. As we were doing all of this and starting the Before Start Checklist we got an ACARS from Dispatch saying we were to fly at FL 280 and CI 100.

I called them on the phone. [Dispatch] told me that we were over fueled and needed to burn off 2000 pounds of fuel, or we would be overweight for landing. With the current routing that was filed, we couldn't have burned off that much fuel. I asked if we could defuel and the Agent said it would take too much time. [Dispatch] then rerouted us over a longer route that would burn the fuel off.

We got a second Dispatch Release, started to go over it, and were interrupted by the Agent, giving us yet another Release. Also we were interrupted by Flight Attendants and Ground Crew who wanted to get going and wanted to know what the delay was. As I started to look at the third Dispatch Release, Clearance Delivery called with our amended clearance. I stopped looking at the Dispatch Release numbers to focus on the clearance. The clearance was incorrect, because ATC couldn't believe we would want such a LONG route to go to ZZZ1. We explained our predicament, and got the clearance as filed.

We loaded the new routing and briefed it carefully. By now both my FO and I were clearly in the Yellow and trying to get back into the Green. By that time, Passengers had been on the aircraft and waiting at least 20 minutes, and were getting irritated. At that point we did the Before Start Checklist and got the loading schedule. I was rushed, but trying to do things methodically; however, I missed going over the third Dispatch Release carefully enough and comparing the zero fuel weight and takeoff weight with what was on the loading schedule. There was a 16,345 pound difference in the takeoff weight and 16,137 pound difference in the zero fuel weight. Dispatch had planned us with a full Passenger load, but we only had 75 Passengers. I missed it. The good news is we were at the actual weight on the loading schedule and not the planned weight on the Dispatch Release.

Once airborne I discovered the error when I had a chance to look at the Release more carefully, and contacted Dispatch immediately. I tried to reach ZZZ Operations but no one
answered the radio. We determined the loading schedule was correct and landed uneventfully in ZZZ1. All I can say is I’m sorry. I have learned a lot from this flight and will be more diligent in the future, slow down, and try to minimize the risks of fatigue, multiple interruptions and changes to our normal flow.

We were late and felt rushed. We needed to slow down. We were getting tired; it was the last day of a long hard four-day trip. We could have called in fatigued, drank coffee or eaten something. We were distracted by Ground Crew and Flight Attendants and Agents as we were trying to sort out the new route and communicate with Dispatch. We could have told them to leave us alone while we did our job. I think the other Employees might be made aware that distracting the Pilots at times like this adds stress and causes errors.

**Narrative: 2**

Pushed back and taxi out to start cross bleed. Started takeoff roll and at V1 rotate I pulled back and the yoke was very heavy, I told the CA that it was very nose heavy. Trimmed out and continued on the departure. At cruise we discussed what may have happened and began looking at the numbers between the release and the load sheet and discovered a discrepancy of over 16K LBS. Dispatch had planned the flight full and in actuality we only had 75 passengers. We sent ACARS back and forth with dispatch and determined the load sheet was correct and landed uneventfully at ZZZ1.

Minimize distractions from crew and ground OPS, slow down and realize that we were getting tired and should slow down more and be extra diligent when loading performance numbers. Other work groups IE. attendants and OPS need to be made aware of interrupting pilots during checklists.

**Synopsis**

B737NG flight crew reported multiple distractions along with being late on the last leg of a fatiguing four day trip which resulted in them departing weighing less than what was shown on the release.
**ACN: 1418104 (43 of 50)**

**Time / Day**
- Date: 201701
- Local Time Of Day: 0601-1200

**Place**
- Locale Reference.ATC Facility: ZME.ARTCC
- State Reference: TN

**Environment**
- Flight Conditions: VMC
- Light: Daylight

**Aircraft**
- Reference: X
- ATC / Advisory.Center: ZME
- Aircraft Operator: Air Carrier
- Make Model Name: Widebody Transport
- Crew Size: Number Of Crew: 3
- Operating Under FAR Part: Part 121
- Flight Plan: IFR
- Mission: Cargo / Freight
- Nav In Use: FMS Or FMC
- Nav In Use: VOR / VORTAC: BWG
- Flight Phase: Cruise
- Airspace.Class A: ZME

**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: 1418104
- Human Factors: Situational Awareness
- Human Factors: Workload
- Human Factors: Distraction
- 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
- Qualification: Flight Crew: Air Transport Pilot (ATP)
- ASRS Report Number. Accession Number: 1418105
Narrative: 1

We were given holding instructions to hold NW on the 320 radial of the BWG VOR. Setup and the initial turn was with the inbound course set to 320 (holding SE of the BWG VOR). When we realized that our clearance was to hold on the other side of BWG, we told ATC we needed to turn back to BWG and re-enter holding.

We were pretty busy at this time because [of] a system malfunction. Entering a random holding pattern (and not the published database hold) is an infrequent event in our daily operations. We were also probably pretty tired at this point. We probably could have taken the time to discuss the hold among all three crew members to make sure we all agreed on the holding pattern. We may have also asked ATC for clarification if there was any confusion about the clearance.

Narrative: 2

[Report narrative contained no additional information.]

Narrative: 3

[Report narrative contained no additional information.]

Synopsis
Air carrier flight crew reported entering a holding pattern on the unprotected side of the hold clearance.
ACN: 1417108 (44 of 50)

**Time / Day**
- Date: 201701
- Local Time Of Day: 1801-2400

**Place**
- Locale Reference.Airport: LGA.Airport
- State Reference: NY
- Altitude.AGL.Single Value: 0

**Environment**
- Flight Conditions: VMC
- Weather Elements / Visibility: Turbulence

**Aircraft : 1**
- Reference: X
- ATC / Advisory.Ground: LGA
- Aircraft Operator: Air Carrier
- Make Model Name: Medium 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: Taxi

**Aircraft : 2**
- Reference: Y
- ATC / Advisory.Ground: LGA
- Aircraft Operator: Air Carrier
- Make Model Name: A320
- Crew Size.Number Of Crew: 2
- Operating Under FAR Part: Part 121
- Flight Plan: IFR
- Mission: Passenger
- Flight Phase: Taxi

**Aircraft : 3**
- Reference: Z
- ATC / Advisory.Ground: LGA
- Aircraft Operator: Air Carrier
- Make Model Name: Airbus 318/319/320/321 Undifferentiated
- 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 : Instrument
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
ASRS Report Number.Accession Number : 1417108
Human Factors : Fatigue
Human Factors : Distraction
Human Factors : Situational Awareness
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : ATC
Communication Breakdown.Party2 : Flight Crew

Person : 2
Reference : 2
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)
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Instrument
Experience.Flight Crew.Total : 4000
ASRS Report Number.Accession Number : 1417111
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : ATC
Communication Breakdown.Party2 : Flight Crew

Events
Anomaly.ATC Issue : All Types
Anomaly.Deviation - Procedural : Clearance
Anomaly.Ground Incursion : Taxiway
Detector.Automation : Air Traffic Control
Detector.Person : Air Traffic Control
Were Passengers Involved In Event : Y
When Detected : Taxi
Result.General : None Reported / Taken

Assessments
Contributing Factors / Situations : Airport
Contributing Factors / Situations : ATC Equipment / Nav Facility / Buildings
Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1
I was the First Officer (FO) on [the] flight. We landed on 31 from the expressway visual and made the T turnoff. Tower had said make the left turn off at T. I switched the radio to ground and the captain took the ground frequency while I called ramp to get clearance
into the gate. After I had come back to ground frequency the captain had not gotten a word in yet as the frequency was congested and there was a lot of traffic.

We were still on T at an angle to B. I checked in with ground finally and stated we were off (runway 31) and joining B. Ground said go straight ahead on bravo and hold short of G. There was an Airbus making the turn from A to G. We were told to give way to Airbus and then hold short of F.

Ground changed their mind and said Airbus gives way to you, proceed on B and hold short of F. Then ground asked if we were cleared in to the gate. I stated after 2 outbound aircraft out of the alley we were cleared into the gate. They said okay go F and A and hold short of your alley until you can get in. We taxied from B and took a left on F and a second left on A and held short of the alley while a company aircraft exited the alley. After they were clear we turned right into the alley and into the gate. We followed all of these instructions as stated.

Upon reaching the gate, the captain received a phone call from the tower stating we did not hold short of the taxiways we were told to on the way in. We in fact held short of G when asked and also held short of F and the ramp as we were told or until we were told otherwise. The controller also said on the phone, according to the captain, that we were originally told to turn left onto B after exiting the runway. If the case, I did not hear nor read back the instruction to turn left onto bravo.

I believe we followed the instructions as they were issued. Some factors though that may have contributed to any deviation that occurred according to the controllers could’ve been misinterpretation of the taxi instructions on our part or ATC forgetting what instructions they gave us. It was the last leg of days of work for me so fatigue was starting to set in. I could have missed an instruction issued by ground and as a result did not read back the correct instructions and was also not corrected by the controller.

It is important to listen to all instructions closely as they are given and confirm them if any doubt exists. There were a number of distractions including talking to ground/tower, calling the ramp to find out the status of the gate, completing the after landing flows/checklist, and most importantly keeping a heads up awareness outside the aircraft especially in a designated Hotspot.

**Narrative: 2**

During the landing roll out, between 80 and 60 knots, tower commands take "T or S, your choice" to exit the runway. Before the FO transfers controls I respond to tower that we can take T taxiway, the response I remember was "...left T and contact ground."

As we taxi off the First Officer (FO) announces he is contacting Ops and Ramp on VHF 2 as I monitor VHF 1 for any further commands. I slow my taxi speed and head towards GG taxiway that points straight to the ramp of gate. Before proceeding any further towards the gate I remain on B short of GG and wait for confirmation from the FO that we are cleared in to our ramp.

Once we receive word on who to wait for on the ramp the FO returns to VHF 1 and is able to get a word in with ground between the radio traffic and ground commands to "continue on B hold short of G." I move a short distance down B taxiway holding short of G, indicated by the 3 amber lights and was blocked by an A320 on G holding short of runway 4.
Landing traffic on 31 exits on S taxiway and an Airbus on A taxiway, Ground commands the Airbus on A taxiway to taxi on G and B in front of me but they wanted to give way to us. Ground commands us to taxi on B and hold short of F without delay. Once I set the parking brake ground asks about if we are cleared into the gate. The FO responds with what ramp stated, "One out cleared in" but we were both confused because another aircraft had pushed back into the alley, and we asked ramp to clarify if we were cleared in behind the last outbound which he did verify.

The next command from ground was to taxi "F and A hold short of your ramp." Once the last aircraft exited the FO told ground we were cleared in and I heard ground respond we were cleared in.

As passengers were disembarking the Gate agent told me there was an emergency phone call for me. The airport operations supervisor said that I had not complied with any instructions. That I was to taxi off of the runway and make a left onto B taxiway but did not. Later was commanded to hold short of G and did not comply, and entered the Ramp without clearance.

Have better coordination with ops, ramp, and ground. Verify that the message ATC is sending is what they are intending to communicate. Remove the need to verify with Ops on ground that gate assignment is correct.

**Synopsis**

Air carrier flight crew reported that the Tower informed them they had not followed their taxi clearance correctly. However, the flight crew believed they followed it as it was assigned by ATC.
ACN: 1417095 (45 of 50)

Time / Day
Date: 201701
Local Time Of Day: 1801-2400

Place
Locale Reference.Airport: LIT.Airport
State Reference: AR
Altitude.MSL.Single Value: 10000

Aircraft
Reference: X
ATC / Advisory.TRACON: LIT
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: Initial Approach
Airspace.Class C: LIT
Airspace.Class E: LIT

Component
Aircraft Component: Radio Altimeter
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: Captain
Function.Flight Crew: Pilot Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1417095
Human Factors: Confusion
Human Factors: Fatigue
Human Factors: Training / Qualification

Events
Anomaly.Deviation - Procedural: Published Material / Policy
Anomaly.Inflight Event / Encounter: Weather / Turbulence
Detector.Person: Flight Crew
When Detected: In-flight
Result.Flight Crew: Executed Go Around / Missed Approach
Result.Flight Crew: Became Reoriented

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

Narrative: 1

I was acting as Pilot in Command and pilot flying of a flight to Little Rock where an incorrect DH set for a Cat II approach led to two missed approaches. While setting up the flight we checked the weather forecast for Little Rock which was 1/2 sm and VV002 at our time of arrival. During our preflight briefing, we discussed the weather and to expect the Cat II approach. We read through the QRH CAT II checklist to familiarize ourselves with it and to review all the callouts. I then turned my attention back to the weather since the only Cat II approach was to 22R, yet the winds were out of the Northeast. Both the TAF and METAR were showing winds between 030 and 040 at 6-8 knots. Since this was a tailwind, I reviewed both the POH and FOM to verify the limitations for a tailwind on a Cat II. I determined that the winds were within limits. Once airborne in cruise flight, I returned to the FOM to verify the visibility requirements since the D-ATIS in Little Rock was not reporting RVR. I sent an ACARS Message to dispatch asking to send the current RVR, which was 6000 RVR. We continued to discuss the weather and again reviewed the wind and visibility requirements for the Cat II approach, which we were still expecting. When about 30 minutes from landing, we received a new D-ATIS in which was reporting 030/7 1 SM VV003 and ILS Approaches to 4L. Based on this ATIS, I elected to set up for the ILS 4L and briefed that approach. Just after briefing the approach, ATC gave us a descent from FL360 to cross 30 nm east of LIT at 10,000. I set that up in the FMS and started the descent. The FO then called the FA's, sent the in-range and built the approach. About 20 minutes from landing, we were handed off to approach and checked in. We were given a vector and told to expect the ILS 22R. At the same time, we received an auto-update of the ATIS with was now reporting back down to 1/2sm and VV002. I then briefed the Cat II for 22R. During the briefing, I stated that DH would be set to RA of 128. The FO stated, that it should be set to 362. For a moment, I hesitated, saying, no, it should be 128. However, because I was tired, and despite knowing it should be 128, I then believed that I was wrong and the FO was correct. We set the DH to [RA] 362 and continued the briefing and then ran the CAT II descent Checklist. Because of the error, we executed a missed approach and cleaned up the aircraft. I then did a quick fuel calculation for diversion fuel. We had about 8200 lbs on board and I calculated about 3000 lbs to divert to either of our 2 alternates. I then determined that we had enough fuel to make another attempt. We then reset the approach and double checked the course, frequency and altitude. At this time, still believing the DH set to 362 was correct, I did not change it when we reran the CAT II descent checklist. We were given vectors for the ILS 22R and reconfigured for the approach in which we went missed again for the same reason. At this point I again checked out fuel, which was around 7,700lbs. I also realized that something was not right when an aircraft which was following us saw the runway and landed. I then realized that the DH set to 362 was in correct and that it should be 128. We verified this with the example on the descent checklist. We corrected the DH setting and I determined that we still had enough fuel to make one more attempt before having to divert. On this attempt, I saw the runway and landed with no further incident. There are several factors which led to this error. My attention was divided by the weather as well as being tired. Although we reviewed the CAT II requirements, call outs, and approach plate prior to departing, I was fixated on the weather conditions. My major concern was if we were legal for the approach based on the winds and visibility. When we briefed the check list and call outs, we were focused on the weather and call outs, making sure we both knew what we were supposed to say, and did not discuss what the DH setting should be before we left. At the start of this flight, I was not feeling fatigue even though I had been awake for nearly 14 hours at that point. However, after being in the air for about a hour and half, I could feel fatigue.
starting to set in. When the time came to brief the CAT II, I was getting very tired and when the FO challenged me on the DH setting, my judgment was not clear. I did not trust my instinct which told me that I was correct and instead I believed the FO. Since we had discussed the CAT II several times, I believed that we had the DH set correctly and since we were getting close to the airport, I did not ask to double check the setting with the example in the checklist. In the future, I will make sure that the DH setting is briefed as per the example provided and double check the setting if there is any question as to the correct setting.

Synopsis

Air carrier Captain reported setting the incorrect decision altitude in the Radar Altimeter for a CAT II approach to LIT, resulting in two missed approaches. Fatigue was cited as a factor.
ACN: 1414879 (46 of 50)

Time / Day
Date: 201701
Local Time Of Day: 0001-0600

Place
Locale Reference.Airport: ANC.Airport
State Reference: AK
Altitude.AGL.Single Value: 10000

Environment
Flight Conditions: IMC

Aircraft
Reference: X
ATC / Advisory.TRACON: A11
Aircraft Operator: Air Carrier
Make Model Name: Widebody Transport
Operating Under FAR Part: Part 121
Flight Plan: IFR
Mission: Passenger
Nav In Use: FMS Or FMC
Flight Phase: Initial Approach
Airspace.Class C: ANC

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: 1414879
Human Factors: Distraction
Human Factors: Fatigue
Human Factors: Situational Awareness

Events
Anomaly.Aircraft Equipment Problem: Less Severe
Anomaly.Deviation - Procedural: Published Material / Policy
Anomaly.Inflight Event / Encounter: Weather / Turbulence
Anomaly.Inflight Event / Encounter: Unstabilized Approach
Detector.Person: Flight Crew
When Detected: In-flight
Result.Flight Crew: Became Reoriented

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

**Narrative: 1**

On arrival into Anchorage, ILS 7R, visibility was reported as 6000 RVR. However, upon arrival at minimums, the approach lights were in sight but the entire threshold and threshold and centerline lights were obscured by fog so a go-around was initiated. On the go-around, my EFB popped up multiple (5 or more) updates since it connected to cellular data when near the surface. This blocked the view of the missed approach procedure. I quickly cleared them, while flying the FMC missed and I elected to remain at Flaps 1. Return vectors were quickly issued. I missed calling for the after takeoff checklist, and when vectored back around for an approach to 7L which was reportedly VFR, upon calling for "Gear Down, Flaps 20" the Pilot Monitoring (PM) placed the gear to "OFF" rather than "Down." Subsequently, the gear warning illuminated when landing flaps were selected. I again called for gear extension which completed extending and the landing checklist was finished slightly after passing 1000 feet AGL. However, it was decided that continuing to land rather than executing a second go-around while fatigued with rapidly changing visibility conditions along with having visual contact with the runway was the safest option.

Fatigue: Leading up to the event, we had flown 13 hours block the previous day followed by near minimum legal rest. Although we all felt rested, this must have accumulated some level of fatigue. We then arrived at the aircraft to experience an hour passenger boarding delay. While airborne, due to in-seat entertainment audio failure, the movie was played over the PA system which delayed the start of crew rest breaks. While on my crew rest break for approximately one hour, I was called back to the cockpit to review an unfamiliar FMC message regarding the Inertial Reference Systems.

Early in the approach, the Autoland Status Annunciator also annunciated "No Land 3" this diverted some attention but I do not believe it to be the cause of the event. Distraction: While flying the missed approach, I was distracted by the offering of updates while attempting to glance at the approach plate. My election to remain at flaps 1 after which the "Flaps Up" call would have stated "After takeoff checklist"

The PM’s action of moving the gear lever 1 notch rather than to Down.

As soon as I recognized the gear position (still above 1000 feet AGL), I made an immediate call for gear down landing checklist, and assessed the safety of waiting for the gear vs executing a second go-around.

While many factors played into the culmination of events, I believe the most prevalent were fatigue and distraction. However, calling for the after takeoff checklist would have prevented the occurrence entirely as the gear handle would have been in a position that would only require one action. As such, my recommendation would be to emphasize the importance of completing the after takeoff checklist following a go-around procedure.

**Synopsis**

Air carrier Captain reported fatigue and distractions led to some errors on a go-around from a low visibility approach.
ACN: 1414631 (47 of 50)

**Time / Day**
- Date: 201611
- Local Time Of Day: 0601-1200

**Place**
- Locale Reference: Airport: ZZZ.Airport
- State Reference: US
- Altitude: MSL. Single Value: 16000

**Environment**
- Flight Conditions: VMC

**Aircraft**
- Reference: X
- ATC / Advisory.Center: 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
- Nav In Use: FMS Or FMC
- Flight Phase: Cruise
- Airspace: Class E: ZZZ

**Component**
- Aircraft Component: Autopilot
- 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: 1414631
- Human Factors: Fatigue

**Events**
- Anomaly: Aircraft Equipment Problem: Less Severe
- Anomaly: Inflight Event / Encounter: Weather / Turbulence
- Detector: Person: Flight Crew
- When Detected: In-flight
- Result: General: Work Refused
- Result: Flight Crew: Overcame Equipment Problem

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

**Narrative: 1**

During [the] flight to ZZZ I calculated fuel and decided the aircraft would be easier to hand fly at 16000 feet instead of FL260. The ride was forecasted rough there by ATC so I opted to stay at 16000 feet as I showed landing fuel of 3400 LBS and was ACARS messaged "What possible scenario could make you fly at 16000 feet instead of FL260 as filed". I found that very aggressive and questioning of my judgment and after the event on the previous flight and the strenuous [maintenance] delay I decided my mind had reached its max for the day from [an early] wake up and found the bad questioning and wording to frustrate me, and me airing on the side of safety to be unprofessional and I took myself off line. Keep in mind the First Officer (FO) nor Flight Attendants felt comfortable going but I assured their safety and completed the flight.

After having a pitch trim runaway on [a previous] flight on short final with little elevator authority and zero left aileron authority I made a quick sound decision to land the aircraft with the assistance of the FO. Once on touch down we had zero ground dump spoilers and the controls were stuck in the full left deflection all the way to the gate until hydraulic pumps were turned off. No question a major fault in the system which was diagnosed to be the autopilot which then they MELed. This resulted in a fatigue call.

**Synopsis**

CRJ-700 Captain reported flying at a lower than filed altitude due to a previous maintenance issue with the aircraft.
**ACN: 1412767 (48 of 50)**

**Time / Day**
- Date: 201612
- Local Time Of Day: 0601-1200

**Place**
- Locale Reference.Airport: ZZZ.Airport
- State Reference: US
- Altitude.MSL.Single Value: 25000

**Environment**
- Flight Conditions: IMC
- Light: Night

**Aircraft**
- Reference: X
- ATC / Advisory.Center: ZZZ
- Aircraft Operator: Air Carrier
- Make Model Name: A300
- Crew Size.Number Of Crew: 2
- Operating Under FAR Part: Part 121
- Flight Plan: IFR
- Mission: Cargo / Freight
- Flight Phase: Climb
- Airspace.Class A: ZZZ

**Component : 1**
- Aircraft Component: Air Conditioning and Pressurization Pack
- Aircraft Reference: X
- Problem: Malfunctioning

**Component : 2**
- Aircraft Component: APU Pneumatic System & Ducting
- 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: Captain
- Function.Flight Crew: Pilot Not Flying
- Qualification.Flight Crew: Air Transport Pilot (ATP)
- ASRS Report Number.Accession Number: 1412767
- Human Factors: Fatigue
- Human Factors: Physiological - Other
- Human Factors: Troubleshooting

**Person : 2**
Narrative: 1

We had flown a 2 hour flight just prior to this flight. Prior to this flight, we had a min layover after flying from four hours during the day from the west coast to the East coast. Upon arrival at our first destination, we were scheduled for a day room for 5 hours but stayed at the airport so that we could leave 2 hours earlier than scheduled. Our airplane had four MEL items. Two were re-inspections each flight, one was a FADEC issue and the other pitch feel deferral. We had to de-ice prior to engine start. During the week all de-ice events were done after engine start. We took off at max thrust. During climbout, passing about 25000 feet MSL, we experienced a dual pack failure. We placed our oxygen masks on, established communication between ourselves, then began to coordinate a descent to 10,000 ft with ATC and started going through our ECAM procedures. We descended to 10,000 feet. We contacted flight control and established contact with maintenance control. We determined, with flight control, we could make it to our destination at 10,000 feet with the fuel we had on board. As we were going through the ECAM procedures and attempting to reset the packs as per maintenance direction, we realized that our APU was on and the APU bleed valve was open. We turned the APU off and closed the APU bleed valve. We were then able to reset the AC packs. We climbed to FL360 and continued uneventfully.

Leaving the APU and APU bleed on were not returned to their proper position after we de-iced. This was the cause of our dual pack failure. Fatigue, failure to utilize checklist discipline, change in de-icing procedure and MEL re-inspections were all contributing factors in this event.

Narrative: 2

[Report narrative contained no additional information.]
Synopsis

A300 flight crew reported experiencing a dual pack failure necessitating an emergency descent. After troubleshooting, the crew discovered the source of the failure and was able to climb back to the planned cruise altitude.
Time / Day
Date: 201612
Local Time Of Day: 0601-1200

Place
Locale Reference.Airport: CLT.Airport
State Reference: NC

Environment
Light: Daylight

Aircraft
Reference: X
ATC / Advisory.Tower: CLT
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: Initial Climb
Airspace.Class B: CLT

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: 1412019
Human Factors: Confusion
Human Factors: Fatigue
Human Factors: Situational Awareness

Events
Anomaly.ATC Issue: All Types
Anomaly.Deviation - Track / Heading: All Types
Anomaly.Deviation - Procedural: Clearance
Anomaly.Deviation - Procedural: Published Material / Policy
Detector.Person: Air Traffic Control
When Detected: In-flight
Result.Flight Crew: Returned To Clearance
Result.Flight Crew: Became Reoriented

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

**Narrative: 1**

What: Took off on Runway 36C and turned right to heading 018 instead of left to heading 330

Why:
1) I programmed the wrong runway (36R) into the single FMS.
2) We didn’t thoroughly brief the departure.
3) I didn't catch my First Officer inadequately briefing the center runway and not going over the FMS
4) The First Officer saw 36 in the MFD and FMS, but did not catch the R versus C
5) Fatigue: After two weeks of night schedule I had 10 hours to fly again at night then be up to fly an early morning schedule. I was feeling very tired all day.
6) Charlotte ATC: I asked the controller for the proper heading before we turned, her reply was to fly the SID, not helpful.

I’ve flown the LGA 9 Canarsie/Whitestone climb 100 times without messing it up, yet this is the second time that this has happened to me in CLT. I have to examine every possible cause I can think of. I should never have allowed this to happen. Charlotte is the one place where I never know what the controllers will tell us on takeoff. Sometimes it's the SID, sometimes it's the heading on the SID, if we takeoff in NAV with the SID, CLT then gives us a heading, so we change to HDG, they then turn us to the heading back to the runway, then clear us back to a fix on the SID, then a heading. It's not consistent, it's in the most dangerous part of the flight, and it's very work intensive. This could be better.

Next Time:
1) I will not allow the FO to brief the departure this way. We are trained to do it a certain way for a reason. If we had been standard, we would have caught the mistake.
2) The next time ask a controller for a heading, I will insist on a heading.
3) If I'm that darn tired I will call in fatigued. I must admit, our current fatigue conference call system intimidates me.

What [the company] could do better:

**SCHEDULES:**
1) Night flying or day flying, pick one, people aren't machines. Eventually someone's going to get hurt if we keep building our schedules this way.
2) Hot or Cold: Night 2 67 degrees, Night 3 17 degrees, good way to get sick, hard to pack, hard to rest, hard to exercise to stay sharp.

Dismiss this as whining if you like. In 23 years of Military Flying I never encountered the disregard for the human need for circadian rest, and physiological adaptation as I have [here] with our current schedules. I know the direct causal factor of this was my mistake, but I am not a careless or lazy person. I am thoroughly aware that the cost of failure in this business is the lives of my crew and passengers. Their lives are every bit as valuable to me as my own, and I really would like to avoid making such stupid mistakes again.

**Synopsis**
CRJ-700 Captain reported a track deviation on departure out of CLT citing fatigue, ATC inconsistencies, and company policies on fatiguing schedules as contributing.
ACN: 1411815 (50 of 50)

Time / Day
Date: 201612
Local Time Of Day: 0001-0600

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

Environment
Flight Conditions: VMC
Weather Elements / Visibility: Icing
Light: Night

Aircraft
Reference: X
ATC / Advisory. CTAF: 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: Landing
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 Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1411815
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: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1411814
Human Factors: Fatigue

Events
Anomaly.Flight Deck / Cabin / Aircraft Event : Passenger Misconduct
Anomaly.Ground Event / Encounter : Loss Of Aircraft Control
Detector.Person : Flight Crew
When Detected : Taxi
Result.Flight Crew : Diverted

Assessments
Contributing Factors / Situations : Airport
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Weather
Primary Problem : Ambiguous

Narrative: 1
This flight was the result of a diversion of the original flight to ZZZ. After receiving clearance from approach for the visual into ZZZ was informed by the dispatcher via ACARS that the airport ops was reporting a NOTAM of a FICON (Field Conditions) of ice (Tower is Closed at this point in time airport is uncontrolled). Upon receiving this information myself along with the first officer and dispatcher concluded that a diversion was the best course of action at that point in time until we could get some better information on the conditions at ZZZ airport. Diversion went as planned no issues. Once parked and at the gate, I called the dispatcher to see if we couldn't figure out a course of action. We discussed a couple of things as he was in direct contact with the ZZZ operations. Eventually we were informed that the landing runway had been treated and the NOTAM of 1/1/1 had been removed and the airport was reporting a FICON of 5/5/5 braking action good. We decided that based upon this information there was no reason that we could not proceed to ZZZ. We re boarded the airplane and proceeded on our way to ZZZ.

The departure, enroute flight and approach were uneventful. After landing is when I noticed that we as a crew and the dispatcher had been misinformed. The runway was covered with ice and the braking action was very poor almost nil in some areas. I was able to eventually bring the airplane to a complete stop using brakes, and thrust reversers. We were able to gingerly taxi the airplane off of the landing runway onto the intersecting runway where we further started to slide about and ability to maintain aircraft control was almost impossible. We brought the aircraft to a complete stop again on the runway in a last effort to further taxi to the terminal we tried to turn north onto a taxiway and began to slide again uncontrollably eventually leading the aircraft almost doing a 180 with the tail facing north. We were able to get the airplane to stop on the taxiway now partially on the taxiway facing south with the airplane’s nose touching runway. After this we decided that further trying to taxi would not be a safe option so we shut down the engines and contacted operations as to our situation. Stranded on our own for roughly an hour and a half we tried to come up with a plan while talking to the airport operations to which were pretty much left stranded on our own. The only help we received was a lone fireman that was able to help us deplane the passengers 2 to 3 at a time while making runs from the airplane to the terminal.

Late night, we were misinformed to the true state of the airport in ZZZ the airport was pretty much one huge sheet of ice. Airport ops was no help as the airplane was unable to taxi as well as stuck on a taxiway about half a mile from the airport terminal. Overall this is a huge learning experience on so many levels. I guess what bothers me the most is that in this situation there was a feeling of helplessness and frustration not with the company or the crew, but with the ZZZ facility and the information given to us prior to flying there and once on the ground. Honestly it’s going to be hard for me to trust this station or
anything associated with it from now on. All of this could have been avoided if people were honest.

**Narrative: 2**

We asked the station operations if they had transportation available to pick them up at the airplane and take them to the terminal, they stated they had none. We then had them get ahold of the local sheriff and fire departments to ask them for assistance, which he said he would do, in addition to calling the airport manager to ask him for any other options. Two hours went by before we had anyone show up at our aircraft for assistance. It was one gentleman driving a pickup truck from the fire department. We decided to take advantage of his assistance, and started to deplane the passengers beginning with the elderly followed by families with their children, then the most irritated/outspoken. Some of the passengers were becoming very unruly during this time, and threatened to walk off the aircraft and walk. We were able to appease them long enough to allow the fire department to assist them to the terminal. One particular passenger saw the truck driver pull up to the aircraft and yelled "I'm getting off this airplane right now," and pushed his way out of the airplane and walked down to the truck. Another truck driver pulled up after we had offloaded about half of the 45 passengers to assist. It took us approximately an hour and a half to finish deplaning everyone.

In the meantime, the station had been treating the taxiway with an ice removal chemical, as they wanted us to finish taxiing to the gate. There was still patchy ice in several areas, so we decided to leave the plane where it was overnight. The station and our company wanted us to wait for a few hours to allow the rest of the taxiway to be cleared to accomplish this final portion of the taxi, but we discussed our level of fatigue between us two pilots and determined we were too exhausted to continue crew duty. We called in fatigue at this point, and finally got to our hotel at approximately 7:30 in the morning. There was no damage to the aircraft during this entire ordeal, and the airplane never left any portion of the prepared surface. In addition, no passenger was injured during the entire evening. There was nothing we could do to improve our situation. We were given incorrect information regarding the runway contamination and we did not do anything outside normal procedures.

**Synopsis**

CRJ-200 flight crew reported braking action was found to be poor or nil during landing despite good reports and the aircraft could not be taxied to the gate. The aircraft was shut down on a taxiway and the passengers were taken to the terminal in airport vehicles.