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, 2017

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

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

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.
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
ACN: 1402673 (1 of 50)

Synopsis
B737 NG Captain reported the aircraft moved about a foot after parking at the gate in a high wind environment when the Captain neglected to keep the parking brake set as required by the SOP in those conditions.

ACN: 1402222 (2 of 50)

Synopsis
Two B777 First Officers reported questioning the Captain’s interpretation of FAR 117 that he believed requires the pilot flying to take the last break. The flying First Officer preferred the second break citing "sleep inertia" but complied with the Captain's wishes.

ACN: 1392765 (3 of 50)

Synopsis
B737 flight crew reported that fatigue and distractions resulted in the approach being flown to 500 ft AGL without the Landing Checklist being run.

ACN: 1391957 (4 of 50)

Synopsis
B737 Check Captain as pilot monitoring, reported missing a crossing restriction during descent when the flying Captain forgot to reset the MCP altitude.

ACN: 1385120 (5 of 50)

Synopsis
A319 flight crew reported departing without an updated release after a long delay for maintenance that created an MEL that the crew was not aware of. As a reserve crew they were concerned about their duty limits under FAR 117 and spent much time arguing with crew scheduling over their start time and overlooked the MEL item.

ACN: 1384970 (6 of 50)

Synopsis
Air carrier flight crew reported lining up with the wrong airport on a visual approach to LAW.

ACN: 1382375 (7 of 50)

Synopsis
A B737-NG flight crew reported lining up for the wrong runway on final. The crew felt rushed which caused cognitive tunneling to the exclusion of basic heading and the loss of situational awareness.
Synopsis
MD11 flight crew reported descending below their assigned altitude of 3000 feet prior to reaching LIMES (IAF) after being cleared for the ILS Runway 7L approach to VHHH. ATC detected the error and issued a climb back to 3000 feet. Fatigue was cited as a factor in the incident.

Synopsis
B767 Captain reported becoming incapacitated in flight on an international leg possibly because of food poisoning.

Synopsis
CRJ-200 First Officer reported flight crew failed to shut down #2 engine at arrival airport due to lack of checklist discipline.

Synopsis
B737-800 flight crew reported diverting when they received a low fuel pressure indication after mistakenly departing with 10,000 lbs less fuel than calculated.

Synopsis
A321 flight crew reported a track deviation and altitude overshoot resulted from task saturation on arrival into LAX as ATC changed the runway and arrival clearances several times.

Synopsis
Air carrier flight crew reported not making a crossing restriction on the FRNCH3 STAR to DEN.

Synopsis
A CRJ-900 Captain described a trip during hot weather in aircraft with either the APU or a pack MELed, multiple MELs, ATC reroutes in weather and a return to the departure airport following a lightning strike. The crew ultimately called in fatigued.
<table>
<thead>
<tr>
<th>ACN: 1361990 (15 of 50)</th>
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<tbody>
<tr>
<td><strong>Synopsis</strong></td>
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<tr>
<td>A320 flight crew reported missing a crossing restriction at SPIEK on the DELTA 4 Arrival SLC. The FMGC had reverted to vertical speed with 11000 feet set. The flight crew detected the error just before ATC issued a low altitude alert. Fatigue was cited as a contributing factor.</td>
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<tr>
<th>ACN: 1360278 (16 of 50)</th>
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<tr>
<td><strong>Synopsis</strong></td>
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<tr>
<td>An air carrier diverted because of thunderstorms. After 21+44 hours on duty, the crew ceased attempting to get clearance to destination, a 2+09 flight, despite company personnel threats about dire consequences for failing to depart.</td>
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<tr>
<th>ACN: 1360235 (17 of 50)</th>
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<tr>
<td><strong>Synopsis</strong></td>
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<tr>
<td>B737-700 Captain reported a track deviation resulted after they got a late runway change and the FMC was not properly re-programmed.</td>
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<tr>
<th>ACN: 1357199 (18 of 50)</th>
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<tr>
<td><strong>Synopsis</strong></td>
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<tr>
<td>B767 international Captain reported he felt less rested and therefore less safe following the FAA mandated international rest break schedule.</td>
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<tr>
<th>ACN: 1354159 (19 of 50)</th>
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<tr>
<td><strong>Synopsis</strong></td>
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<tr>
<td>Air carrier flight crew reported a NMAC with VFR traffic while on the ILS 13R approach to BFI. The flight crew received an RA/TA, but did not take evasive action because they had the VFR traffic in sight.</td>
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<tr>
<th>ACN: 1351339 (20 of 50)</th>
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<tr>
<td><strong>Synopsis</strong></td>
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<tr>
<td>Air carrier First Officer described a fatiguing trip and mistakes that he made, necessitating a fatigue call.</td>
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<tr>
<th>ACN: 1350897 (21 of 50)</th>
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<td><strong>Synopsis</strong></td>
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<tr>
<td>B757-200 flight crew reported being informed after a flight that the Loadmaster had not accounted for additional passengers that were boarded at the previous stop resulting in a 3,900 KG error. The Loadmaster had been on the aircraft for 10 days and was very fatigued.</td>
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<tr>
<td>ACN: 1349312 (22 of 50)</td>
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<td><strong>Synopsis</strong></td>
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| ACN: 1347852 (23 of 50) | 
|---|---|
| **Synopsis** | A320 Captain reported extreme fatigue resulted from his three day assignment that included a "red eye" leg on day two. |

| ACN: 1347678 (24 of 50) | 
|---|---|
| **Synopsis** | B757-200 First Officer reported he and the Captain committed several errors on their flight because of fatigue and workload. |

| ACN: 1346948 (25 of 50) | 
|---|---|
| **Synopsis** | Air carrier flight crew reported being cleared to cross Runway 25R at LAX, but made an incorrect turn and ended up on the runway. They exited at the next intersection. |

| ACN: 1345428 (26 of 50) | 
|---|---|
| **Synopsis** | B737 flight crew reporting diverting to an alternate after executing a go-around at EWR due to high winds, turbulence, and an unstable approach. |

| ACN: 1344331 (27 of 50) | 
|---|---|
| **Synopsis** | An air carrier flight crew reported confusion during transition from taxi-in to tug hook up for the final pull-in to the gate. The tug crew's actions, incomplete instructions from Ramp Tower as to parking instructions, and fatigue contributed to the crew's confusion. In addition, the crew did not follow published procedures for parking at the assigned gate. |

| ACN: 1343692 (28 of 50) | 
|---|---|
| **Synopsis** | During cruise flight and while flying the RNAV arrival, a fatigued, recently ill Captain dozed off several times. The First Officer aggressively took control of the aircraft and landed. The Captain removed himself from the next flight. |
ACN: 1343438 (29 of 50)

Synopsis
CRJ flight crew experienced a late descent clearance from ATC. As a result the spoilers were used to get back on a proper glide path and never fully retracted prior to the flare. Stick shaker is activated in the flare and the Captain quickly retracts the spoilers. Glideslope and VASI were both out of service due recent runway modifications.

ACN: 1342318 (30 of 50)

Synopsis
A Captain reported inadvertently entering a dead-end taxiway, commenting that the taxiway charting could be improved at EAT airport.

ACN: 1341482 (31 of 50)

Synopsis
Air carrier flight crew received an EGPWS while descending into ABQ from the east on a visual approach to Runway 3.

ACN: 1340998 (32 of 50)

Synopsis
Dash-8-400 Captain reported being task-saturated by weather and legalities resulting in forgetting to accomplish the Approach Checklist. The flight landed uneventfully.

ACN: 1339065 (33 of 50)

Synopsis
First Officer describes a day's events which resulted in flight time over 8 hours and duty time. He was forced to call in fatigued after crew scheduling refused to permit a later check in trip.

ACN: 1339060 (34 of 50)

Synopsis
A320 First Officer described an extremely fatiguing three day pairing that is exacerbated by insufficient brightness of the cockpit display screens.

ACN: 1331351 (35 of 50)

Synopsis
B757 flight crew reported they rejected the takeoff when engine EGT temperatures reached the amber range.

ACN: 1330424 (36 of 50)
<table>
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<tr>
<th>Synopsis</th>
<th>ACN: 1330266 (37 of 50)</th>
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<tbody>
<tr>
<td>A Captain called off a trip fatigued on the third day after two nights of sleep deficit at hotels where late loud noise interfered with rest opportunities.</td>
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<tr>
<th>Synopsis</th>
<th>ACN: 1327658 (38 of 50)</th>
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<tbody>
<tr>
<td>Air carrier flight crew reported descending below the glideslope on approach to CHO when the First Officer's glideslope indications were erroneous.</td>
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<tr>
<th>Synopsis</th>
<th>ACN: 1327199 (39 of 50)</th>
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<tbody>
<tr>
<td>B787 First Officer reported his rest was interrupted by noises from a galley cart that was parked next to the bunk room door.</td>
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<tr>
<th>Synopsis</th>
<th>ACN: 1326553 (40 of 50)</th>
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<tbody>
<tr>
<td>A B777 First Officer described his company's inhospitable crew rest bunk conditions which are not conducive to sleep and result in flight crew fatigue during the flight's final stages.</td>
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<tr>
<th>Synopsis</th>
<th>ACN: 1325857 (41 of 50)</th>
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<tbody>
<tr>
<td>Air carrier Captain reported they did not configure final flaps in the approach and thus executed a missed approach.</td>
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<tr>
<th>Synopsis</th>
<th>ACN: 1325157 (42 of 50)</th>
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<tr>
<td>The pilots of a small transport aircraft reported departing in a time pressure condition only to discover that the requested fuel load had not been added. This resulted in a return to the departure airport.</td>
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<tr>
<th>Synopsis</th>
<th>ACN: 1324319 (43 of 50)</th>
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<tr>
<td>The A320 lost the yellow hydraulic system and diverted, which put them in a confusing FAR 117 situation.</td>
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<th>Synopsis</th>
<th>ACN: 1324177 (44 of 50)</th>
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<td>The pilots of a small transport aircraft reported descending below the glideslope on approach to CHO when the First Officer's glideslope indications were erroneous.</td>
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<tr>
<th>Synopsis</th>
<th>ACN: 1323519 (45 of 50)</th>
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<tr>
<td>A Captain called off a trip fatigued on the third day after two nights of sleep deficit at hotels where late loud noise interfered with rest opportunities.</td>
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<th>Synopsis</th>
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<tr>
<td>Air carrier flight crew reported descending below the glideslope on approach to CHO when the First Officer's glideslope indications were erroneous.</td>
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<tr>
<th>Synopsis</th>
<th>ACN: 1321924 (47 of 50)</th>
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<tbody>
<tr>
<td>B787 First Officer reported his rest was interrupted by noises from a galley cart that was parked next to the bunk room door.</td>
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<tr>
<th>Synopsis</th>
<th>ACN: 1321170 (48 of 50)</th>
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<tr>
<td>A B777 First Officer described his company's inhospitable crew rest bunk conditions which are not conducive to sleep and result in flight crew fatigue during the flight's final stages.</td>
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<tr>
<th>Synopsis</th>
<th>ACN: 1320475 (49 of 50)</th>
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<tr>
<td>Air carrier Captain reported they did not configure final flaps in the approach and thus executed a missed approach.</td>
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<tr>
<th>Synopsis</th>
<th>ACN: 1319728 (50 of 50)</th>
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<tr>
<td>The pilots of a small transport aircraft reported departing in a time pressure condition only to discover that the requested fuel load had not been added. This resulted in a return to the departure airport.</td>
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</table>
B737 flight crew forgot to set the flaps before taxi, but discovered the mistake during the throttle check while taxiing out. Fatigue and distractions during pushback reportedly played a role in the mistake.

**ACN: 1323105 (44 of 50)**

**Synopsis**
Flight crew neglected to connect the generators due to not completing the checklist properly. Transitioning from old procedures to new procedures caused the flight crew to get out of sequence while accomplishing the checklist.

**ACN: 1322997 (45 of 50)**

**Synopsis**
On approach in a B737, ATC issued an improper vector which sent the flight crew through the localizer. While attempting to recapture the localizer and glideslope the flight crew began to fall behind the aircraft resulting in breaking out of the clouds to the right of the runway.

**ACN: 1322034 (46 of 50)**

**Synopsis**
After takeoff, B737 crew raised the flaps from flaps 1 to up prior to reaching the minimum cleanup altitude or attaining minimum maneuvering speed for flaps up. Crew received an "Airspeed Low, Airspeed Low" aural alert and reacted by lowering the nose and quickly gaining sufficient airspeed.

**ACN: 1321489 (47 of 50)**

**Synopsis**
Air carrier Captain on visual approach to SFO descended below glideslope by following incorrectly programmed FD bars. Fatigue was listed as a contributing factor.

**ACN: 1321321 (48 of 50)**

**Synopsis**
B737 Captain reported a low altitude unstable condition occurred rapidly and without obvious cause on an approach to IAD.

**ACN: 1320299 (49 of 50)**

**Synopsis**
B737 Captain laments a grueling duty day, in bad weather, during which he is badgered by scheduling to accept a duty day extension and a trip assignment on his day off as the junior Captain available.
**Synopsis**
Due to adverse winds on approach, flight executed a go around. Due to low fuel amounts then diverted to another airport.
Report Narratives
**ACN: 1402673 (1 of 50)**

**Time / Day**
- Date: 201611
- Local Time Of Day: 1801-2400

**Place**
- Locale Reference: Airport: LAS.Airport
- State Reference: NV
- Altitude.AGL.Single Value: 0

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

**Person**
- Reference: 1
- Location Of Person: Aircraft: X
- Location In Aircraft: Flight Deck
- Reporter Organization: Air Carrier
- Function.Flight Crew: Captain
- Qualification.Flight Crew: Air Transport Pilot (ATP)
- ASRS Report Number.Accession Number: 1402673
- Human Factors: Fatigue
- Human Factors: Situational Awareness

**Events**
- Anomaly.Deviation - Procedural: Published Material / Policy
- Anomaly.Ground Event / Encounter: Other / Unknown
- Detector.Person: Flight Crew
- When Detected: Aircraft In Service At Gate
- Result.Flight Crew: Became Reoriented

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

**Narrative:** 1
Landed uneventfully in LAS in high winds. Taxied to gate and parked. Winds were reported from mid to upper 20s gusting to mid to upper 30s out of SW. Received "chocks in" signal and released parking brake and called for parking check like normal. I totally forgot about
the wind and responded "released" to FO's "parking brake" challenge on parking check. Finished checklist and began packing up our stuff when FAs halted deplaning when jetway moved about a foot off the airplane. FO and I both immediately realized the parking brake should still be set. I immediately set the brake and the gate agent moved the jetway up to the door and deplaning resumed. The wind blowing on the tail had moved the nose wheel about a foot off the J-line.

It had been a two-leg, 9 hour day so I was tired but not overly so. I HAD flown a red eye, arriving at XA:00 am the morning prior to this event. My sleep recovery from the red eye MAY have had an impact, but I didn't feel tired when I reported for work 9 hours earlier.

My experience has been that it is rare to find myself in a situation where the brake should be left set as covered in the Flight Manual. Perhaps there was an expectation bias on my part that the brake was to be released like it always is.

Synopsis

B737 NG Captain reported the aircraft moved about a foot after parking at the gate in a high wind environment when the Captain neglected to keep the parking brake set as required by the SOP in those conditions.
**Time / Day**
- Date: 201611
- Local Time Of Day: 0601-1200

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

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

**Aircraft**
- Reference: X
- ATC / Advisory: TRACON: ZZZ
- Aircraft Operator: Air Carrier
- Make Model Name: B777-200
- Crew Size: Number Of Crew: 3
- Operating Under FAR Part: Part 121
- Flight Plan: IFR
- Nav In Use: FMS Or FMC
- Flight Phase: Final Approach
- 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: Relief Pilot
- Function: Flight Crew: Pilot Not Flying
- Function: Flight Crew: First Officer
- Qualification: Flight Crew: Air Transport Pilot (ATP)
- ASRS Report Number: Accession Number: 1402222

**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: 1402243
- Human Factors: Fatigue

**Events**
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Person : Flight Crew
When Detected : In-flight
Result.General : Flight Cancelled / Delayed
Result.General : Maintenance Action

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

Narrative: 1

We had a pickup of XA10 for a XD40 departure local time. We arrived at the airport approximately one hour and 25 minutes before sign in time. Doing the preflight I discovered signs of engine oil leaking from the left engine. After reporting it to maintenance and [making] an appropriate [entry] in the logbook maintenance [and after] talk with Maintenance Control decided we needed to do an engine run and leak check. Maintenance advised us that to do this check, all passengers have to deplane the aircraft. We perform[ed] the procedure and then all passengers were re-boarded. Taxiing out we discovered that we were reaching [our operating] time limit without an extension. We all decided that we would do a 30 minute extension and continue to destination. The takeoff and en route was uneventful.

The captain made it mandatory that the pilot flying would take the last break. He was quoting FAR 117 that states that the pilot flying will have two hours available to him duing the last half of the flight. The first officer, the pilot flying, said that he would prefer the second break because it took him longer to wake up. The captain told him to come back early. At top of climb I did the breaks shorting them to allow the first officer to come back 40 minutes early.

I took the first break and got very little sleep at all. After my break I came up and relieved the captain for the second break. Everything was uneventful up to the point of the approach. Approach gave us vectors and radar descent to final. As they gave us a turn to the Base leg they turned us inside the outer marker and told us to maintain 170 knots to the FAF. The First Officer also used vertical speed of 1500 feet/minute to get down to the glideslope and we arrived there approximately 1000 feet slightly above the glideslope. Completed the approach on the glideslope and landed uneventfully.

The pilot flying should have the opportunity to select which break that he would prefer. Everyone knows their body and their sleep patterns. Some people like the last break and then wake up just fine. Some people take longer to wake up.

Narrative: 2

Assigned a XA10 local pickup from hotel for a XD40 local departure. This is the first issue as it put us at the airport 1 hour and 25 minutes prior to sign in time. I understand the issue with local traffic, but that traffic dies down around XA30-XB00 local and the late departure trip need not leave the hotel that early. That was a lost opportunity for another hour plus of sleep before pickup.

Aircraft preflight revealed oil leaks from both engines. Following several maintenance actions, to include engine runs, we pushed back 3 hours and 20 minutes late. As we approached the end of RWY for departure it became apparent that we would not be able to make our [operating time limit] of XH24 local. Since we were at the runway hold short line
we (Captain, Relief Pilot (FB), myself) agreed to extend just to get airborne. Captain (CA) coordinated an extension of a few minutes to allow departure. Takeoff and departure were uneventful. Cruise was uneventful until it came time to split the flight time for breaks. I was Pilot Flying (First Officer) for this leg.

The CA had flown the first leg and told us on that leg he was adamant that FAR 117 required the Flying Pilot to take the last break. On this leg CA again asserted his belief that FAR 117 required the Flying Pilot to take last break. Both the FB and I referenced FAR 117 and showed the CA that the time during the last break was to be "available" to the Pilot Flying. Having spoken to several check airman previously about this issue, the given interpretation of "available" was taken to mean that [if] the Flying Pilot chose to take that block of time, it was theirs for the taking. I notified the CA that I prefer the second break period because I am greatly affected by sleep inertia and would be negatively affected by taking the last break. The FB indicated a similar preference also because of sleep inertia. At two points the discussion even became a bit heated. Finally, I acquiesced to the CA and resigned myself to the last break. I was tired enough at the conclusion of my break, that the FB had to repeat call [to] the crew bunk phone to wake me. As anticipated I felt the effects of sleep inertia. I sat in the FO seat just before I (as FB) had to begin descent. Descent was uneventful.

Arriving the RNAV arrival, Approach assigned the ILS. This was expected and had been briefed as a visual approach with ILS backup guidance. As I was descending, I attempted to wake myself by drinking coffee and chewing gum and felt generally better, but slightly still affected by sleep inertia. Approach descended us to 3000 feet, then turned us to heading 350 with a descent to 1500 feet. I configured the aircraft as appropriate. Approach control then turned us to heading 060 to intercept localizer final at 1500 feet. The CA (Pilot Monitoring) attempted to extend the RWY centerline on the FMS, but instead initiated a Direct-to the FAF. This cut the corner and effectively took away room for further descent during the normal turn to final. Approach control had requested we maintain 170 knots until 5 mile final, then sent us to tower frequency. Because we had cut the corner (as a result of the direct to) we were above the glideslope. I selected Vertical Speed down 1500 FPM to attempt to capture the glideslope from above per procedure. I slowed the aircraft toward final approach speed and requested flaps 30 (landing flap setting). While I believe the flaps were down by 1000 AGL I am not positive. After I initiated the procedure to capture the glideslope from above, it became apparent that we were a little too high, so I disconnected the Auto Pilot and manually corrected the flight path. Because I was focused on flying the aircraft at the time, I could not be positive the flaps had reached the final setting by 1000 feet AGL. Once attaining the normal glideslope, the approach was stable and on speed. Touchdown, rollout, and ground taxi to the gate were uneventful.

This event was rooted in fatigue (fatigue report filed). Unnecessarily early bus time caused loss of opportunity for another hour of sleep. Maintenance issue with engine oil leaks delayed departure for 3 hours and 20 minutes. Finally, the Captain's interpretation of FAR 117 that the Pilot Flying MUST take the last break (despite objection of FO and FB), propagated the aforementioned fatigue. As a result, I was forced to fly the approach under the effects of sleep inertia. As such, I was slower to recognize that we were proceeding direct to the FAF as opposed to intercepting extended final. Once I recognized that, as a result, we were high, I initiated the procedure to correct back to the flight path and called for final flaps. I believe the flaps were deployed prior to 1000 feet AGL, but I am not sure as I was focused on correcting the flight path.

Hotel pickup times cannot be made in a vacuum. While such an early pickup might be appropriate for earlier flights that are more affected by traffic, the later flights are not, and
the early pickup wastes sleep time for the flight crew.

Operational implementation of FAR 117 must be clarified. Though we have been operating under this rule for some months now, there still appears to be areas that are left to "interpretation." CA felt very strongly that the provision of FAR 117 requiring the last two hours be available to the Pilot Flying means that the Pilot Flying MUST take that break. Despite being challenged by FB and myself, detailing our concerns about sleep inertia, CA believed that was the requirement of FAR 117. This issue needs to be clarified to remove interpretation. I know I fly better as Pilot Flying when I take the second break and have the time over the next break to recover from inertia.

Synopsis

Two B777 First Officers reported questioning the Captain's interpretation of FAR 117 that he believed requires the pilot flying to take the last break. The flying First Officer preferred the second break citing "sleep inertia" but complied with the Captain's wishes.
ACN: 1392765  (3 of 50)

**Time / Day**
- Date: 201610
- Local Time Of Day: 1801-2400

**Place**
- Locale Reference.Airport: ORF.Airport
- State Reference: VA
- Altitude.AGL.Single Value: 1000

**Environment**
- Flight Conditions: Mixed
- Weather Elements / Visibility: Visibility: 10
- Light: Night
- Ceiling: Single Value: 2700

**Aircraft**
- Reference: X
- ATC / Advisory.Tower: ORF
- Aircraft Operator: Air Carrier
- Make Model Name: B737 Undifferentiated or Other Model
- Crew Size.Number Of Crew: 2
- Operating Under FAR Part: Part 121
- Flight Plan: IFR
- Mission: Passenger
- Nav In Use.Localizer/Glideslope/ILS: Runway 5
- Flight Phase: Final Approach
- Airspace.Class C: ORF

**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: 241
- ASRS Report Number.Accession Number: 1392765
- Human Factors: Situational Awareness
- Human Factors: Confusion
- Human Factors: Distraction

**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, Last 90 Days: 151
Experience: Flight Crew, Type: 800
ASRS Report Number: Accession Number: 1393395
Human Factors: Situational Awareness
Human Factors: Confusion
Human Factors: Fatigue

Events
Anomaly: Deviation - Track / Heading: All Types
Anomaly: Deviation - Procedural: Published Material / Policy
Anomaly: Deviation - Procedural: Clearance
Anomaly: Inflight Event / Encounter: Unstabilized Approach
Detector: Automation: Aircraft Other Automation
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
I was PM on an ILS into ORF Runway 5. We broke through a cloud layer and were turned on a vector to intercept final. The PF turned too far and went through final, and he realized he was getting wrong information due to the wrong ILS frequency set. I redialed it in for him. We had started to descend as well and I asked him to level off at 1500 ft until we were straightened out. We had already gotten to gear down flaps 15 at this point.

Tower queried us to if we had the field in sight, which we did. We then intercepted glideslope and started down once we got straightened out, and did not do the 1000 ft call due to workload and just plain missed it. Our speeds were 133/148 due to gusty winds and I should have noticed the power settings were off as well. I called 500 ft and verified cleared to land. Shortly after the Too Low Flaps squawk went off and I realized we hadn't done the Landing Checklist. We were still at flaps 15. I selected flaps 30, armed the speedbrake, and did the Landing Checklist before the 100 ft call came, and we elected to land uneventfully.

The FO stated, before we took off, he was tired so to please speak up. I was unhelpful to him as PM by not staying on top of things and let our crew down by not heightening my awareness.

Narrative: 2
I was woken up [early] by loud talking and doors slamming in the hallway at the hotel. I didn't sleep well after that. Lack of proper sleep and stress were contributing factors. I should have called out fatigued. But I was thinking two [short] flights, I decided to go and instead brief PM that I was tired and in the Yellow. I got distracted trying to figure out what was wrong with the localizer and got behind the aircraft. In the future, if I'm in this situation, I will call out fatigued.

Synopsis
B737 flight crew reported that fatigue and distractions resulted in the approach being flown to 500 ft AGL without the Landing Checklist being run.
ACN: 1391957 (4 of 50)

Time / Day
Date: 201609
Local Time Of Day: 1201-1800

Place
Locale Reference.Airport: RDU.Airport
State Reference: VA
Altitude.MSL.Single Value: 23500

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

Aircraft
Reference: X
ATC / Advisory.Center: ZDC
Aircraft Operator: Air Carrier
Make Model Name: B737 Undifferentiated or Other Model
Crew Size. Number Of Crew: 2
Operating Under FAR Part: Part 121
Flight Plan: IFR
Mission: Passenger
Nav In Use: FMS Or FMC
Flight Phase: Descent
Route In Use.STAR: MALNR1
Airspace.Class A: ZDC

Component
Aircraft Component: MCP
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: Instructor
Function.Flight Crew: Pilot Not Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
Experience.Flight Crew.Last 90 Days: 101
ASRS Report Number. Accession Number: 1391957
Human Factors: Distraction
Human Factors: Fatigue
Human Factors: Situational Awareness
Events
Anomaly.ATC Issue : All Types
Anomaly.Deviation - Altitude : Undershoot
Anomaly.Deviation - Altitude : Crossing Restriction Not Met
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : Clearance
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Returned To Clearance
Result.Flight Crew : Became Reoriented

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

Narrative: 1
I was acting as the Pilot Monitoring and giving IOE during the event flight. We had begun our arrival into RDU on the MALNR1 Arrival and had briefed the arrival, completed the Descent Checklist and were in reasonably good shape. We had been given an initial descent and started down when there were multiple frequency changes and finally a clearance to descend "Pilots Discretion to FL 240". The Pilot Flying (our IOE candidate on day three of IOE, third leg) set 240 and I had verified this.

Then another frequency change and the new section (ZDC low in the vicinity of SDZ working KCLT and KRDU arrivals) gave us clearance to cross SDZ at FL 230. The IOE/PF set 230 in the FMC and forgot (not the first time on this trip) to reset the MCP. Crew factors - long day, running behind, I'm worn out from teaching, he's thinking the aircraft will automatically descend (since his past aircraft did) and I missed verifying the altitude. This is a mistake I totally made and assume responsibility for, since the [verification] chain was broken with me not verifying the altitude, I looked up pointed and saw what I wanted to see, not what was there. We passed our Top of Descent and I noticed (thankfully) on the DES page that we were high and trending higher, asked the PF to descend and he was confused. I then asked him again to start down, which he did, and we missed the crossing by 300-400 feet high. Oh yeah, another frequency change (I think our fourth on the arrival.)

If at all possible, could the ATC procedures department check with ZDC and ZJX and ask if there is any chance that we can receive a descent clearance on the arrival and not have to contact four different Controllers with different clearances? Maybe that's too much as I know we leave JAX high airspace for JAX low airspace to Wash low airspace in a busy arrival corridor. Not placing any blame on anyone but me as the Controllers didn't miss my crossing altitude, I did.

Synopsis
B737 Check Captain as pilot monitoring, reported missing a crossing restriction during descent when the flying Captain forgot to reset the MCP altitude.
ACN: 1385120 (5 of 50)

Time / Day
Date: 201609
Local Time Of Day: 1801-2400

Place
Locale Reference.Airport: BOS.Airport
State Reference: MA
Altitude.AGL.Single Value: 0

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
Flight Phase: Parked

Component
Aircraft Component: Cowling
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
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1385120
Human Factors: Distraction
Human Factors: Confusion
Human Factors: Time Pressure
Human Factors: Fatigue

Person: 2
Reference: 2
Location Of Person.Aircraft: X
Location In Aircraft: Flight Deck
Reporter Organization: Air Carrier
Function.Flight Crew: First Officer
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1386693
Human Factors: Distraction
Human Factors: Confusion

Events
Anomaly.Aircraft Equipment Problem: Less Severe
Anomaly.Deviation - Procedural: Published Material / Policy
Anomaly.Deviation - Procedural: MEL
Anomaly.Deviation - Procedural: FAR
Detector.Person: Flight Crew
When Detected: In-flight
Result.General: Maintenance Action
Result.General: Flight Cancelled / Delayed
Result.Flight Crew: Became Reoriented

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

Narrative: 1
The First Officer discovered a large crack in the cowling of aircraft. We took a picture and sent it over to maintenance. They came back with it was only paint and required no further action. I insisted contract maintenance come out and have a look. Contract maintenance came out and looked at the crack. I told him I wanted it written in the aircraft logbook. He went and took a look then returned to tell us it was way worse than paint chipping but was actually a delamination issue. He told us this would take a while and he would need to get a document to make sure it was within limits. He said this could take anywhere from 30 minutes to who knows how long.

My Reserve Availability Period (RAP) duty started at XA:45. I immediately saw this as a problem for getting the flight completed if it took as long as contract maintenance was hinting. I called crew scheduling. The first scheduler I talked to tried to convince me that my duty started XF:59 and that I could work 16 hours from that point. I disagreed and talked to a supervisor. He told me the same thing and handed me off to a Flight Time Analyst. He also told me the same thing. After reviewing the actual regs I still disagree with all three individuals and realize how poorly written our Flight Operations Manual is and how difficult this concept is because 117. I spent an exhausting 30 minutes dealing with this instead of focusing on the maintenance item that I should have been. Then to make matters worse and hours later the lead Flight Attendant (FA) comes up and tells me she thinks flight attendant C is timing out. Now I have to do the entire thing again with crew scheduling to ensure my flight attendant is legal to fly!

Finally maintenance finishes and the mechanic comes up, describing the item as watch item. He has three separate write ups with sign offs that are very difficult to read on the Carbon Copy especially. I reviewed them, made sure they were signed, closed up the book and got ready to go. We ensured our flight plan was still current and closed the doors. I made one last call to crew scheduling to ensure duty was within limits but ended up hanging up. If it was out limits but only contractually and even if I was able to get an answer out of them of when I really started we would just disagree.

We taxied out and took off, never heard a word from maintenance or dispatch in our 20 minute taxi out. After taking off I wanted to have a closer review of the write up and understand it better since it was probably the most complicated I had ever seen. In reading the 3rd write-up I noticed he had put an NEF MEL. I had just taken off with no
amended release. The item had been described as watch items not MELs so I never even tried to get one.

I contact dispatch telling him this and all he gave me was attitude, argument and tried to place blame. I was not worried about blame it was on honest mistake but clearly he was worried and wanted to place blame. He refused to give me an amended release at that time. After landing I tried to call him and discuss. He had already gone home so I shared my story with the supervisor.

Fatigue was part of the issue due to starting at XA:45 AM, being up since XW:00 AM and an exhausting situation and exhausting discussions both with maintenance and crew scheduling.

If MEL is attached to watch item don't call it a watch ITEM. Don't make flight crew describe duty limits to 3 different people when calling crew scheduling. Adds to confusion. Flight should not leave gate until amendment received which is contrary to company policy.

Narrative: 2

We were both reserve assigned the pairing, I was RXE and the captain was RXX but was rest adjusted to RXA45 due to sim the night before. We departed for ZZZ without issue at XG44. On the walk-around in ZZZ, I noticed a crack in the lower rear cowl of the number 2 engine. We wrote it in the book and called contract maintenance. Maintenance requested a picture of the crack and stated it appeared to be just paint cracking. However, the contract mechanic determined it to actually be delamination of the composite material to the surrounding metal. The mechanic stated it would take quite some time to dig through the manuals and determine if the crack was within limitations. Being that we still had a 3-hour block scheduled, the captain started assessing his FDP remaining.

At cruise we looked more closely at the logbook and realized that on one of the watch items, we overlooked that the mechanic put an NEF MEL on one of the corrective action items, thus we realized we had departed without the associated amendment to the release.

The captain and I believe that after arguing with crew scheduling, our attention was focused on trying to find a definitive answer to the start of the FDP. Therefore, when it came time to push, we were focused on leaving within our limit and overlooked the MEL on the logbook. The best solution is to always give the due diligence required during preflight items, no matter what external factor is presented.

Synopsis

A319 flight crew reported departing without an updated release after a long delay for maintenance that created an MEL that the crew was not aware of. As a reserve crew they were concerned about their duty limits under FAR 117 and spent much time arguing with crew scheduling over their start time and overlooked the MEL item.
ACN: 1384970

Time / Day
Date: 201609
Local Time Of Day: 1201-1800

Place
Locale Reference.Airport: LAW.Airport
State Reference: OK
Altitude.MSL.Single Value: 2300

Environment
Flight Conditions: IMC

Aircraft
Reference: X
ATC / Advisory.Tower: LAW
Aircraft Operator: Air Carrier
Make Model Name: Medium Transport
Crew Size.Number Of Crew: 2
Operating Under FAR Part: Part 121
Flight Plan: IFR
Flight Phase: Descent
Airspace.Class D: LAW

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: 1384970
Human Factors: Confusion
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: 1384971
Human Factors: Confusion
Human Factors: Situational Awareness

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

Narrative: 1
From [departure airport] to LAW, uneventful flight until descent into LAW. ATIS calling better than 5/5. However, broken layer at 4,000 to 7,000. Descending from 7,000 to 3,000 ATC (Ft. Sill) asks to call runway in sight. We are IMC. Asks if we want a vector to downwind (presently direct to airport in descent at 6,000). Yes, vectored 60 degrees right for left downwind. I noted to First Officer (FO) this was a bit extreme. We descend below 4,000 and see runway. Ft. Sill clears us for visual to runway 17. We are very wide on the downwind, so I begin to return back to my usual road for the visual to runway 17. We switch to tower. Cleared to land 17. I had fully briefed that I would be 2,600 downwind with gear down, flaps 45. I would turn within 2 miles to the base leg at approach speed and 2,300, then 1800 feet turn final. Approximately when I thought I was exactly downwind abeam about to call flaps 45, Tower says Ft. Sill wants us to turn base. I think wow, that's pretty close in for base, so I turn. In the turn I see only red roofed buildings and realize this is not LAW. I said to the FO, this is not LAW. That's when Tower says to turn left 200 and climb to 3,000. I complete this and see LAW in front of us approximately 4 miles. I set up to land at LAW and am again cleared to land by the tower.

First I have been to LAW on several different occasions and am familiar with the field and the visual to 17. I briefed exactly how I would execute this arrival and approach. I reviewed the Company 10-7 page to make sure we were aware of the factors involved. I did NOT note that there was an exact replica airport (Ft. Sill) that was 4 miles north of the LAW airport and double checked after this mistake. I had not noticed this airport during prior visual approaches.

Please add that there is another airport that is set up exactly like LAW just 4 miles to the north.

I had commuted in the night prior and had to fly to ZZZ1 then ZZZ to get to work. I can easily say I am tired and that played a factor. I am not fatigued, however I have flown over 40 plus hours in the past 9 days. This is the first leg of a four day with a new FO.

Ft. Sill and LAW tower never indicated that I had the improper airport in sight. LAW tower might have given an indication that LAW was at my 9 o'clock, but no input from them.

I take full responsibility for the incorrect identification of LAW.

In 37 years of flying I have never lined up for the incorrect airport. I could have had the FO create a line from 17 out 3 miles to assist in my situational awareness, however we were busy with the weather that was not noted on the ATIS.
I will be more communicative with ATC & Ft. Sill when asking for vectors to the 17 runway. I will insure that I have set up a point from 17 to approximately 3 miles.

If weather permitting I will ask for a straight in to 35.

**Narrative: 2**

During the approach we became a bit task saturated and perhaps missed or didn't interpret the approach controllers cues to airport direction and distance as he was handing us off to tower before even asking if we had the field in sight. In Lawton we rarely land 17 unless wind is a limiting factor. Recency since flying into Lawton also played a role.

**Synopsis**

Air carrier flight crew reported lining up with the wrong airport on a visual approach to LAW.
**Time / Day**
Date: 201608
Local Time Of Day: 0601-1200

**Place**
Locale Reference.Airport: ZZZ.Airport
State Reference: US
Altitude.AGL.Single Value: 1000

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

**Aircraft**
Reference: X
ATC / Advisory.Tower: 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: Final Approach
Flight Phase: Initial Approach
Airspace.Class C: ZZZ

**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: 1382375
Human Factors: Time Pressure
Human Factors: Workload
Human Factors: Distraction
Human Factors: Situational Awareness

**Person: 2**
Reference: 2
Location Of Person.Aircraft: X
Location In Aircraft: Flight Deck
Reporter Organization: Air Carrier
Function.Flight Crew: Captain
Function.Flight Crew: Pilot Not Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1382063
I was acting as Pilot Flying on our flight. Everything was normal until we began our initial descent. ARTCC had begun descending us much earlier than the RNAV arrival would’ve. Since we started down early, I felt a slight time compression in getting the brief done and calling for the Descent Checklist. After reviewing the 10-9 and the 10-7, we determined there was nothing urgent that would affect us other than an ACARS outage on the ground at this station. I proceeded to brief the rest of the briefing items and we ran the Descent Checklist. Shortly thereafter we were cleared to cross an arrival waypoint at 11,000 ft, then were vectored on a 140 heading. We switch to HDG SEL and the PM built a course intercept to the FAF. We were then cleared to descend and maintain 2,000 ft and were asked if we had the field in sight approximately 10 NM to the west while descending through 6,000 ft on a left downwind. I told the PM I had it in sight and that he could call it if he saw it, and I called for flaps 1. We were then cleared for the visual approach to Runway XX. A course intercept was built to the FAF. I adjusted the HDG to turn toward the FAF and disconnected the autopilot/auto throttle. I called for and the flaps were set to 5. Approach then asked if we would keep our base and final short and switched us to tower. I immediately called "Gear Down." As I turned base, I visually acquired what I thought was Runway XX and noticed we were high and crossing the extended runway centerline. I increased my rate of turn and continued configuring flaps while the PM selected the requested flap setting, switched to tower and acquired a landing clearance. I called "Flaps 30, Landing Checklist" approaching 1,000 ft AGL. At that time we joined the visual path using the PAPI and I spooled the engines. Shortly thereafter we were advised by the tower that we were "apparently aligned with Runway YX." I immediately initiated a Go Around. We were told to maintain an altitude and heading and switched to departure, who vectored us around for another visual approach to Runway XX. The second approach and landing happened without incident.

I was visually aligning myself with what I thought was Runway XX, but which was actually Runway YX. Due to the fact that I was VMC and cleared for the visual but was high, I
focused too much of my attention to managing energy and being stabilized but neglected to check the LOC/GS or the ND to assure my alignment with the proper runway. I also felt pressure from approach which asked if we'd keep our visual approach close in. That is a normal request but since I hadn't mentally prepared for the fact that our visual approach from the west would cross us through the approach path to another runway, I missed an opportunity to trap a threat before it resulted in an undesired aircraft state.

**Narrative: 2**

I was unfamiliar with airport, we had reviewed 10-9 and 10-7, and thoroughly briefed approach and airport, flight was cleared visual approach to Runway XX. Pilot flying was hand flying and had airport in sight we continued downwind, configured aircraft and were requested by approach control to begin base turn. A bit of a "slam dunk". I got focused on getting down for stabilized approach. Was dividing time between HUD (in IMC mode to utilize "3.0 degree line") and observing outside. I omitted the "heads down" displays from my "scan". ATC instructed us to contact tower on "base" leg, tower was contacted and flight was cleared to land Runway XX, aircraft was configured and stabilized prior to 1000 AGL. I heard tower clearing a Heavy to high speed taxi on Runway YX and noticed an aircraft on our runway, I thought that was odd and was starting to question the approach when tower informed us we appeared to be lined up for Runway YX. I immediately called for go-around. PF initiated a go-around from approximately 1000 AGL. At that point tower cleared us to land on Runway YX, I declined and we continued the go-around. We were assigned a heading and altitude and handed off to approach for vectors for XX. We cleaned up aircraft and almost immediately began process to configure for the visual approach to Runway XX that resulted in an uneventful approach and landing on Runway XX.

PM unfamiliar with airport (first time), a bit of a slam dunk visual, PM fixation on stabilized approach and HUD while omitting from my usual scan cues from Flight Displays and FMC led to hampered situational awareness. Early morning reserve callout most likely contributed to some fatigue as well.

**Synopsis**

A B737-NG flight crew reported lining up for the wrong runway on final. The crew felt rushed which caused cognitive tunneling to the exclusion of basic heading and the loss of situational awareness.
**Time / Day**
Date: 201608
Local Time Of Day: 0001-0600

**Place**
Locale Reference.Airport: VHHH.Airport
State Reference: FO
Relative Position.Angle.Radial: 337
Relative Position.Distance.Nautical Miles: 3
Altitude.MSL.Single Value: 2650

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

**Aircraft**
Reference: X
ATC / Advisory.TRACON: VHHH
Aircraft Operator: Air Carrier
Make Model Name: MD-11
Crew Size.Number Of Crew: 2
Operating Under FAR Part: Part 121
Flight Plan: IFR
Mission: Cargo / Freight
Nav In Use: FMS Or FMC
Flight Phase: Initial Approach
Route In Use.STAR: SIERA 7A

**Component**
Aircraft Component: MCP
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)
Experience.Flight Crew.Total: 6000
Experience.Flight Crew.Last 90 Days: 150
Experience.Flight Crew.Type: 1000
ASRS Report Number.Accession Number: 1382019
Human Factors: Human-Machine Interface
Human Factors: Situational Awareness
Human Factors: Fatigue
Events

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

Assessments

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

Narrative: 1

Descending into VHHH, on the SIERA 7A arrival, given a descent to 6000 and direct LIMES when able. We were proceeding to Silva per original clearance. Once we got below approximately 10,000 ft we were given 3000 ft cleared for the ILS 07L via TOMIC. I asked the FO to set 2000 ft in the Altitude window since we were cleared for the approach and 2000 ft was the next (TOMIC) altitude. We were approx. 3-4 miles from LIMES when I started down out of 3000 ft. At approximately 2650 ft ATC told us to remain at 3000 ft.
disconnected the autopilot and climbed back to 3000 ft. The rest of the approach was normal. There was no altitude on the approach plate for LIMES, all I saw was the "at or above 2000 ft" for TONIC in the FMS and the 2000 ft on the approach plate. I didn't realize that LIMES was the IAF. I know that we couldn't descend below the clearance altitude until establish inside the IAF. I just missed it.

**Narrative: 2**

[Report narrative contained no additional information.]

**Narrative: 3**

I did not verify their decision per the chart as they seemed very confident, and I was preoccupied with the fact that the spoilers were still out, and missed the real threat. The aircraft descended to about 2650 ft and the controller told us to maintain 3000 ft. The captain corrected immediately and got back to 3000. I think it was just a mental error on the part of three guys who were all tired after a 10 hour flight. I should have backed up their decision to descend.

**Synopsis**

MD11 flight crew reported descending below their assigned altitude of 3000 feet prior to reaching LIMES (IAF) after being cleared for the ILS Runway 7L approach to VHHH. ATC detected the error and issued a climb back to 3000 feet. Fatigue was cited as a factor in the incident.
After leaving [an international airport] (late by three hours due to late arriving aircraft) started wondering if I was feeling alright or was I just tired. Had eaten some breakfast
early in the flight but couldn't finish it because it seemed like it was bad. Bad as in "gone bad". Throughout the flight across the ocean it became obvious to me that I was feeling worse and worse as time went by. I threw-up in a garbage bag in the cockpit at one point. Did not have time to make it to the lav. Thought about diverting at that point but felt better after throwing up and decided maybe I was okay now that I’d just eaten something bad. Breakfast on the airplane perhaps. Went on break (third break) feeling so-so but still thought I might be getting better. After my break, back in the cockpit and about to start the descent, I started feeling very, very sick again. I turned the flying over to the FO and had the IRO take my seat. I was sitting on the jumpseat throwing up violently into a garbage bag as we descended through about 10,000 ft. I heard [the FO advised ATC] at that point and heard him state to ATC that the Captain was incapacitated and that also he wanted an ambulance to meet the airplane. I was too sick to even comment at that point. After landing I was feeling better again after heaving and suggested that after [the IRO] made the turn-off from the left-seat, he should set the brakes (which he did) and I would retake my seat and taxi into the gate. Which I did. I then walked off the aircraft after the checklists and met the paramedics [who] took me to the hospital.

**Synopsis**

B767 Captain reported becoming incapacitated in flight on an international leg possibly because of food poisoning.
**ACN: 1379652 (10 of 50)**

**Time / Day**

Date: 201608
Local Time Of Day: 0601-1200

**Place**

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

**Aircraft**

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

**Person**

Reference: 1
Location Of Person.Aircraft: X
Location In Aircraft: Flight Deck
Reporter Organization: Air Carrier
Function.Flight Crew: First Officer
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1379652
Human Factors: Fatigue
Human Factors: Situational Awareness

**Events**

Anomaly.Deviation - Procedural: Published Material / Policy
Anomaly.Ground Event / Encounter: Other / Unknown
When Detected: Aircraft In Service At Gate
Result.Flight Crew: Became Reoriented

**Assessments**

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

**Narrative: 1**

Captain called for shutdown checklist. First Officer (FO) read checklist and Captain confirmed all items. FO failed to validate all items completed. Main cabin door was opened, cockpit door opened, jet bridge secured to aircraft and FO began post flight walk around. FO discovered engine 2 still running. FO notified Captain and engine 2 was shut down.

Captain failure to complete checklist items. FO failure to validate checklist completion. Captain rush to exit aircraft. FO fatigue due to non-nominal sleep night prior. FO working on day off. Company failure to promptly file departure paperwork for international
departure. Maintenance issue with aircraft causing unintended international overnight.

Cross validation techniques should always be followed.

**Synopsis**

CRJ-200 First Officer reported flight crew failed to shut down #2 engine at arrival airport due to lack of checklist discipline.
**Time / Day**
- Date: 201608
- Local Time Of Day: 0001-0600

**Place**
- Locale Reference: ATC Facility: ZZZ.ARTCC
- State Reference: US

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

**Aircraft**
- Reference: X
- ATC / Advisory.Center: ZZZ
- Aircraft Operator: Air Carrier
- Make Model Name: B737-800
- Crew Size: Number Of Crew: 2
- Operating Under FAR Part: Part 121
- Flight Plan: IFR
- Mission: Passenger
- Nav In Use: FMS Or FMC
- Flight Phase: Cruise
- Airspace: Class A: 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)
- ASRS Report Number: Accession Number: 1379064
- 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 Flying
- Qualification: Flight Crew: Air Transport Pilot (ATP)
- ASRS Report Number: Accession Number: 1379066
- Human Factors: Situational Awareness
Events
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : Fuel Issue
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Became Reoriented
Result.Flight Crew : Diverted
Result.Flight Crew : Landed As Precaution

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

Narrative: 1
We departed with less than minimum takeoff fuel. After [leaving the hotel, we had] nearly 3 hours of grappling with a discrepancy on the first aircraft, we were on our third gate, and second aircraft, and still awaiting transfer of bags, catering, and our fuel. The aircraft had several maintenance items deferred, to include an inoperable, placarded center fuel tank quantity indicator. Along with several MEL reviews, we needed manual confirmation of required fuel, and a paper fuel receipt. FO visited the fueler to confirm what we needed. We needed 37,400 pounds of fuel.

Just before [departure], we received our fuel slip - showing 37,400 pounds of fuel, which we entered manually into the FMS. We calculated that we would see a reliable in-flight fuel indication when the center tank was dry. When the center tank Low Pressure lights came on [earlier than expected enroute], we became aware of our actual fuel situation. I looked again at the fuel slip, which indicated 37,400 pounds. Then I recalculated the fueler's math, realizing that he had loaded 27,400 pounds vice 37,400, and had added incorrectly. We contacted company, then diverted to [a nearby airport].

Even after multiple issues and delays, a careful review of a fuel receipt is useful. The bottom line may look enticing, but it is ultimately only a number written on paper. For such a rare situation, a directed fuel slip review should be included in the MEL procedure. We rely on the accuracy of others in many aspects of our duties. We count on correct numbers on passenger counts, hazmat type quantity, location, and baggage and cargo numbers. Fuel is the same, especially when we go to alternative fueling operations, and receive a fuel receipt. Ultimately, I am responsible for the safety of the aircraft and passengers, but these numbers have to be right. On domestic operations we rarely see paper fuel chits. The natural scan or flow of reviewing such a document is not part of our normal habit. For rare and critical items, we often use checklists. In the MEL we encounter a number of checklists for placarded items. Although the MEL calls for alternative fueling procedures, it certainly would be pilot-useful to include the checklist reminder to re-calculate paper document fueling numbers. On this evening we were approaching hypnotic trance with the time we had spent in the MEL, over several hours. My ongoing mantra to my FO was to focus on our procedures and checklists, since we were in a rare, irregular operation. Had we encountered a simple MEL checklist reminder to review the numbers on the paper fuel chit, I have no doubt that I would have looked more closely at the fuel numbers. We were saved in a relatively timely, comfortable manner because we had determined, pointedly, when we expected to see our center tank indicate empty. This precaution made the rest of the night easy, albeit long and a touch embarrassing.

Narrative: 2
[Report narrative contained no additional information.]

Synopsis

B737-800 flight crew reported diverting when they received a low fuel pressure indication after mistakenly departing with 10,000 lbs less fuel than calculated.
**Time / Day**
- Date: 201607
- Local Time Of Day: 0001-0600

**Place**
- Locale Reference: Airport : LAX.Airport
- State Reference: CA
- Altitude: MSL.Single Value: 3700

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

**Aircraft**
- Reference: X
- ATC / Advisory.Center: ZLA
- ATC / Advisory.TRACON: SCT
- 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: GPS
- Nav In Use: FMS Or FMC
- Flight Phase: Initial Approach
- Route In Use.STAR: SEAVU 2
- Airspace.Class B: LAX
- Airspace.Class E: ZLA

**Person: 1**
- Reference: 1
- Location Of Person.Aircraft: X
- Location In Aircraft: Flight Deck
- Reporter Organization: Air Carrier
- Function.Flight Crew: Pilot Not Flying
- Function.Flight Crew: Captain
- Qualification.Flight Crew: Air Transport Pilot (ATP)
- ASRS Report Number.Accession Number: 1368777
- Human Factors: Fatigue
- Human Factors: Workload

**Person: 2**
- Reference: 2
- Location Of Person.Aircraft: X
- Location In Aircraft: Flight Deck
- Reporter Organization: Air Carrier
- Function.Flight Crew: Pilot Flying
- Function.Flight Crew: First Officer
Arriving at LAX enroute approaching [late evening], we were originally assigned the SEAVU2 arrival landing west. I was pilot monitoring, and giving my arrival PA. As I was making announcement, the First Officer received a new clearance, the RDEYE arrival landing east. She put the new arrival in the FMGC. We were cleared to descend to 17000 ft at KONZL intersection. As I finished my PA, I acknowledged the new clearance with First Officer. ATC then changed us back to the SEAVU2 arrival landing west and the First Officer loaded the information into FMGC. As we accomplished this task, we passed KONZL intersection still at 17,000 ft cleared for the ILS 25L. We had 24R programmed, so we had to make a quick change to 25L. We did that, but we were still not cleared to descend and getting very high as we were reprogramming the FMGC. We overshot the 25L localizer, but quickly turned to the left to avoid conflict. I tried to enter a direct to GAATE intersection, but the FMGC would not accept any input from my side. I took control of the aircraft and the First Officer attempted to input the FMGC. Still no acceptance of input. I turned off Autopilot and hand flew aircraft. We asked to be vectored off the arrival, but they said you're high, but you'll be okay.

Now we are high, trying to reconfigure FMGC, and ATC gives us S-Turns to try to get on profile. We're still high, so ATC gives us a turn to the left and descent to 4000 ft. We did that but with all the task loading and high workload, we descended to 3700 ft. ATC asked why we went below 4000 ft. We told them high workload and corrected our altitude. They vectored us to the 25L localizer and [we] landed uneventful.

Two arrival changes below 18000 ft too close to the airport, high task loading, confusion with runway assignment, 3rd leg on a pairing after midnight.

This was a high workload and task saturation by ATC. Bottom line, fly the aircraft, and don't let ATC fly the aircraft. Had we gotten the original requested vector off course to regroup and finish programming the FMS this would not have occurred.
Synopsis

A321 flight crew reported a track deviation and altitude overshoot resulted from task saturation on arrival into LAX as ATC changed the runway and arrival clearances several times.
**ACN: 1365129 (13 of 50)**

**Time / Day**
- Date: 201606
- Local Time Of Day: 1801-2400

**Place**
- Locale Reference.Airport: DEN.Airport
- State Reference: CO
- Altitude.MSL.Single Value: 12500

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

**Aircraft**
- Reference: X
- ATC / Advisory.TRACON: D01
- 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
- Nav In Use: FMS Or FMC
- Flight Phase: Descent
- Route In Use.STAR: FRNCH3
- Airspace.Class E: D01

**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: 1365129
- Human Factors: Situational Awareness
- Human Factors: Fatigue
- Human Factors: Human-Machine Interface

**Person: 2**
- Reference: 2
- Location Of Person.Aircraft: X
- Location In Aircraft: Flight Deck
- Reporter Organization: Air Carrier
- Function.Flight Crew: Pilot Not Flying
- Function.Flight Crew: First Officer
- Qualification.Flight Crew: Air Transport Pilot (ATP)
Human Factors : Human-Machine Interface
Human Factors : Fatigue
Human Factors : Situational Awareness

Events

Anomaly.Deviation - Altitude : Crossing Restriction Not Met
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : Clearance
Detector.Person : Flight Crew
Detector.Person : Air Traffic Control
When Detected : In-flight
Result.Flight Crew : Returned To Clearance
Result.Air Traffic Control : Provided Assistance

Assessments

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

Narrative: 1

This occurred on the second day of a three-day am trip. Both of the two mornings were about (time removed) reports and I hadn't slept a full night before either day. I recall that both the First Officer and I were fighting to keep alert on this leg as we began the arrival. The FRNCH3 Arrival was briefed as normal, but not very far into the arrival, we were vectored off and given multiple vectors and descents which I complied with using Heading Select and Level Change. Finally, we were cleared direct to BABAA intersection to rejoin the arrival and to descend via the remainder of the FRNCH3.

LNAV was engaged direct to BABAA and we set 11,000 feet in the MCP altitude window, as this was the lowest altitude on arrival. However, I failed to reselect VNAV mode, and with the aircraft still in Level Change, we descended through the BABAA restriction of 13,000 feet prior to BABAA. At about 12,500 feet and nearly to BABAA, Approach queried us by asking if we were going to cross BABAA at 13,000 feet. I quickly climbed back up to 13,000 feet but crossed BABAA at 12,500 feet, and promptly got the aircraft back into VNAV for the rest of the uneventful arrival and flight.

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

Air carrier flight crew reported not making a crossing restriction on the FRNCH3 STAR to DEN.
Time / Day
Date: 201606

Place
Altitude.AGL.Single Value: 0

Environment
Flight Conditions: IMC
Weather Elements / Visibility: Thunderstorm

Aircraft
Reference: X
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: Taxi
Flight Phase: Parked

Component: 1
Aircraft Component: APU
Problem: Failed

Component: 2
Aircraft Component: Hydraulic System Pump
Problem: Malfunctioning

Component: 3
Aircraft Component: FMS/FMC
Problem: Improperly Operated

Person
Reference: 1
Location Of Person: Flight Deck
Reporter Organization: Air Carrier
Function.Flight Crew: Captain
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number: 1362768
Human Factors: Communication Breakdown
Human Factors: Fatigue
Human Factors: Situational Awareness
Human Factors: Troubleshooting
Human Factors : Workload
Human Factors : Distraction
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Maintenance
Communication Breakdown.Party2 : Ground Personnel
Analyst Callback : Attempted

Events
Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.ATC Issue : All Types
Anomaly.Flight Deck / Cabin / Aircraft Event : Other / Unknown
Anomaly.Deviation - Procedural : MEL
Anomaly.Inflight Event / Encounter : Weather / Turbulence
Anomaly.Inflight Event / Encounter : Fuel Issue
Detector.Automation : Aircraft Other Automation
Detector.Person : Flight Crew
When Detected : In-flight
When Detected : Taxi
Result.General : Maintenance Action
Result.Flight Crew : Became Reoriented
Result.Flight Crew : Returned To Departure Airport
Result.Aircraft : Aircraft Damaged

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

Narrative: 1
On a three day trip dealing with multiple MELs on every leg including either a single pack operation or no APU operation while temperatures are in 90 degree range, making the cockpit at points in the 110 degree range. This is neither comfortable nor safe for either the passengers or crew. Final day of the trip and we receive a plane with, you guessed it, no APU. As I got into the cockpit it was obvious that the previous crew had not shut the plane down properly, because the fuel pumps were still on, the transponder was still on and I didn't notice it at the time, but the First Officer (FO) had placed his HSI in "No Needles". Not white needles, not green needles, but no needles at all. 8 years and 6,000+ hours on this plane and I've never seen it left like that before and since it was not my side, and the FMS allowed me to auto tune, such a possibility never occurred to me. Anyways, in the swarming heat we boarded close to a full load of passengers and got ready for our external air start (which we were very familiar with at that point in the trip). We get one started, pushed then cross-bled the other engine. As soon as I taxi out, I get a HYD 3B Caution. I park, get on the phone with Maintenance (MX) and try an assortment of switch positions and circuit breaker resets. Unable to fix it or MEL it, we return to the gate MX telling us that 3A can be MELed, but 3B can't, and swapping them will take about 2 hours. 8 hours later the issue is resolved with a combination of MELs, while we have been sitting on an aircraft that, even though plugged into PC air is pretty darn warm. Tired and ready
to get done, we board once again as quickly as we can attempting to beat a storm that is approaching. We do the external start, then the cross bleed and head out, but by the time we are at the end, the worst of the storm has hit and we decide to shut one down and wait for the heavy bit to pass. While we are waiting, with one engine running, we are burning a significant amount of fuel compared to if we had an APU. ATC gives us a re-route due to the storm and I check to make sure that we have enough fuel for that route, I feel comfortable that we do, provided that we get out soon as we are burning fuel for the engine. The heavy bit passes, ATC clears us for takeoff direct to a fix. As I am the pilot monitoring, I engage nav mode and it fails to engage. I try going direct once again in the FMS and still can't engage NAV, I look over and I see no green needles so I try it again and still nothing, so I instruct the FO to fly in heading mode towards the fixes while I trouble shoot the problem. Right around that time, my radar ceases to work for a short time, and mind you we are dodging several cells. Shortly after, the controller informs us that our route will put us into the worst of the storms and he will need to send us far west and north of our current route (Which I think we have just enough fuel for). At that point, we decide to go back to the departure airport as we know the weather is decent and we can make it in, rather than put ourselves in a fuel critical situation. I advise ATC, the Passengers/Flight Attendants and Dispatch. While getting vectored the aircraft receives a lightning strike stronger than I've ever encountered. Everything onboard seems fine, so we have no problem continuing back. Given the fact that we are worn out from three days of super hot planes, the issues currently face and the whole day sitting on one waiting for MX to be finished. We are happy to be on the ground safe, rather than put ourselves in a more precarious situation. I land, write up the lightning strike, auto pilot pitch trim caution encountered on final and intermittent stall fail caution. Then contact crew tracking to advise them of our situation and that we will not be flying anymore. In typical fashion, they make us wait almost two hours before dutying us off and letting us know that we'll have close to minimum rest to report in the morning to ferry the aircraft. I advise them that we [are] quite worn out after the last three days, and especially today, where we were close to a max duty day, and min rest is not a good idea, besides that we won't even know if the aircraft will be ready by that time in the morning. They say something to the effect of "ok, but that's your schedule". I check several times the next morning and it shows us showing at that scheduled time, even though the aircraft has been down for the night and morning and nobody has even looked at. Finally, just as we're about to leave for the airport, they bump the departure time up a couple hours, and then finally cancel the repo completely as the aircraft is not even worthy to fly a repo.

The "No needles" scenario is something I've never encountered, so perhaps we can make it an item to leave the plane in white needles.

Maintenance seems like an after thought here, MEL'ing seems like the first thought. I once had an APU that wouldn't start in a MX base and assumed that they might look at it, maybe at least just check the oil. Nope, mechanic shows up and straight MELs it. That incident caused me plenty of trouble that day due to faulty ground equipment at outstations. The amount of MELs that I have been flying with lately is sometimes exorbitant, that flight mentioned above dispatched with I believe 9. Each one adding to our work load. I have also received a plane that had an expired FMS database, that had sat on the ground overnight, no one took the time, then did a turn and sat for another 2 hours, once again, no one took the time. I went into the MX office and asked if someone could do it while we boarded, and he did which is a great help to have actual and proposed fuel numbers while flying in inclement weather. Because pilots are goal oriented people that want to get the job done, I was ready, willing and thought able. Looking back in all the legs of the trip, it was so damn hot in there that I always rushed to get one started so that I could have some airflow, which may have led to rushed procedures and poor
decision making, and with a new FO, I always tell them to let me know if I'm going too fast, but they may be too afraid or ashamed to ask me to slow down for the same reason mentioned above. Many airlines have a limit on the number of MELs are allowed, perhaps that can be implemented here.

Perhaps crew tracking can look at the bigger picture of what is going on, rather than what is the legal minimum which is what is commonly assigned even, when in many cases clearly makes no sense. Example, my overnight to an outstation was cancelled, so they gave me minimum rest to deadhead to the outstation, sit there for 6 hours, then fly back. I called and asked for a hotel for the 6 hour wait and they changed it to me deadheading on the outbound plane that I was to bring back, genius.

I'm not sure what can be done about ATC re-routes, but lately I have been given several that have actually put me in the worst of the weather. Just the other day, Center had me go way west into weather that I could see then come back, adding about 25 minutes to the flight. I informed the controller that that routing will put me in the worst of the weather, and present position direct the field will keep me clear. His response was "I've been hearing that a lot" a few minutes later, he cleared me direct a fix near the field and I was clear.

After 10 years with this company I'm reaching my breaking point with maintenance issues, problem FO's and Flight attendants, since we seem to hire anybody. Crew tracking and dispatch issues which could be solved by hiring more competent staff and more training. One of my FO's was scared when he was told by an instructor, that that instructor would never put his family on a flight operated by our air carrier. That says a lot because anything that happens is a bunch of links in a chain and lined up right together is a recipe for disaster.

**Synopsis**

A CRJ-900 Captain described a trip during hot weather in aircraft with either the APU or a pack MELed, multiple MELs, ATC reroutes in weather and a return to the departure airport following a lightning strike. The crew ultimately called in fatigued.
ACN: 1361990 (15 of 50)

Time / Day
Date: 201606
Local Time Of Day: 1801-2400

Place
Locale Reference.Airport: SLC.Airport
State Reference: UT
Altitude.MSL.Single Value: 11500

Environment
Flight Conditions: VMC
Light: Night

Aircraft
Reference: X
ATC / Advisory.TRACON: S56
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
Nav In Use: FMS Or FMC
Flight Phase: Descent
Route In Use.STAR: DELTA4
Airspace.Class E: S56

Component
Aircraft Component: FMS/FMC
Aircraft Reference: X
Problem: Malfunctioning

Person: 1
Reference: 1
Location Of Person.Aircraft: X
Location In Aircraft: Flight Deck
Reporter Organization: Air Carrier
Function.Flight Crew: Pilot Not Flying
Function.Flight Crew: First Officer
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1361990
Human Factors: Fatigue
Human Factors: Human-Machine Interface

Person: 2
Reference: 2
Location Of Person.Aircraft: X
Location In Aircraft: Flight Deck
Event:

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Deviation - Altitude : Crossing Restriction Not Met
Anomaly.Deviation - Altitude : Overshoot
Anomaly.Deviation - Procedural : Clearance
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : CFTT / CFIT
Detector.Person : Flight Crew
Detector.Person : Air Traffic Control
When Detected : In-flight
Result.Flight Crew : Returned To Clearance
Result.Flight Crew : Became Reoriented
Result.Air Traffic Control : Issued Advisory / Alert
Result.Air Traffic Control : Issued New Clearance

Assessment:

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

Narrative: 1

On the Delta 4 arrival into SLC was cleared to cross JAMMN at 17000. Had verified altitude restrictions with the pilot flying. Approaching the fix was cleared to descend via. PF selected 11000 for lowest restriction at MAGNE. We were still in managed descent. Prior to SPIEK we both verified altitude and noticed we were low. The aircraft had reverted to vertical speed. Started the correction and advised ATC asking for a safe altitude. Was given 13000. We had visual on terrain and no TCAS warning. Was then cleared to maintain 11000 and given a runway assignment of 16L. Continued on downwind and cleared for a visual.

The flight started with a three hour round trip. We had a mechanical upon return and changed planes. Had to wait for a security check on the plane prior to boarding. Then 2 mechanical issues. No catering bins, had to wait on that. Late push. Late arriving into SLC. I feel fatigue was the main factor in catching the event immediately. The aircraft losing automation was the ultimate cause of the event but was preventable had we been more alert.

Narrative: 2

Vertical Speed being activated at some point without us being aware of the change from Managed Descent. High task loading at this phase of flight. Distraction with the FA announcement procedures as the PF and approach chart verification.

Synopsis
A320 flight crew reported missing a crossing restriction at SPIEK on the DELTA 4 Arrival SLC. The FMGC had reverted to vertical speed with 11000 feet set. The flight crew detected the error just before ATC issued a low altitude alert. Fatigue was cited as a contributing factor.
ACN: 1360278 (16 of 50)

Time / Day
Date: 201605
Local Time Of Day: 1801-2400

Place
Locale Reference: ATC Facility: ZZZZ.ARTCC
State Reference: FO

Environment
Flight Conditions: IMC
Weather Elements / Visibility: Thunderstorm
Light: Night

Aircraft
Reference: X
ATC / Advisory.Center: ZZZZ
Aircraft Operator: Air Carrier
Make Model Name: Widebody, Low Wing, 2 Turbojet Eng
Crew Size.Number Of Crew: 4
Operating Under FAR Part: Part 121
Flight Plan: IFR
Mission: Passenger
Flight Phase: Landing
Flight Phase: Parked

Person
Reference: 1
Location Of Person.Aircraft: X
Location In Aircraft: Flight Deck
Reporter Organization: Air Carrier
Function.Flight Crew: Captain
Function.Flight Crew: Pilot Not Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
Experience.Flight Crew.Total: 9260
Experience.Flight Crew.Type: 1905
ASRS Report Number.Accession Number: 1360278
Human Factors: Communication Breakdown
Human Factors: Confusion
Human Factors: Fatigue
Human Factors: Time Pressure
Human Factors: Workload
Human Factors: Distraction
Communication Breakdown.Party1: Flight Crew
Communication Breakdown.Party2: Ground Personnel
Communication Breakdown.Party2: Dispatch

Events
Anomaly.Flight Deck / Cabin / Aircraft Event: Other / Unknown
Anomaly.Deviation - Procedural: Published Material / Policy
Anomaly: Inflight Event / Encounter: Weather / Turbulence
Detector: Person: Flight Crew
Were Passengers Involved In Event: Y
When Detected: Aircraft In Service At Gate
When Detected: In-flight
Result: General: Work Refused
Result: Flight Crew: Became Reoriented
Result: Flight Crew: Took Evasive Action

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

Narrative: 1

[Destination Airport ZZZZ] was temporarily closed due to thunderstorms. With more than 20 aircraft ahead there was no chance of landing during the next lull after which more cells were bearing down on the airport. [ZZZZ1], although not closed, was also reporting storms. [ZZZZ2] was closed. We consulted with the dispatcher and diverted to [ZZZZ3].

By itself the above events don’t merit a Flight Safety Awareness Report. The facts imply no regulatory or safety concerns. However, this report is not about a simple divert, but interference and misinformation that contaminated the process.

Well on our way to ZZZZ3 we received a dispatcher message that the Operations Manager preferred we divert to ZZZZ4. I strongly support a dispatcher's willingness to utilize various resources and inputs to inform his input and recommendations. I even understand, particularly if caught unaware, that his initial opinion might change. But this message was noteworthy in that the Dispatcher conspicuously eschewed ownership but passed it along anyway.

The Ops Manager's preference was not the safest alternative or even remotely equivalent. Case closed. An unplanned border crossing between hostile countries is a risky endeavor. More likely than not, ZZZZ4 would simply deny incursion. Landing a United States airplane and crew [on foreign soil] should not be taken lightly. And only dire circumstances merit taking a planeload of [foreign] nationals to ZZZZ3. Such issues impose risk for the plane, passengers and crew. Even the best outcome would ultimately require Captain's authority to escape.

By my estimation the best case would be for ZZZZ3 authorities, after some delay for interrogation, to insist that the airplane depart. I would have no choice but exercise emergency authority to exceed regulatory duty limits notwithstanding certain fatigue.

After I rejected the alternative, the Dispatcher passed a message from the Ops Manager that ZZZZ3 would not allow us to land. Purportedly, they had too many airplanes on the ground already. If we persisted to ZZZZ3 landing clearance would only be given for [priority status]. I replied with a willingness to oblige, if necessary. But I was not persuaded by the twisted logic that ZZZZ3 would turn us away and ZZZZ4 would welcome an incursion with open arms.
Next we were warned that customs would not clear the flight in ZZZZ3 and occupants would be required to remain onboard. This also did not persuade me to reverse course to [departure airport].

Of course, in reality we encountered no resistance from Air Traffic Control.

Safely on the ground I now welcomed input from the Ops Manager. I spoke directly to her. Surprisingly, the discussion revealed her to be a very intelligent woman. So I doubt she was oblivious to the challenges diverting would create.

She blamed our staff in ZZZZ3 for prior misinformation but was adamant about her second warning that neither passengers nor crew would be allowed to deplane. On that basis, to keep the option alive, we prepared for a possible return. However, a return flight could only be conducted under [my] authority as doing so would exceed regulatory duty limits. So I also obtained documents authorizing regulatory exemption on the premise that passengers and crew were hostage to the aircraft.

More than a little suspicious of information being passed, I let it be known I would independently verify the facilitation issue. And when time allowed I did exactly that. The reality was again much different than what had been represented. I was told passengers and crew could all deplane. However, there was some noise about immigration officials possibly holding passports of deplaning occupants but this, too, was soon resolved.

I again spoke directly to the Ops Manager. When informed that deplaning would be allowed with the possible holding of passports she said that's what she meant when she warned ZZZZ3 would not clear the flight. She claimed that equated to occupants being hostage on the aircraft.

From a regulatory perspective, allowing crewmembers to deplane into crew rest is the polar opposite of forcing the crew to remain on the airplane. The actual circumstance did not qualify for regulatory exemption. I immediately ceased all efforts to further extend duty under the regulatory exemption.

We had been on duty for 21 hours and 44 minutes when the return to [destination] was cancelled. The flight was planned for 2 hours and 9 minutes.

Synopsis
An air carrier diverted because of thunderstorms. After 21+44 hours on duty, the crew ceased attempting to get clearance to destination, a 2+09 flight, despite company personnel threats about dire consequences for failing to depart.
Time / Day
Date: 201605
Local Time Of Day: 1801-2400

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

Environment
Flight Conditions: VMC
Light: Daylight

Aircraft
Reference: X
ATC / Advisory.Center: 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
Nav In Use: FMS Or FMC
Flight Phase: Descent
Route In Use.STAR: ZZZZZ

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)
Experience.Flight Crew.Last 90 Days: 225
Experience.Flight Crew.Type: 10000
ASRS Report Number.Accession Number: 1360235
Human Factors: Fatigue
Human Factors: Situational Awareness
Human Factors: Distraction

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: Returned To Clearance
Result.Flight Crew: Became Reoriented
Result.Air Traffic Control: Issued New Clearance
Assessments

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

Narrative: 1

Prior to departure, we verified flight routing with flight plan. We were unable to verify with actual ATC clearance, because it was received on taxi out. This is the procedure at this specific international city. No problems with this, just unusual from our standard SOP. The route had just loaded, and we had just [arrived], so we were familiar with the peculiarities of the day. It was a holiday weekend, and there was a runway closure earlier in the day. Previous flights into and out of [the airport] were conducted with the specific runway closed. The expectation was that we would land on the same runway.

The First Officer, in the loading of the FMC, put the anticipated runway in before departure. That's not something that is usually done, but given the previous flights, and the weather and winds, it seemed reasonable to leave it in the FMC. Takeoff, enroute, all uneventful briefings were conducted early and verified for the planned runway. Got the ATIS, and the other runway had opened. We set the courses and the ILS frequencies for the new runway in use. Prior to beginning the descent, the Pilot Monitoring (PM) had to use the lavatory, and had called the Flight Attendants, to ensure proper cockpit access. The Flight Attendants (FA) were not immediately available, as they were involved with the international forms for the Passengers.

When they called to relieve the PM, we were in the middle of the ATIS, and the runway change. We received the descent clearance when the PM was not in the cockpit. With the additional communication difficulty of the oxygen mask, and the PM calling to regain entry back at that time, I do not recall the Controller giving us a descent clearance specific to a runway. I do know we were cleared to descend via the Arrival, and he also increased our speed to maintain 310 knots until ZZZZZ. Descent was uneventful in LNAV/VNAV. We turned earlier then the Controller anticipated, and he issued a heading to fly. At that point, we verified we were set for the correct runway.

The ILS, CRS, and minimums for Runway XXR were set. The FMC had the wrong transition, which was overlooked in the planning phase of the approach, due to the expectation bias, and distractions at the moment the actual clearance was given, and the descent clearance that may not have been given specific to a runway. (I may have missed it I can't recall). There were no traffic conflicts, and I don't know what the lateral deviation was from the course. We may have been within limits of the RNP 1.

Contributing to the error:
*Distraction, as mentioned in narrative.
*Fatigue and possible burnout, last leg of a [multiple]-day trip
*Relatively short overnights of 12 hours the previous two nights
*The first day very long, within 20 minutes of timing out with a FDP of 15 hours; getting to sleep [at a very early time].
*Approximately on duty 10 hours at the point of error that day as well.
*PM new to airline and lack of line experience

Synopsis

B737-700 Captain reported a track deviation resulted after they got a late runway change and the FMC was not properly re-programmed.
Time / Day
Date: 201605

Place
Locale Reference. ATC Facility: ZZZZ.ARTCC
State Reference: FO
Altitude. MSL. Single Value: 35000

Environment
Flight Conditions: VMC

Aircraft
Reference: X
ATC / Advisory. Center: ZZZZ
Aircraft Operator: Air Carrier
Make Model Name: B767 Undifferentiated or Other Model
Crew Size. Number Of Crew: 3
Operating Under FAR Part: Part 121
Flight Plan: IFR
Mission: Passenger
Flight Phase: Descent

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: 20080
Experience. Flight Crew. Last 90 Days: 151
Experience. Flight Crew. Type: 4483
ASRS Report Number. Accession Number: 1357199
Human Factors: Fatigue

Events
Anomaly. Other
Detector. Person: Flight Crew
When Detected: In-flight
Result. General: None Reported / Taken

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

Narrative: 1
[On this international flight] we complied with the letter of the new FAR on crew rest. The government has now managed to legislate me into a lower level of safety! Only an individual pilot can know what his body responds to and won't respond to. On the ultra-long haul flights I can see how having the flying pilot's break all in the second half makes sense. On mid-level Europe flying it lowers the level of safety. My entire career almost all flying pilots chose the mid break. They got some level of sleep, were back in the cockpit a few hours before landing to thoroughly plan the descent and approach. Now, after being forced by the government to take the last break, you get back to the flight deck just before beginning descent. You don't have adequate time to get ATIS, plan the descent and find hidden gotchas. Same goes for the approach. If you get assigned an approach you're not used to flying you don't have adequate time to plan for it. The big question, "why don't you have adequate time"? The reason we all chose the mid breaks before is when your body is already sleep deprived from multiple overseas trips per month, it takes much longer than normal to fully wake and get your head back in the game. I've watched many of my co-pilots (and myself) over the years and we tend to be sluggish and lethargic for a longer period of time than you might think. On [this] flight I found myself reacting to the situation. My mind is normally three miles ahead of the aircraft, in this case it was all I could do to keep up.

Earlier this month I [flew another international flight] with a new hire on his first day in the airplane. The other first officer was on his fifth day in the airplane! I really needed to have my approach and descent well planned out since I would also be in teaching mode with my new pilots. [The destination airport] can be very difficult if you don't manage your energy level perfectly as they often give you a direct that cuts a few miles off the approach. If you have not managed your energy, you will find yourself high and fast rolling out on a short final. This leads to an unstable approach. I found it more difficult to stay ahead of the aircraft and perform to the level that I expect of myself than before the FAA mandated a rest break that my body doesn't adapt to.

**Synopsis**

B767 international Captain reported he felt less rested and therefore less safe following the FAA mandated international rest break schedule.
**Time / Day**

- Date: 201605
- Local Time Of Day: 0601-1200

**Place**

- Locale Reference: Airport: BFI.Airport
- State Reference: WA
- Altitude.MSL.Single Value: 2600

**Environment**

- Flight Conditions: VMC
- Light: Daylight

**Aircraft : 1**

- Reference: X
- ATC / Advisory: Tower: BFI
- Aircraft Operator: Air Carrier
- Make Model Name: Commercial Fixed Wing
- Crew Size.Number Of Crew: 2
- Operating Under FAR Part: Part 121
- Flight Plan: IFR
- Flight Phase: Final Approach
- Airspace.Class E: S46

**Aircraft : 2**

- Reference: Y
- Make Model Name: Small Aircraft
- Flight Plan: VFR
- Airspace.Class E: S46

**Person : 1**

- Reference: 1
- Location Of Person: Aircraft: X
- Location In Aircraft: Flight Deck
- Reporter Organization: Air Carrier
- Function: Flight Crew: Captain
- Function: Flight Crew: Pilot Flying
- Qualification: Flight Crew: Air Transport Pilot (ATP)
- Experience: Flight Crew: Total: 13800
- Experience: Flight Crew: Last 90 Days: 140
- Experience: Flight Crew: Type: 10500
- ASRS Report Number: Accession Number: 1354159
- Human Factors: Fatigue

**Person : 2**

- Reference: 2
- Location Of Person: Aircraft: X
- Location In Aircraft: Flight Deck
We were on the 3rd leg of our trip flying into Boeing Field. We were on the LOC for [13R] and approximately 15 miles from the runway. We were told to descend to 2600 ft then re-cleared to 3500 ft due to VFR traffic below us. We spotted two aircraft below us at our 2 o'clock and I said that was a close one as they passed near each other. Shortly after that we were re-cleared to 2600 ft. During our descent we got another traffic call from Approach and we saw a red plane below us at 10-11 o'clock. At around 2600 ft Approach said VFR traffic 12 O'clock and a mile, switch to Tower. I tried to reference him on our VSI/TCAS, but I soon realized trying to judge distance on that was useless. About that time we got the Traffic call so I shifted my scan to outside the aircraft. Then came the RA Climb. I was slow to process this and by the time I was ready to perform the maneuver I spotted a white Cessna going down our left side. Figuring this was our traffic I decided not to respond to the RA thinking that might create more problems for us given the busy skies. We reported the incident to Tower and continued the approach to an uneventful landing.

In hind sight I am disappointed with my performance and how the event unfolded. First of all Approach put us on a collision course with another airplane and then switched us off to Tower. I think in some way I was a little numb to the situation with all of the traffic calls we had received, it was almost like flying an obstacle course. I think the biggest contributor however was a lack of sleep. We arrived in the morning at XA30 am local time. We got to the hotel at XB:30 and I went to sleep at XE:00. I slept soundly until XM:00 and got up feeling great. As the evening came upon me I knew that I was going to need some rest before my next day's flight so I laid down around XV:00 and tossed and turned until YB:30 when I got up. I may have had 2 hours sleep during that time. When I got up I took
a shower and prepared for work. I felt fine and looked forward to getting this last day of flying behind us so we could get home. I flew the first leg and felt fine. On the second leg, the F/Os, could tell I was slowing down a bit with fatigue starting to catch up with me. The third leg was mine and I think I got a bit of a second wind, but as the third flight progressed though I could feel the fatigue taking its toll. In hind sight and with a fresh mind, I am disappointed with my lack of performance. The TCAS training I have received in the sim has been more than adequate and I have never had a problem performing the appropriate maneuver in response to an RA. Similarly I also realize that the aircraft that passed down our left side may not have been the one that TCAS was looking at and I should have done the Climb maneuver anyway. In the future when I get into a high density traffic situation like this one was, I am going to bring up the topic of TCAS with my FO and discuss what each of us are going to do if we get an RA.

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

Air carrier flight crew reported a NMAC with VFR traffic while on the ILS 13R approach to BFI. The flight crew received an RA/TA, but did not take evasive action because they had the VFR traffic in sight.
The night prior I had a lot of trouble sleeping because the room was insanely hot. I turned the temperature as low as it would go, but it was still sweltering. I got maybe 4 hours of sleep. My wakeup call was for XA:00 for a XB:10 van. Immediately we had problems due to gate issues (another aircraft on our gate). As soon as we were ready for pushback, the...
flight attendant called up to say a nervous passenger wanted to deplane. After deplaning
said passenger, the Captain became concerned because he had seen this passenger at the
gate with another passenger and things just didn't add up, so after consulting with the
Duty Manager and Dispatch, we had to bring the jetway back again, to remove the second
passenger. We were now late. As soon as we pushed back, we noticed a line of at least 20
aircraft ahead of us for departure. By the time we got airborne we were over an hour late.
Enroute the Captain sent crew scheduling a message indicating that we would not make it
in time for our next scheduled flight. Crew scheduling wrote back saying that they had
reassigned us to do an LAX turn after arriving. We would keep the same plane.

We land and proceed to hurry through Customs and go back to the aircraft for our LAX
turn. By the time we got back, about 30 minutes later, the aircraft was pushing back! The
agent says: oh, if you're here for LAX, that has been moved to another gate. So off I go.
When we arrive, the plane is just pulling up. Now we are looking at our watches because
we are already at least 30 minutes later that our XH:30 departure time and it becomes
evident that our duty day is going to easily go over 12 hours. We turn the plane as quickly
as possible, and launch for LAX.

It was about this time that I started making errors. I missed a call from Tower to go into
position and hold. The Captain caught it and we departed. Enroute I made several more
communications errors, using incorrect and previous call signs. The flight attendants called
the cockpit with our meals, and I just looked at the Captain. I did not respond to them.
I'm really not sure why. We were given several crossing restrictions from SoCal approach
and I was having trouble getting them into the FMC correctly. As we turned downwind and
were cleared for a visual approach, the Captain asked me to extend the centerline in the
FMC. I went to do that and looked at the box and I literally could not remember how. I've
done this thousands of times. It was then that I realized I was fatigued and I needed to
remove myself from flight status, which I did after we blocked in.

**Synopsis**

Air carrier First Officer described a fatiguing trip and mistakes that he made, necessitating
a fatigue call.
Time / Day
Date : 201604
Local Time Of Day : 0001-0600

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

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

Person : 1
Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1350897
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 : 1350898
Human Factors : Distraction
Human Factors : Time Pressure

Events
Anomaly.Deviation - Procedural : Weight And Balance
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : FAR
Detector.Person : Ground Personnel
When Detected : Aircraft In Service At Gate
Result.General : None Reported / Taken
Assessments
Contributing Factors / Situations: Company Policy
Contributing Factors / Situations: Human Factors
Primary Problem: Human Factors

Narrative: 1

I operated the flight, and upon arrival at the hotel I was informed by the new Captain who was onboard the aircraft, that there had been a discrepancy on our weight and balance paperwork and that the aircraft had departed 3,982 KG over the weight listed on the weight and balance manifest. This discrepancy was discovered when the load master was preparing the loading supervisor verification form for the next leg. It was during this time that the load master realized he had failed to recalculate the actual passenger weight [before departure] after additional passengers had boarded the aircraft.

The discrepancy on our weight and balance paperwork occurred because the load master provided me with a loading supervisor verification form which contained the actual passenger weight from the previous leg, and did not account for the additional passengers that had boarded the aircraft [at our departure airport]. I spoke to the load master about the error over the phone and he admitted to giving me an inaccurate loading supervisor verification form [before departure] and apologized. The aircraft was never over max gross weight and no limitations were exceeded due to this error.

The load master was fatigued, when I spoke to him on the phone he told me he was tired and had been on the airplane for 10 days straight.

I see the same level of fatigue in our ride-along mechanics. Company employees are required to stay onboard the aircraft for long periods of time with little to no time for adequate rest in hotels. This leads to extreme levels of fatigue that I often witness in our load masters and ride-along mechanics. Human performance at this level of fatigue is severely degraded.

The loading supervisor verification form itself is not well suited for military flights that require actual passenger and baggage weights. The form was designed for scheduled service flying and translates poorly to military flying as there is no place for the load masters to write the actual weights or the calculations used to obtain those weights. Actual weights are often scribbled in a random location on the form.

Calculations used to derive those weights are seldom provided. Readability and ease of use of this form is critical as it is often one of the last forms we receive immediately prior to closing the door and preparing for takeoff. This provides little time for verifying accuracy of calculations, etc. when up against time constraints for an on-time departure. I strongly recommend revising this form.

Upon our arrival to the aircraft [at the departure airport,] dispatch was having a lot of difficulty filing a flight plan that would be accepted by ATC. Multiple flight plans were filed and subsequently rejected by ATC which lead to multiple versions of important paperwork being sent to the aircraft. Our workload was abnormally high as we tried to sort through all the revisions, assist dispatch in verifying flight plan status with local ATC, and obtain new versions of paperwork as they were released. This led to decreased amounts of time for me to scrutinize the work of others, such as the load master and his calculations on the loading supervisor verification form.
**Narrative:** 2

I helped operate a flight. I was informed later that the Captain had found out an error that had occurred with the weight and balance for the flight. The error occurred because the weight and balance manifest form was completed improperly and the wrong weight was written down for the actual passenger weights. This incorrect information caused a difference of 3,900 KG from the actual takeoff weight and the takeoff weight found on the weight and balance. The flight did not exceed any limitations and the weight used on the [takeoff and landing report] was still valid so all our flap settings and takeoff speeds were not affected. There is a need for a location on the weight and balance manifest form for actual passenger weights.

**Synopsis**

B757-200 flight crew reported being informed after a flight that the Loadmaster had not accounted for additional passengers that were boarded at the previous stop resulting in a 3,900 KG error. The Loadmaster had been on the aircraft for 10 days and was very fatigued.
ACN: 1349312 (22 of 50)

**Time / Day**

Date: 201604  
Local Time Of Day: 0001-0600

**Place**

Locale Reference.Airport: PHL.Airport  
State Reference: PA  
Altitude.MSL.Single Value: 2100

**Environment**

Flight Conditions: VMC  
Light: Dawn

**Aircraft**

Reference: X  
ATC / Advisory.Tower: PHL  
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: Final Approach  
Route In Use: Visual Approach  
Airspace.Class B: PHL

**Component**

Aircraft Component: Flight Director  
Aircraft Reference: X  
Problem: Improperly Operated

**Person**

Reference: 1  
Location Of Person.Aircraft: X  
Location In Aircraft: Flight Deck  
Reporter Organization: Air Carrier  
Function.Flight Crew: First Officer  
Function.Flight Crew: Pilot Flying  
Qualification.Flight Crew: Air Transport Pilot (ATP)  
ASRS Report Number.Accession Number: 1349312  
Human Factors: Situational Awareness  
Human Factors: Training / Qualification  
Human Factors: Confusion  
Human Factors: Fatigue

**Events**

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

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

Narrative: 1
Cleared for visual 27R and although familiar with PHL and clear sky, couldn't pick out runway initially. Vectors were to a visual inside FAF and picked up runway a bit late, selected autopilot off, but failed to turn off flight directors. Speed was managed so just as flaps three called for and selected by captain, speed increased to over speed flaps. Go around was conducted while nose was pulled up and power manually reduced and flight directors turned off. After vectors to final again, almost did the same thing as flight directors had been turned back on again while hand flying aircraft, when power came up again, captain turned off flight directors and landing was made.

After shutting down at gate, we had [a] discussion about what we had done wrong and about remembering to shut off flight directors in manual flight unless right on course and slope. After all night flight with minimal to no sleep in previous 24 hours I was not on my game but should have caught flight directors. I let automation surprise me and got complacent going into a known field.

Flying approximately once every two to three weeks on reserve since January I just feel comfortable in plane again before sitting for another few weeks. I therefore have flown mostly ILS and rarely hand fly visuals. After little sleep [the] previous day and flying all night I should have chosen to take ILS rather than short vectors for a visual. I need to fly more visuals at more appropriate times to become comfortable with them.

Synopsis
A fatigued Airbus First Officer attempted a hand flown visual approach to PHL Runway 27R, but was forced to execute a go-around after failing to turn the flight directors off. Autothrust advanced power on the approach which also resulted in a flaps overspeed.
For some reason, this company is building pairings that violate their own policy on safety and fatigue. This is a relative new practice and is unprecedented in terms of forcing unsafe human factors on the pilots.
I spoke to a scheduler about this and was told, "well, you're legal for it". I tried to explain that being legal was not the point of my phone call. Being safe and fit for duty was.

These red eyes built into the middle of a pairing are unsafe. That's a strong word but 100% accurate.

I just finished one of these and have never been so exhausted in my career. I had every intention of calling off "too fatigued to fly" on the last day of the pairing. But, as it turned out I was in a hotel that was well designed for daytime sleep and I got three hours which allowed me to finish my trip while maintaining an adequate degree of safety. Had that not been the case I positively would have called off fatigued.

Dangerous fatigue reoccurred on the drive home from the airport. I nodded off three time (split second) while driving. I pulled over and napped in a parking lot. This all happened as the direct result of the construction of this pairing.

But it's not unique. There are many pairings that now have red eye legs in the middle. These pairings are built looking only at legalities and ignore all human factors. Inadequate rest has residual effects and cause mistakes to be made in the airplane. Even if they are small ones, like missing a radio call, they are the direct result of fatigue.

Each pilot handles the decision individually. Unfortunately for me, I made the incorrect decision and kept pressing on when I know I should have called off "too fatigued". That's a tough call to make for a professional pilot.

[On this assignment] the first leg was an evening leg to [our destination]. We arrived at the hotel at XA:30 EST only to learn the hotel restaurant and bar were closed for renovation. We were hungry so my FO (First Officer) and I left the hotel to find a restaurant a small distance away. We returned a little after XC:00 EST [early morning].

The construction noise started at XG:30 AM local and lasted continuously until XS:00 local. After two hours I called the front desk and spoke to the manager on duty. I explained we needed to sleep during the day but he replied there was nothing he could do. The hammering and saws continued non-stop until after our departure time for the red eye leg.

We flew [two more legs] and landed at XE:07 AM EST. When wheels touched down we had been awake for nearly 29 hours without opportunity to sleep. We both discussed calling off too fatigued but decided to try to force some rest. We were expecting street noises to be a problem but the new hotel is actually perfect for daytime sleep and we got through it.

I don't know why but there are times when being overtired actually interferes with sleeping. I got 2.5 hours of sleep and my FO reports he got 6 hours. We departed that same day at XR:25 local for two legs getting back to [home base] after midnight.

Although this is a specific case, the general point I am making is that these red eyes built into the middle of a pairing are unsafe. They violate company policy as stated in the [company manuals and training courses], and they force the pilot into a tough decision when inserting the Fit for Duty prompts, a federal requirement. And scheduling says you are FAR 117 legal. They have no clue how these impact the body.

Falling asleep at the wheel on the drive home has gelled the safety issue in my mind and caused me to pledge to myself that I will never do this again. It may not be convenient for
company if I call off [fatigued] but next time I am faced with these circumstances there will be no decision to be made because the decision has already been made. Safety first.

Synopsis

A320 Captain reported extreme fatigue resulted from his three day assignment that included a "red eye" leg on day two.
**Time / Day**

Date: 201604  
Local Time Of Day: 0601-1200

**Place**

Locale Reference.Airport: PHL.Airport  
State Reference: PA  
Altitude.MSL.Single Value: 10000

**Environment**

Flight Conditions: IMC  
Weather Elements / Visibility: Rain  
Weather Elements / Visibility: Turbulence  
Light: Dawn

**Aircraft**

Reference: X  
ATC / Advisory.TRACON: PHL  
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: Initial Approach  
Airspace.Class E: PHL

**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: 1347678  
Human Factors: Distraction  
Human Factors: Fatigue  
Human Factors: Workload

**Events**

Anomaly.Deviation - Altitude: Crossing Restriction Not Met  
Anomaly.Deviation - Speed: All Types  
Anomaly.Deviation - Procedural: FAR  
Anomaly.Deviation - Procedural: Published Material / Policy  
Anomaly.Deviation - Procedural: Clearance  
Detector.Person: Flight Crew  
When Detected: In-flight  
Result.Flight Crew: Became Reoriented
Assessments
Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Human Factors
Primary Problem : Ambiguous

Narrative: 1

The event occurred on the second leg of the morning pairing at the end of six days of work. The week began with a night hub turn sequence followed by a 24 hour layover switching to day flying followed by a 24 hour layover switching back to a night hub turn sequence. Basically night hub turn to day hub turn to night hub turn all flown as the regularly scheduled bid pack line. The last pairing of the six day trip had a two leg sequence. The second leg was conducted in early morning day IMC conditions at a cruise altitude of 13,000 ft.

Event #1: Did not comply with crossing restriction.

ATC issued a clearance to cross 25nm this side of DQO at 9000 ft. Our current altitude was 13,000 ft. There were three fixes in our flight plan between our current fix and DQO spaced out by small mileages (10nm, 5nm, 7nm etc.). Since we were not cleared direct first I had trouble as the PM inputting the crossing restriction into the FMS because I had to do the math to determine which fix and which mileage to attach the restriction to. I definitely recognized some cognitive "slowness" on my behalf due to fatigue that made it difficult to figure out where to attach the restriction. In the end we added up all the distances between us and DQO and determined we had time to make the descent and gave up on trying to program the FMS so we could use VNAV PATH. As we approached 10,000 ft in VNAV SPD with the speed window closed, the speed bug did not move from 325kts to 240kts automatically and we began to pass through 10,000 ft at 325 kts. The captain as the PF disengaged the autopilot to stop his descent below 10,000 ft above 250kts. He opened the speed window and selected 240kts. As the aircraft slowed he engaged FLCH 240 and re-commenced his descent to make the 9000 ft restriction at DQO. As the airspeed slowed he re-engaged VNAV and the speed bug cycled back up to 325kts, the thrust levers advanced and we reached about 270kts in a descent at approximately 9,500 ft. As the PM, I sensed the captain was overtasked and having trouble recognizing the problem so with one hand I opened the speed window and inserted 240kts and with the other hand I manually overrode the thrust levers and brought them to IDLE while the captain continued to hand fly the aircraft to attempt to maintain 10,000 ft while we slowed. Once the situation was stabilized the captain re-engaged the autopilot, allowed the aircraft to slow below 250kts and then finished the descent to 9000 ft. In the end we did not make the 9000 ft crossing restriction 25nm from DQO.

Contributing factors were fatigue and the reduction in cognitive ability to solve a non-routine FMS drill, IMC conditions and steady precipitation, the low altitude/dense traffic area between [our departure airport] and PHL and the unexpected failure of the FMS to slow at 10,000 ft. For whatever reason, the VNAV side of the LEGS page listed .59M/9,000 at DQO instead of 240/9,000. The airplane wanted to maintain .59M below 10,000 ft instead of 240kts. The FMS VNAV DES page did not have the "240/10,000" speed rest like it normally does. I'm not sure why this was but feel it had something to do with our low cruise altitude of 13,000 ft. I'm not sure what could have been done as I would consider this the perfect storm of events. High density traffic environment, lots of low altitude fixes on a Victor Route, a non-routine crossing restriction, IMC and steady precipitation conditions, fatigue and unexpected auto-flight system behavior. We had multiple problems confront us at once. The rest of the flight was uneventful. The second half of a hub turn utilizing multiple legs in a high density environment is tough. The second leg of the pairing
is usually when the morning flights of the passenger carriers are the busiest, it's at a low altitude where more low-flying slow speed aircraft are and it's at high density airports. Because of the IMC conditions between ZZZ-PHL we had a 30 minute ground delay after blackout further delaying our flight. This pairing is much different from [other] pairings where there isn't as much activity. It's all a part of the job, I understand but there is more operational risk with these types of pairings because of the time of day and location/operating environment. Fatigue was definitely at play as the week-long sequence had multiple shifts between day flying and night flying. While there was a 24 hour rest period between these shifts it can still be different to shift from a day sequence to a night sequence because it is hard to sleep normally at night and then try to take a nap in the middle of the day before your night sequence begins. It is challenging to have a two-leg pairing on a night hub turn immediately following a day to night switch like [this] pairing does.

**Synopsis**

B757-200 First Officer reported he and the Captain committed several errors on their flight because of fatigue and workload.
**Time / Day**

Date: 201604
Local Time Of Day: 1201-1800

**Place**

Locale Reference.Airport: LAX.Airport
State Reference: CA
Altitude.AGL.Single Value: 0

**Environment**

Flight Conditions: IMC
Weather Elements / Visibility: Rain
Weather Elements / Visibility. Visibility: 2
Light: Daylight
Ceiling. Single Value: 500

**Aircraft**

Reference: X
ATC / Advisory.Tower: LAX
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: 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: 171
ASRS Report Number. Accession Number: 1346948
Human Factors: Communication Breakdown
Communication Breakdown.Party1: Flight Crew
Communication Breakdown.Party2: Flight Crew

**Person : 2**

Reference: 2
Location Of Person.Aircraft: X
Location In Aircraft: Flight Deck
Reporter Organization: Air Carrier
Function.Flight Crew: Captain
Function.Flight Crew: Pilot Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
Experience: Flight Crew: Last 90 Days: 140
Experience: Flight Crew: Type: 140
ASRS Report Number: Accession Number: 1346893
Human Factors: Situational Awareness
Human Factors: Fatigue
Human Factors: Distraction
Human Factors: Communication Breakdown
Human Factors: Confusion
Communication Breakdown: Party1: Flight Crew
Communication Breakdown: Party2: Flight Crew

Events
Anomaly: Deviation - Procedural: Clearance
Anomaly: Ground Incursion: Runway
Detector: Person: Flight Crew
When Detected: Taxi
Result: Flight Crew: Became Reoriented

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

Narrative: 1

We were instructed to cross Runway 25R on Taxiway P and turn left onto parallel Taxiway B. While I was reading back instructions to Ground Control, Captain turned left onto Runway 25R. I tried to motion him to stop the turn and continue straight across on P, but by time he realized his mistake we were too far into the turn. We continued down the runway to the next intersection (Taxiway T) and exited there.

I should have stopped my communications with Ground Control to verbally alert the Captain. He would have most likely responded more quickly to my verbal communication than he did to my gestures.

Narrative: 2

[Narrative contained no additional information.]

Synopsis

Air carrier flight crew reported being cleared to cross Runway 25R at LAX, but made an incorrect turn and ended up on the runway. They exited at the next intersection.
**ACN: 1345428 (26 of 50)**

**Time / Day**
- Date: 201604
- Local Time Of Day: 0001-0600

**Place**
- Locale Reference.Airport: EWR.Airport
- State Reference: NJ
- Altitude.AGL.Single Value: 300

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

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

**Person: 1**
- Reference: 1
- Location Of Person.Aircraft: X
- Location In Aircraft: Flight Deck
- Reporter Organization: Air Carrier
- Function.Flight Crew: Pilot Not Flying
- Function.Flight Crew: First Officer
- Experience.Flight Crew.Type: 171
- ASRS Report Number.Accession Number: 1345428
- Human Factors: Fatigue
- Human Factors: Workload

**Person: 2**
- Reference: 2
- Location Of Person.Aircraft: X
- Location In Aircraft: Flight Deck
- Reporter Organization: Air Carrier
- Function.Flight Crew: Captain
- Function.Flight Crew: Pilot Flying
- Experience.Flight Crew.Last 90 Days: 200
- Experience.Flight Crew.Type: 927
- ASRS Report Number.Accession Number: 1345462
Events

Anomaly.Inflight Event / Encounter : Weather / Turbulence
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Executed Go Around / Missed Approach
Result.Flight Crew : Diverted

Assessments

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

Narrative: 1

We were aware of forecasts for extreme winds in EWR at the time of our arrival, and had coordinated with dispatch for an alternate with forecast winds that we felt gave us the strongest diversion option if landing at EWR was not possible. On arrival into EWR, the wind was gusting at over 40 knots and favoring the shorter runway 29. We used the RNAV approach, which got quite rough below 2,000 feet. Additionally, the window between our gust protection speed and our max flap speed was very narrow. Within about the final 800 feet of descent, maintaining runway alignment became increasingly difficult, and maintaining speed within tolerance proved impossible, at which point we executed a go-around. Given the difficulty of the previous approach at such a low altitude, and our having flown all night, we felt that attempting another approach was not the safest option, and opted to divert to ZZZ. Someway into the diversion, dispatch contacted us to request we change our diversion airport to ZZZ1. The combination of the go-around and the two diversions, followed by another fairly high-wind gust approach to landing into ZZZ1 was quite labor-intensive, and through the process, we found ourselves making a number of small mistakes with automation management, CRM, etc.

When we landed, we were advised that the company was planning on having us refuel and operate the aircraft on to EWR. Upon weighing the conditions in EWR against our own physical state, and the mental fatigue of the preceding hour of flight, we felt that it was not possible for us to provide an acceptable margin of safety for the continuing flight to EWR, at which point we advised the company of our need to remove ourselves from that flight segment.

Narrative: 2

Flew RNAV approach to RWY 29 in high wind, low visibility, and moderate turbulence. I fought the entire way down with ref speed close to flap speed, flaps blowing up several times, and moderate turbulence. At approximately 100 feet while the aircraft was in the correct position I was unable to stabilize the airspeed enough to continue to touchdown and so went around. The go around was not the result of not being configured, or being in a bad position.

I reasoned that a second approach would end with the same wind conditions so elected to divert. During the go around and divert the First Officer and I fought to keep the aircraft in the correct modes, with turbulence causing the autopilot to revert to Control Wheel Steering (CWS) mode several times. We first completed all necessary items to divert to
ZZZ, our flight plan choice. Then on advice of Dispatch we did it all again to divert to ZZZ1. During this we made several errors due to stress/fatigue including typing in an incorrect fix and initially turning in the wrong direction catching it before the turn was complete. While the weather was better the landing also included 40 plus knot winds. After completing our assigned flight to a miss, and a second intense flight we felt mentally and physically exhausted and did not feel that we were capable of safely operating a third leg.

**Synopsis**

B737 flight crew reporting diverting to an alternate after executing a go-around at EWR due to high winds, turbulence, and an unstable approach.
ACN: 1344331 (27 of 50)

**Time / Day**
- Date: 201604
- Local Time Of Day: 0001-0600

**Place**
- Locale Reference.Airport: MEM.Airport
- State Reference: TN
- Altitude.AGL.Single Value: 0

**Aircraft**
- Reference: X
- Aircraft Operator: Air Carrier
- Make Model Name: Commercial Fixed Wing
- Crew Size.Number Of Crew: 2
- Operating Under FAR Part: Part 121
- Flight Phase.Other

**Person : 1**
- Reference: 1
- Location Of Person.Aircraft: X
- Location In Aircraft: Flight Deck
- Reporter Organization: Air Carrier
- Function.Flight Crew: First Officer
- Function.Flight Crew: Pilot Not Flying
- Qualification.Flight Crew: Air Transport Pilot (ATP)
- ASRS Report Number.Accession Number: 1344331
- Human Factors: Confusion
- Human Factors: Fatigue
- Human Factors: Situational Awareness
- Human Factors: Communication Breakdown
- Communication Breakdown.Party1: Flight Crew
- Communication Breakdown.Party2: Ground Personnel

**Person : 2**
- Reference: 2
- Location Of Person.Aircraft: X
- Location In Aircraft: Flight Deck
- Reporter Organization: Air Carrier
- Function.Flight Crew: Captain
- Function.Flight Crew: Pilot Flying
- Qualification.Flight Crew: Air Transport Pilot (ATP)
- ASRS Report Number.Accession Number: 1344335
- Human Factors: Situational Awareness
- Human Factors: Fatigue
- Human Factors: Communication Breakdown
- Human Factors: Confusion
- Communication Breakdown.Party1: Flight Crew
- Communication Breakdown.Party2: Maintenance
Events
Anomaly.ATC Issue : All Types
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Ground Event / Encounter : Other / Unknown
Detector.Person : Flight Crew
When Detected : Taxi
Result.Flight Crew : Became Reoriented

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

Narrative: 1
Assigned parking gate ZZZ via spot ZZ. ACARS message noted tow in. Contacted ramp control approaching Taxiway ZZ and cleared in. Instructed to hold short of drive lane. Aircraft stopped prior to taxi line for gate ZZZ facing west, brake set, taxi light off. After some time, tug refused to approach the aircraft and began to flash lights to indicate they wanted additional action from the crew prior to hook up. After consultation between crew members we elected to position the aircraft to facilitate a tow that the tug crew was willing to accommodate. After further review, it appears we should have held position until the tug crew approached the aircraft in its previous orientation.

Causes were a combination of ambiguous instructions from ramp tower and a failure of the flight crew to clarify. Flight crew should have done a more detailed review of parking notes to ensure that all procedures were adhered to. Compounding the error was a tug crew that insisted on using non standard communication (flashing lights to message the crew). Suggest crews review and follow Jepps parking notes irrespective of outside influences.

Narrative: 2
"In Range"- flight assigned gate ZZZ, tow-in, blast critical gate, ground power available.

"Spot XX" - ramp tower verbally confirms gate ZZZ with additional statement "hold short of the "drive lane" for tow-in the tug will meet you there".

Captain stopped aircraft prior to the taxi lane (intersection) leading straight into the hangar, set the parking brake, turned off the taxi light. The tug was sitting facing south toward the heavy weight facility centered on the taxi line leading to the hangar and proceeded to flash its lights at the aircraft without moving forward to retrieve the aircraft. After 30-45 seconds with no movement from the tug, the Captain after a short discussion with the First Officer wrongly taxied the aircraft to face the tug, shut down the engines and was then towed to the gate. While under tow, the crew reviewed notes for specific gates to find that gate ZZZ requires a tow-in from a west facing position at the taxi entrance to the hangar.

Cause:

Captain did not follow through on plan to park the aircraft short of the taxi lane to the hangar and shutdown for tow-in. Flight crew failed to read all notes due to perceived familiarity with ZZZ ramp. Ramp tower issued what the flight crew perceived to be clear yet misleading/non-standard tow-in directions. Tug crew demonstrated non-standard behavior by not moving in a timely manner toward the aircraft once it parked and shut off
taxi light and by flashing its lights at the aircraft - all of which was perceived by the crew as "pull up to the tug" for towing (in light of the ramp tower directions).

A level of crew fatigue - perceived by the Captain as normal. Two nights prior a major weather event caused a significant delay of departure from ZZZ. Crew also experienced an additional delay. Crew did not arrive at the hotel until after 0A:30 local (w/FAAR extension). Captain raised the concern and crew discussed sleep periods during preflight brief next evening and determined each crew member experienced approximately 4 hours of sleep during the rest period - no action taken. One night prior to event crew again experienced another delayed departure from ZZZ and another outbound maintenance event that required a return to the gate adding approximately a 1 1/2 hour delay. Crew discussed sleep period again during the next evening preflight brief and concluded 5-6 hours of sleep was about it. So, with 20/20 hindsight, in reality the crew had approximately 10 hours of sleep in the two rest periods. Crew did use hub sleep facility as a matter of habit, so an undetermined amount of sleep was added during hub turn.

Suggestions:

Captain correctly had the parking brake set - once a question arose as to our correct positioning for tow-in; event could have been prevented by contacting ramp tower for clarification. Flight crew should have read all notes pertaining to parking spot regardless of perceived familiarity - adherence to required duties would have prevented the event. Ramp tower should use standard phraseology as printed on the parking diagram - "stop at intersection of lead-in line to hangar heading WEST" IF they are going to issue those directives AT ALL - procedural change to prevent future event.

Tug crew should not use NON-STANDARD procedures such as flashing their lights to attempt to communicate with the aircraft. There was also failure of the tug to move toward the aircraft in a timely manner once it was parked in the correct position for tow-in. Captain discussed the event once parked at the gate with tug crew and was told that they flash the lights to "tell the crew to shutdown the engines".

Captain was actively assessing crew fatigue, but took no action due to "normalization of deviance" - we accepted our rest periods as "normal" - Captain could have possibly prevented event by being more aggressive with fatigue call.

Synopsis

An air carrier flight crew reported confusion during transition from taxi-in to tug hook up for the final pull-in to the gate. The tug crew's actions, incomplete instructions from Ramp Tower as to parking instructions, and fatigue contributed to the crew's confusion. In addition, the crew did not follow published procedures for parking at the assigned gate.
**ACN: 1343692** (28 of 50)

**Time / Day**
- Date: 201603
- Local Time Of Day: 1201-1800

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

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

**Aircraft**
- Reference: X
- ATC / Advisory.TRACON: ZZZ
- Aircraft Operator: Air Carrier
- Make Model Name: EMB ERJ 170/175 ER/LR
- Crew Size.Number Of Crew: 2
- Operating Under FAR Part: Part 121
- Flight Plan: IFR
- Mission: Passenger
- Nav In Use: GPS
- Nav In Use: FMS Or FMC
- Flight Phase: Descent
- Flight Phase: Initial Approach
- 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 Flying
- Qualification.Flight Crew: Air Transport Pilot (ATP)
- ASRS Report Number.Accession Number: 1343692
- Human Factors: Distraction
- Human Factors: Fatigue
- Human Factors: Physiological - Other

**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: 1343695
Events

Anomaly.Flight Deck / Cabin / Aircraft Event : Other / Unknown
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : FAR
Detector.Person : Flight Crew
When Detected : In-flight
Result.General : Physical Injury / Incapacitation
Result.Flight Crew : Became Reoriented
Result.Flight Crew : Took Evasive Action

Assessments

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

Narrative: 1

Starting the day early and commuting to work with a fairly long drive. I felt fine for reporting for duty and felt fine to complete the rest of the day’s flights. Even though I had not slept very good the last few nights before. Due to feeling sick, because of a common cold, and having other issues on my current thoughts. Before departure I signed the flight release, and signed the fit for duty part of the release in the FMS. While on the way to our destination I had trouble staying alert and kept dosing off for very short intervals. While on the early part of the descent phase, my ability to stay alert and dosing off became somewhat more difficult. The First Officer who I was flying with, noticed my troubles, and told me he would like to take over as pilot flying. So we wouldn't have a conflict while flying, and while in a critical phase of flight. I decided to just let him take the aircraft from there. At this time, I started to think about after arriving calling in fatigued. Upon landing, after completing the last of the checklist, before I had a chance to discuss the matter with my First Officer he immediately left the aircraft and notified the company of what happened.

After feeling ill, having several other issues on your mind over a period of days, and not sleeping well over that particular time period; It would be a good idea to give yourself some extra sleep. Maybe something like an extra couple of hours on top of the recommended eight hours.

Narrative: 2

I was pilot monitoring during the flight and multiple times I looked over and saw the captain sleeping. While on the arrival at 6,000 feet, I saw the captain sleeping again. I woke him and notified him that I was taking the controls for the rest of the flight. We did not violate any FAR's or deviate from ATC instructions and landed safely.

Synopsis

During cruise flight and while flying the RNAV arrival, a fatigued, recently ill Captain dozed off several times. The First Officer aggressively took control of the aircraft and landed. The Captain removed himself from the next flight.
Time / Day
Date: 201603
Local Time Of Day: 0601-1200

Place
Locale Reference.Airport: CRW.Airport
State Reference: WV
Altitude.AGL.Single Value: 1000

Environment
Flight Conditions: VMC
Weather Elements / Visibility: Turbulence
Light: Daylight

Aircraft
Reference: X
ATC / Advisory.Tower: CRW
Aircraft Operator: Air Carrier
Make Model Name: Regional Jet CL65, Undifferentiated or Other Model
Crew Size.Number Of Crew: 2
Operating Under FAR Part: Part 121
Flight Plan: IFR
Mission: Passenger
Flight Phase: Final Approach
Route In Use: Visual Approach
Airspace.Class C: CRW

Component
Aircraft Component: Speedbrake/Spoiler
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: First Officer
Function.Flight Crew: Pilot Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1343438
Human Factors: Distraction
Human Factors: Fatigue
Human Factors: Workload

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

Left spoilers out below 1,000 feet, momentarily received stick shaker in the landing flair.

Fatigue, task saturation. Distractions due to ATC keeping us at higher altitude approaching the airport. Unusual airport environment, distractions from non-standard runway information needed to enter into the FMS. No glide path information available for the runway in use, I was visually focused on the final approach and glide path required adjusting for gusty wind. Spoilers were still partially deployed and omitted from our cross check by both the flying and monitoring pilot.

ATC left us high inbound to CRW. We queried ATC for lower altitude several times. I was flying pilot and had to use spoilers to descend and meet profile for Runway 5 at CRW. During the expedited descent the monitoring pilot was entering runway data into FMS to get landing data. FMS repeatedly sent back "No landing data for the selected runway." I was distracted, and only partially stowed the spoilers.

We had earlier discussed the displaced threshold and I had suggested to check the release for a non-standard runway entry for the FMS. This was accomplished and the FMS returned correct landing data for Runway 5.

Approaching the airport both the glide slope and VASI were inoperative for Runway 5. The runway is unusual and perched atop mountainous terrain and my first time landing there. The new displaced threshold decreased available runway length and also changed the glide path perspective. We were task saturated as a crew and both omitted the spoilers from our scan. Spoilers were still partially deployed as we descended below 1,000 feet. We continued the visual approach configured and on speed. In the landing flair we momentarily received the stick shaker and the Captain retracted the partial spoilers that were deployed. Event was uneventful, normal landing. Incorporating a "spoilers stowed" into the "before landing checklist" would prevent this type of distracted event from happening.
Narrative: 2

Queried ATC several times about descent into CRW. Indianapolis Center left us high (outside a 3 degree descent leading to a 4 degree descent into CRW). Continued descent into CRW having to use flight spoilers to get back on profile for the approach into Runway 5 at Yeager airport. The VASI and glideslope were both inoperative. In addition, the landing distance was decreased due to a new displaced threshold on Runway 5. Spoilers were still deployed going through 1,000 feet while descending to the runway on approach speed. In the flare received momentary stick shaker and retracted the partial spoilers that were deployed.

Fatigue and task saturated. ATC left us high going into CRW that lead to the use of spoilers to get back on profile during our descent to the airport. As a result, we were task saturated as a crew given all surrounding circumstances that led us to keep the flight spoilers out of our cross check between both the pilot monitoring as well as the pilot flying. Landing continued since we were in the flare and about to touchdown. Retracted spoilers, event was uneventful.

After using the spoilers always check to make sure they are retracted when you no longer need them. At 1,000 feet always check spoilers as a final safety check.

Synopsis

CRJ flight crew experienced a late descent clearance from ATC. As a result the spoilers were used to get back on a proper glide path and never fully retracted prior to the flare. Stick shaker is activated in the flare and the Captain quickly retracts the spoilers. Glideslope and VASI were both out of service due recent runway modifications.
After landing Runway 30 at EAT, we cleared the runway via a right turn at A4. Then we made a left turn on taxiway A toward the terminal. We found ourselves at a "dead end" with no way to continue to the terminal ramp from our position. Realizing there was limited space to turn around, we called out wing walkers from the station and they
marshaled us while we turned around and exited the "dead end."

The primary cause of this event is airport facility issues at EAT; specifically, the construction currently ongoing at EAT and how it is depicted on the Airport Info chart (plate 10-9). When viewing the chart, it depicts a width of Taxiway A alongside the construction (XXXXX's) that still provides access to the terminal ramp. This is NOT the case. Further, the chart depicts A as the same scale of width that is depicted by Taxiway A that runs the entire parallel from A5 to A1. This same scale of width is currently open from Taxiway A from A4 to A1.

Further, Dispatch to Pilot communication also was a cause in this event. While Dispatch is trying to be helpful in including a note on the release, (it reads):

"Be advised - NOTAM 02/042: Taxiway Closure between A4 and Terminal Apron requires back taxi on Runway when landing Runway 12."

I was landing Runway 30. Therefore, it caused me to disregard the NOTAM. My recommendation is to change the helpful note to read:

"Taxiway A5 provides the only access to the Terminal (ref NOTAM 02/042)."

Human Factors including....

High workload (tail swap, short flight, brief RNP 30, reports of severe icing on approach and moderate turbulence enroute and approach)

Fatigue (I generally fly morning trips and this was a night trip, last leg of 5, tail swap)

Perceptual illusion (with taxiway A4 open and lit, is inviting to exit there rather than roll to A5; and the reflectors and flags along the construction invite a taxi towards the terminal and into the "dead end", as well as the depiction of the construction on the chart)

...led to an insufficient attention to detail in the case of the pilot team reviewing the NOTAMs critically.

Synopsis

A Captain reported inadvertently entering a dead-end taxiway, commenting that the taxiway charting could be improved at EAT airport.
**ACN: 1341482** (31 of 50)

**Time / Day**
- **Date**: 201603
- **Local Time Of Day**: 0001-0600

**Place**
- **Locale Reference.Airport**: ABQ.Airport
- **State Reference**: NM
- **Relative Position.Distance.Nautical Miles**: 15
- **Altitude.MSL.Single Value**: 8500

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

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

**Person : 1**
- **Reference**: 1
- **Location Of Person.Aircraft**: X
- **Location In Aircraft**: Flight Deck
- **Reporter Organization**: Air Carrier
- **Function.Flight Crew**: Captain
- **Function.Flight Crew**: Pilot Flying
- **Qualification.Flight Crew**: Air Transport Pilot (ATP)
- **Experience.Flight Crew.Total**: 25000
- **Experience.Flight Crew.Last 90 Days**: 130
- **Experience.Flight Crew.Type**: 3000
- **ASRS Report Number.Accession Number**: 1341482
- **Human Factors**: Situational Awareness
- **Human Factors**: Confusion

**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)
Experience: Flight Crew: Total : 13000
Experience: Flight Crew: Last 90 Days : 130
Experience: Flight Crew: Type : 1600
ASRS Report Number: Accession Number : 1341479
Human Factors : Situational Awareness
Human Factors : Fatigue
Human Factors : Confusion

Events
Anomaly: Inflight Event / Encounter : CFTT / CFIT
Detector: Automation : Aircraft Terrain Warning
Detector: Person : Flight Crew
When Detected : In-flight
Result: Flight Crew : Took Evasive Action
Result: Flight Crew : FLC complied w / Automation / Advisory

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

Narrative: 1
Descending into ABQ from the east at 10,000 feet I called the airport in sight and asked for and accepted the visual approach to rwy 3. I was monitoring the terrain via radar and altimeter and continued my descent gradually noting a clear path ahead after crossing what I believed to be the last ridge line. I intentionally delayed commencing my descent to final approach fix alt (7400 ft) until crossing the ridge line area approximately 10 mi east of the field. I had intentionally slowed to approximately 225 kts to limit high speed descent/closure rates over the area terrain. As I extended the speed brakes and began to descend passing approx. 8500 ft the EGPWS went off. Caution terrain immediately followed by pull-up. I commenced the CFIT maneuver and as the power and nose came up the warnings ceased. After ensuring we were clear of terrain I resumed normal flight to the visual approach rwy 3 and landed uneventfully.

In reviewing this event in my mind I recalled extending the speed brakes earlier in the descent to slow to 225 kts in the attempt to avoid and prevent the high descent rates once in terrain. During the recovery and as my FO backed me up on procedures I realized that the speed brakes were extended. I do not recall if the speed brakes had remained extended from the initial descent or from the final descent to the field. In any case the speed brakes extended probably exacerbated the situation. This event is haunting to say the least.

Narrative: 2
On our descent into ABQ, out of 8500 ft, we had an EGPWS alert. The captain was flying, he executed the recovery and we concluded that it was from a high descent rate. We then continued with the visual approach and landed uneventfully. As for the fatigue issue, I had a hard time sleeping before the flight.

Synopsis
Air carrier flight crew received an EGPWS while descending into ABQ from the east on a visual approach to Runway 3.
ACN: 1340998 (32 of 50)

Time / Day
Date: 201603
Local Time Of Day: 1801-2400

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

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

Aircraft
Reference: X
ATC / Advisory.Tower: ZZZ
Aircraft Operator: Air Carrier
Make Model Name: Dash 8-400
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 Not Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1340998
Human Factors: Situational Awareness
Human Factors: Workload
Human Factors: Distraction
Human Factors: Fatigue

Events
Anomaly.Deviation - Procedural: Published Material / Policy
Anomaly.Inflight Event / Encounter: Weather / Turbulence
Anomaly.Inflight Event / Encounter: Fuel Issue
Detector.Person: Flight Crew
When Detected: Taxi
Result.General: None Reported / Taken

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

**Narrative: 1**

After a long day for my FO (well beyond his FDP limit, and only after arguing with scheduling to notify him of that FDP extension) we were flying into ZZZ. It is a very short flight normally. When we checked in with the controller for the approach, we were told that the winds were a straight tailwind at 14 knots, gusting to 20 knots. When I input the landing data for a 20 knot tailwind, the return stated that we were overweight for that runway. The other runway is not permitted by our operation at night. However, if the wind died down (as it was forecast to) to a steady state of 15 knots or less we would be under the max landing weight for that approach. We continued the approach, understanding that we would go missed prior to the MAP if the winds did not die down. During the descent we picked up ice. When I ran the performance numbers with residual airframe ice, we were over landing weight for that approach. By this time we were on the approach, and cleared for it--about 20 miles from the runway. Seeing that we were overweight if the ice remained (the weather was VMC at the field, and a few degrees above freezing) we decided to continue the approach--again understanding that we would go missed at the MAP if the ice was still present.

Just after intercepting the LOC the tower informed us that the wind has calmed down to a steady 11 knot tailwind, with no gusts. We informed them that we would continue, but with the understanding that we might have to go missed due to airframe ice. I also ACARSed dispatch to tell them that if we went missed, that we would likely head to ZZZ1. Also, in our minds ZZZ1 would have some ability to accommodate passengers, as we both knew my FO would not have been able to depart if we diverted at all. Less than a mile prior to the MAP we observed the last ice to melt off the airplane, so we continued the landing and landed without incident. After we landed my FO realized that some control buttons were still off, at which point we realized that in all of the challenge of finding a legal landing solution and considering the missed approach options that we had failed to perform an approach checklist. I should have noted that the pumps were not on as I did the landing checklist, as that would have clued me in to the fact that we had not accomplished the approach checklist.

**Synopsis**

Dash-8-400 Captain reported being task-saturated by weather and legalities resulting in forgetting to accomplish the Approach Checklist. The flight landed uneventfully.
ACN: 1339065 (33 of 50)

**Time / Day**
- Date: 201603
- Local Time Of Day: 1801-2400

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

**Environment**
- Flight Conditions: IMC
- Weather Elements / Visibility: Rain
- Weather Elements / Visibility: Thunderstorm
- Light: Night

**Aircraft**
- Reference: X
- 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

**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: 1339065
- Human Factors: Fatigue
- Human Factors: Situational Awareness
- Human Factors: Workload
- Human Factors: Communication Breakdown
- Communication Breakdown.Party1: Flight Crew
- Communication Breakdown.Party2: Ground Personnel

**Events**
- Anomaly.Other
- Detector.Person: Flight Crew
- Result.General: Physical Injury / Incapacitation
- Result.Flight Crew: Took Evasive Action

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

Narrative: 1

I was flying. Due to weather, maintenance events, and operational issues, I was faced with a duty day extension. With the captain's insistence, I agreed to extend at an outstation to get the plane, passengers, and crew back to our domicile. I ended up extending two hours and ended up blocking 8.5 hours of flights on this day, while a large portion of it was delays in taxi due to weather and ops at our home airport. The total LOGGED duty day was over 13:43 and I state over due to the fact that we had to take the flight attendants' van due to the company's inability to ensure that we had transportation set up for us in overnight station. The company did not have a van for the pilot(s) and we were forced to take the earlier van, thus truly starting this day off earlier than scheduled and adding to the fatigue.

This event only gets worse as this incident report will attempt to summarize. I attempted to secure other transportation but was not able to do so and the captain was unwilling to press this issue. He just wanted to take the earlier van. After going to the room to attempt to get rest in overnight hotel, I was met with a room close to a doorway to hallway stairway and slamming doors. The elevator was also located adjacently. The captain secured a new room but I was not able to secure a new room. He was moved to suite and executive area further up in the hotel. I was not able to get an uninterrupted period of rest due to this and was also forced to take an earlier van which also forced me [to] awaken earlier and cut off 2 hours long and our flight down with all the delays, ended up being right at 4 hours long.

Once on the ground at our overnight station, we were met with an extension request. I agreed to extend to get the passengers, crew and plane home. After agreeing to extend, this trip started to unravel more. I was met with a maintenance issue that had to be addressed and on the taxi out, a data link issue with ACARS occurred that caused a longer delay. By the time we landed and processed in via customs late at night, (global entry was closed and we were forced to be in line with everyone else) my duty day actually hit 15:00+ hours. With the heavy rains, I could not get to the parking lot due to backed up traffic via the employee busses backed up. Due to all this, I got home and in bed around after midnight.

I had another 2-day trip staring mid-morning. On the drive home, I called scheduling, to discuss this etc. During this time, a two-day trip over the same period came into open time with a late afternoon show time. I asked the schedulers if due to this extended trip and late night arrival they would trade a 2-day trip for a 2-day trip that was open and showed later in the afternoon and they REFUSED. All I wanted to do was mitigate a fatigue event by trading my two trip that showed later in the afternoon. Again, the schedulers refused and I declared fatigued for my trip that showed in just a few hours due to all the factors listed in this report, lack of adequate rest in the hotel room provided the night before, lack of contract specified hotel transportation and inability to secure additional transportation, as none was available at the time, and finally, the lack of the scheduler's ability to trade a nest day 2 day trip for a trip in OPEN TIME that would have given me more rest and mitigated this fatigue event all together.

I am being charged sick time for this event. I am requesting that I be paid for this fatigue
event by this company and not by sick time. I exhausted every effort and even went above and beyond to try to mitigate this working with scheduling to fly out later but they refused and chose to instead use 2 reserves instead of trading a 2-day trip for a 2-day trip and allowing me to get rest, go out later, and ultimately run a more efficient operation during a critical weather event.

I understand that it is my job to fly and scheduling’s job to schedule but once again this group could not see the forest for the trees. I looked out for the best interests of the company, crew and safety and now I am being penalized with a deduction of my sick time. This is not right and I am sure that you all will see the large picture in this report. The fact of the matter is that I was not safe to fly the next 2-day and I tried to help by offering a solution that was not going to be accepted based on some principal that made no sense. I was fatigued due to combination of events but more so do to the operational inefficiencies of the scheduling group's inability to work with this event on a perfectly legal trade both in contractual terms and FAR terms.

Synopsis
First Officer describes a day's events which resulted in flight time over 8 hours and duty time. He was forced to call in fatigued after crew scheduling refused to permit a later check in trip.
Time / Day
Date: 201603

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: A320
Crew Size.Number Of Crew: 2
Operating Under FAR Part: Part 121
Flight Plan: IFR
Mission: Passenger

Person
Reference: 1
Location Of Person.Aircraft: X
Location In Aircraft: Flight Deck
Reporter Organization: Air Carrier
Function.Flight Crew: First Officer
Function.Flight Crew: Pilot Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
Experience.Flight Crew.Total: 9091
Experience.Flight Crew.Type: 4496
ASRS Report Number.Accession Number: 1339060
Human Factors: Fatigue

Events
Anomaly.Aircraft Equipment Problem: Less Severe
Anomaly.Deviation - Speed: All Types
Anomaly.Deviation - Procedural: Published Material / Policy
Anomaly.Deviation - Procedural: FAR
Detector.Person: Flight Crew
When Detected: In-flight
Result.General: None Reported / Taken

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

Narrative: 1
Both the captain and I were completely fatigued on the last leg of the trip because of the pairing schedule. We started with an all-nighter, with 13 hours rest during the daytime, flew a late nighter [east coast to west coast] and arrived near midnight. Then we had a short 11 hour rest and then a very early wake up on the last day for a XA:45 AM van pickup for a three leg, 11 hour day. We both realized that we shouldn't have left [on second leg] that morning because we were already feeling the fatigue. But, due to our devotion to the airline and our professionalism we thought we could handle the turn [out and back]. We were wrong. We both were so fatigued on the third leg we were making mistakes. I personally exceeded the 250 KIAS below 10,000 feet MSL limit by about 15 knots, because of my fatigue and the fact that with the sun angle, and even with the PFD (Primary Flight Display) as bright as it would go, I did not see the LVR CLB flashing on the PFD to cue me to select climb power, because the PFD was too dim. If I had not been fatigued I'm sure I would have noticed that we were not maintaining 250 KIAS based on the noise not because I could see the airspeed well enough. I realized at that point just how fatigued I was and it was a painful flight all the way back.

The captain was making his mistakes too, including clearing the ground crew to disconnect electrical power without verifying the APU was operating. He also nearly made some taxi mistakes that I barely caught in time after finishing my "heads down" taxi out duties, e.g., runway change and runway data acquisition. I won't mention any other mistakes the captain made, but it was obvious our fatigue was serious. Our communication skills suffered severely because of or fatigue.

This pairing is a disaster for crew rest. The next time I feel like I did that morning, and have two flights to go, I will not hesitate to call in fatigued. I will just feel bad that the flight will most likely have to cancel. These pairings that mix two all-nighters with [an early morning] departure are a disaster. Haven't we learned that after an all-nighter that a lot more rest is needed than normal? If that pairing had the last flight be the one leg to base that would have been bad enough, but to add on a turn? Disaster! When I mention this screen intensity problem to Standards Captains, LCAs (Line Check Airmen), and PIs (Pilot Instructors) I fly with, they all indicate there's nothing they or anyone can do. I emailed the [Chief Pilot] about it who said he would look into it.

**Synopsis**

A320 First Officer described an extremely fatiguing three day pairing that is exacerbated by insufficient brightness of the cockpit display screens.
ACN: 1331351  (35 of 50)

Time / Day
Date: 201508
Local Time Of Day: 1201-1800

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

Environment
Light: Daylight

Aircraft
Reference: X
ATC / Advisory.Tower: ZZZ
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: Takeoff

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

Person: 1
Reference: 1
Location Of Person.Aircraft: X
Location In Aircraft: Flight Deck
Reporter Organization: Air Carrier
Function.Flight Crew: Pilot Not Flying
Function.Flight Crew: Captain
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1331351
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)
ASRS Report Number: Accession Number: 1331038

Events
Anomaly: Aircraft Equipment Problem: Less Severe
Anomaly: Flight Deck / Cabin / Aircraft Event: Illness
Anomaly: Deviation - Procedural: MEL
Anomaly: Deviation - Procedural: Published Material / Policy
Detector: Person: Flight Crew
Were Passengers Involved In Event: Y
When Detected: In-flight
Result: Flight Crew: Rejected Takeoff
Result: Flight Crew: Returned To Gate

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

Narrative: 1

ATC cleared us for takeoff, taxied onto runway, stopped the aircraft and transferred controls to the FO. He advanced throttles toward manual max TO EPR setting, FO said "set power", when setting power I noticed amber line on EPR below green carrot, looked at the airspeed as it approached eighty knots, then checking engine instrument I had amber indications on both engines, the right EGT rising through 79, and the left N3 amber. For safety of flight I chose to abort not sure of the reliability of both engines. Started the abort, called "abort". The RTO applied brakes aggressively. The aircraft was slowed and we exited the runway. Engine instruments were now at normal indications.

ATC asked reason for abort we said indications, we requested a place to analyze the aircraft (run checklist) [and] they cleared us to taxi to the cargo pad straight ahead. FO made PA to the pax regarding the abort. Upon arrival at pad before we could analyze the aircraft, the FA called up and advised of a medical emergency. We did not know the severity of the medical emergency so, we requested a gate from ATC. We parked at gate, ran parking checklist, talked to FA about medical which ended up being a panic attack. Then had agent to deplane pax. FO went out for post flight walk around the aircraft, [and] FO informed me on his return that the fuse plugs blew. I made phone calls to dispatch, the duty pilot, and mx control. Then went out myself to check the aircraft. Then I called the 757 fleet manager. Outside mx arrived promptly to the aircraft, he asked what happened and to write it up in the logbook. Completed logbook. After pax deplaned and aircraft cleaned, I requested a post briefing with the crew. The extra taxi for the medical emergency added to the already hot brakes causing the fuse plugs to blow.

I feel part of my abort decision was influenced by earlier events in the week. I had a stuck throttle, I heard about a stuck elevator abort, the failure of one engine is manageable when the other engine is at a hundred percent. So even though we briefed the takeoff, in that split second my mind said something's not safe and I aborted. Both the FO and I are new to the aircraft, better AOM/MEL procedures would be of help. The aircraft had [an] MEL which was a factor in the event. It had numerous notes that are different from standard, we looked them up and briefed them before leaving. The takeoff was uneventful but not sure we missed something regarding the MEL we spent cruise studying the manuals. After studying we still weren't sure if we were setting up the aircraft right per the
MEL. I called the 757 fleet manager for clarification, we changed the settings for the takeoff.

**Narrative: 2**

Make improvements to the Minimum Equipment List regarding the operations of a deferred Autothrottle System. Part of the deferral is very vague. It states: "Assumed temperature (if used) will not be available." I understand what it means now, but at the time I assumed that the "Assumed Temperature method" for takeoff was not available. It would be easier to understand the terminology if it were written: "Assumed Temperature (if used) will require manual setting". This was not a direct cause for the aborted takeoff, but it may have prevented the event from occurring due to a lower power setting.

**Synopsis**

B757 flight crew reported they rejected the takeoff when engine EGT temperatures reached the amber range.
ACN: 1330424 (36 of 50)

Time / Day

Date: 201602

Place

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

Aircraft

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

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)
Experience. Flight Crew. Last 90 Days: 144.47
Experience. Flight Crew. Type: 4702.18
ASRS Report Number. Accession Number: 1330424
Human Factors: Fatigue

Events

Anomaly. Deviation - Procedural: Published Material / Policy
Anomaly. Deviation - Procedural: FAR
Detector. Person: Flight Crew
When Detected: Pre-flight
Result. Flight Crew: Took Evasive Action
Result. Flight Crew: Became Reoriented

Assessments

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

Narrative: 1

This is a Fatigue report filed because I called Fatigue on day three of a three day trip and did not complete the last two legs.

I'll mention the first night [Day 0] at the [hotel] (even though it sometimes appears that
really not much weight is given to accumulating sleep deficits) only because the first night of this trip I was already set back in my sleep. We arrived late on Friday night at the [hotel] and I was assigned a midlevel room on the east side of the building. I was awake until about XA:30 as the sounds of people and their motorcycles and cars were quite loud from the street as the bars closed and let out. I slept maybe five hours this first night, but was still fit for duty on day two.

On the second night [Day 1] of this trip, we were at [different] Hotel. It pains me to write anything derogatory about this hotel because it is one of the finest in our system. On Saturday night, however, the annual Winter Ball was at the hotel - and the hotel assigned us rooms in the out building, which is an older building that is not part of the main hotel property. The receptionist said, "I'm sorry, we don't have rooms for you here in this building tonight. You'll be across the street." Immediately outside my door was the elevator doors, and I heard people coming and going until the wee hours of the morning. Worse, right outside my window was a frat house - complete with an outdoor terrace. There was a large frat party this night that went until XA:00, complete with young girls screaming, and the sounds of furniture being tossed out the windows, I kid you not. See the pictures. So I had elevator noise through my door and a great frat party making noise outside my window. I got to sleep at around XA:00 and woke at XE:00 for our pickup. I was facing a 12 hours day on four hours of sleep. Not gonna happen. I did the first leg and called fatigued.

**Synopsis**

A Captain called off a trip fatigued on the third day after two nights of sleep deficit at hotels where late loud noise interfered with rest opportunities.
**Time / Day**
- Date: 201602
- Local Time Of Day: 1801-2400

**Place**
- Locale Reference.Airport: CHO.Airport
- State Reference: VA
- Altitude.MSL.Single Value: 3000

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

**Aircraft**
- Reference: X
- ATC / Advisory.TRACON: PCT
- 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
- Nav In Use.Localizer/Glideslope/ILS: Runway 3
- Flight Phase: Final Approach
- Airspace.Class D: CHO

**Component**
- Aircraft Component: ILS/VOR
- Aircraft Reference: X
- Problem: Malfunctioning

**Person : 1**
- Reference: 1
- Location Of Person.Aircraft: X
- Location In Aircraft: Flight Deck
- Reporter Organization: Air Carrier
- Function.Flight Crew: Pilot Not Flying
- Function.Flight Crew: Captain
- Qualification.Flight Crew: Air Transport Pilot (ATP)
- ASRS Report Number.Accession Number: 1330266
- 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
Narrative: 1

On approach into CHO we were being vectored onto the ILS 3. We were at 3000 when we were given a clearance of "turn right 360 to intercept maintain 3000 till established clear ILS 3." Once on the 360 heading the autopilot captured the LOC and glide slope simultaneously. This caught me off guard because my HSI was not displaying a glide slope indication. I looked over to my FO's HSI (FO was the PF) and his showed us tracking on glide slope and both sides had a good ID. At that point I assumed there was something wrong with my glide slope indication, however it was not flagged, the glide slope was simply out of view. Upon cross checking our altitude with the DME I saw that we were well below that glide slope and that the indication on the FO HSI had to be wrong. It was at that point that ATC advised us that we were below the glide slope and issued us a low altitude alert, to which I replied "correcting." As I was replying to ATC we picked up the field visually. I called the field in sight and we were cleared for the visual. Once on the ground I called MX and wrote up the FO glide slope indication. Upon conference with MX I learned that the aircraft had a history of FO side ILS indication issues.

This event occurred because of a mechanical issue with the FO side NAV equipment. This event took longer than it should have to detect and remedy, because I as PIC and pilot monitoring was feeling the effects of fatigue. It was day 4 that had me working all across the system, going from mornings to nights, with multiple different crews and I had been on duty for almost 12 hours. I believe that if I was not so tired I would have had a better grasp of the big picture and been able to detect the problem and intervene before it became an issue. There is a fatigue report associated with this ASAP.

These ILS issues seem to be becoming more frequent in [our] fleet. In the future, I will be more vigilant of where we are and what ALT we should be at, also I will level off and stop the descent at the first sign of the HSIs disagreeing.

Narrative: 2
[Report narrative contained no additional information.]

**Synopsis**

Air carrier flight crew reported descending below the glideslope on approach to CHO when the First Officer's glideslope indications were erroneous.
During my rest break I was awakened by a loud bang on the pilot crew rest bunk door. I attempted to go back to sleep but couldn't due to a galley cart that was parked in front of the door knocking against it every time the aircraft moved from the light turbulence we were experiencing. I got dressed and attempted to exit the bunk but couldn't because of the galley cart parked in front of the door. I waited for the cart to be moved and exited the bunk. The ISM (Inflight Service Manager)/purser and another flight attendant were in the galley. I told them to stop parking carts in front of the bunk door for two reasons, noise
from the cart knocking on the door, and we couldn't get out of the bunk in the event of an emergency. [The] flight attendant immediately became argumentative with me. He asked me which manual prevented them from parking a cart in front of the bunk door. He said that it's a galley and that I should expect that kind of noise. He told me to use ear plugs. Here's the best one. He said it's a galley design flaw from Boeing. I gave up after that one. From his argumentative careless attitude towards my concern I was obviously wasting my time trying to fix the problem with this flight attendant. This is a constant issue.

In conclusion, I believe that galley carts should not be parked in front of the pilot crew bunk door in the interest of safety. Galley carts banging on the door make sleep impossible and prevent us from exiting the bunk in the event of an emergency.

Synopsis

B787 First Officer reported his rest was interrupted by noises from a galley cart that was parked next to the bunk room door.
ACN: 1327199  (39 of 50)

Time / Day
Date: 201601

Place
Locale Reference. ATC Facility: ZZZ.ARTCC
State Reference: US
Altitude. MSL. Single Value: 34000

Environment
Flight Conditions: VMC

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

Component
Aircraft Component: Other Flight Crew Seat
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: First Officer
Function. Flight Crew: Pilot Not Flying
Experience. Flight Crew. Total: 13944
Experience. Flight Crew. Last 90 Days: 158
Experience. Flight Crew. Type: 9893
ASRS Report Number. Accession Number: 1327199
Human Factors: Fatigue
Human Factors: Distraction

Events
Anomaly. Aircraft Equipment Problem: Less Severe
Anomaly. Flight Deck / Cabin / Aircraft Event: Other / Unknown
Anomaly. Deviation - Procedural: Published Material / Policy
Detector. Person: Flight Crew
When Detected: In-flight
Result: General: Physical Injury / Incapacitation

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

Narrative: 1
I did not sleep during my rest break on this flight. I was very tired during the descent and approach. At that point, it was not practical to go back to the bunk and try again. I'm glad nothing went badly. Here's how I got into this situation.

This plane is one with the "notch" carved out of the head space for stowage of flight attendant emergency equipment. It also has a smoke detector on the ceiling right above the head space. The smoke detector has a bright green indicator light which is too bright and is a nuisance when trying to doze off. Until recently, it has been common to find various light blockers over the green light intended to mitigate the nuisance. Frequently those light blockers were successful. Also frequently they did not impede the light's function. One example is the gray disks that were removed from the MRD folder and placed over the indicator. Those were not opaque, so function was not impaired, but they were enough of a block to reduce if not eliminate the nuisance. Unfortunately, some authority has taken it upon himself to decide that having the light at full brightness directly over the resting pilot's face is more important than allowing the resting pilot to doze off naturally, and has made an issue of having ANY mitigation in place. That was the situation I encountered in this case. The light was directly over my face, and because of the notch space for the flight attendant equipment I could not move my face far enough to the side to get out from under the light. I was unable to doze off because of the light.

This is simply the latest example of the farce that the crew rest facility conversation has become. It is abundantly clear that nobody - is serious about on board crew rest. If anybody was serious about it, something serious would have been done by now.

In this case, the fleet has promised some sort of "stop gap" measure, such as first class eye shields, to provide an ability to manage this light issue. Those have not been provided, but the self-help mitigation measures have been removed and emphatically prohibited. What message does that send? It is yet another acknowledgement that the facility is inadequate, i.e., is not dark enough to allow comfortable sleep, but that it doesn't matter. If it did matter the eye shields at the very least would have been provided before all the planes were "scrubbed" for stickers. This is on top of previous suggestions from the fleet that we should wear foam ear plugs to mitigate the well-documented noise issues. Again, that is an admission that the facility is too noise-prone to allow comfortable sleep.

So here is what the company and the FAA have admitted. The current rest facility is too noisy. Nothing has been done. The current rest facility is too brightly illuminated. Nothing has been done. The temperature cannot be controlled. Nothing has been done. The bed itself is not large enough. Nothing has been done. And that it is more important for the flight attendants to have a vertical stowage closet than for pilots to have adequate head space. All this after years of conversation about an on board rest facility.

Synopsis
A B777 First Officer described his company's inhospitable crew rest bunk conditions which are not conducive to sleep and result in flight crew fatigue during the flight's final stages.
Time / Day
Date: 201601
Local Time Of Day: 1201-1800

Place
Locale Reference.Airport: ZZZ.Airport
State Reference: US
Altitude.MSL.Single Value: 800

Environment
Flight Conditions: VMC
Light: Daylight

Aircraft
Reference: X
ATC / Advisory.TRACON: ZZZ
Aircraft Operator: Air Carrier
Make Model Name: Medium Large Transport
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
Airspace.Class B: ZZZ

Person
Reference: 1
Location Of Person.Aircraft: X
Location In Aircraft: Flight Deck
Reporter Organization: Air Carrier
Function.Flight Crew: Captain
Function.Flight Crew: Pilot Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1326553
Human Factors: Communication Breakdown
Human Factors: Distraction
Human Factors: Fatigue
Communication Breakdown.Party1: Flight Crew
Communication Breakdown.Party2: Flight Crew

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

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

Narrative: 1

Vectored to the usual 35 mile final for ILS. "180 knots to FAF, contact tower at FAF." Coming down the approach that never ends, I noticed traffic backed up on the [local] expressway and started thinking how it was nice not to be stuck in that. Unfortunately, my mind wondered to other related topics. Although I was watching the runway the whole way down, in my apparent daydreaming, it didn't click how close we were getting to it. At about 800 feet AGL, the First Officer says, "Oh, do you want Flaps 3?", followed by a Landing Gear alert from the EGPWS. My mind finally snapping back from LaLa Land, told him "Oh @&$, no, let's go around." We broke off the approach and TRACON was kind enough to get us back in pretty quick. Besides a bruised ego, the second approach attempt was successful and uneventful.

A temporary loss of situation awareness by both crew members and insufficient Threat Management on my part. I think some mild fatigue didn't help.

Unfortunately, being primarily in the Training Department, I don't fly as much as I used to. I pick up trips to stay current. Otherwise, due to training workload, I would fly even less. I used to be able to get right back in the cockpit and not miss a beat. The day prior to this, I would say that was the case. But, with age and maybe some mild fatigue added to the mix, this event has taught me I can no longer rely on that "like riding a bicycle" feeling. I will need to make it more of a point to the First Officers to not let the "CKA" next to my name keep them from watching me.

In this particular case, the First Officer stated that he was distracted as well, which was probably the case since he was pretty sharp. It was also a good training opportunity to emphasize to him to not let a Captain (or himself) try to salvage an un-stabilized approach like that. A non-punitive go-around is much preferable to a starring role in a FOQA video.

Synopsis

Air carrier Captain reported they did not configure final flaps in the approach and thus executed a missed approach.
ACN: 1325857 (41 of 50)

Time / Day
Date: 201601
Local Time Of Day: 1801-2400

Place
Locale Reference.Airport: ZZZ.Airport
State Reference: US
Altitude.MSL.Single Value: 2400

Environment
Flight Conditions: VMC
Light: Night

Aircraft
Reference: X
ATC / Advisory.TRACON: ZZZ
Make Model Name: Small Transport, Low Wing, 2 Recip Eng
Crew Size.Number Of Crew: 2
Operating Under FAR Part: Part 121
Flight Plan: IFR
Mission: Passenger
Flight Phase: Climb
Airspace.Class B: ZZZ

Component
Aircraft Component: Fuel
Aircraft Reference: X

Person: 1
Reference: 1
Location Of Person.Aircraft: X
Location In Aircraft: Flight Deck
Function.Flight Crew: First Officer
Function.Flight Crew: Pilot Not Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1325857
Human Factors: Fatigue
Human Factors: Situational Awareness
Human Factors: Time Pressure
Human Factors: Communication Breakdown
Communication Breakdown.Party1: Flight Crew
Communication Breakdown.Party2: Ground Personnel

Person: 2
Reference: 2
Location Of Person.Aircraft: X
Location In Aircraft: Flight Deck
Function.Flight Crew: Captain
Function: Flight Crew : Pilot Flying
Qualification: Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number: Accession Number : 1325859
Human Factors : Time Pressure
Human Factors : Situational Awareness
Human Factors : Communication Breakdown
Human Factors : Fatigue
Communication Breakdown. Party1 : Flight Crew
Communication Breakdown. Party2 : Ground Personnel

Events
Anomaly. Aircraft Equipment Problem : Less Severe
Anomaly. Deviation - Procedural : Published Material / Policy
Anomaly. Deviation - Procedural : FAR
Anomaly. Inflight Event / Encounter : Fuel Issue
Detector. Person : Flight Crew
Were Passengers Involved In Event : Y
When Detected : In-flight
Result. Flight Crew : Returned To Departure Airport
Result. Air Traffic Control : Issued New Clearance

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

Narrative: 1
To avoid exceeding duty time limitations we were required to execute a quick turn and promptly depart. During our time between flights we placed a fuel order with Dispatch for 34 gallons per side. Shortly after ordering the fuel we requested that the passengers be sent to the aircraft. We then proceeded to taxi out to runway and depart. Upon reaching approximately 2400 feet we observed that we had not received our requested fuel order. Although we did have the required one-way fuel, we decided that due to the winds aloft we would be subject to fuel constraints later in the flight and then decided to return to [the departure airport].

To avoid recurrence of this event, we will perform very thorough flows and make sure that we verify that fuel has been received prior to boarding the aircraft. All flows will be conducted thoroughly and as a First Officer I will verify that all flows and checklists are completed.

Narrative: 2
My copilot and I departed after a quick turn due to a duty time issues so we would not exceed our duty time we had put an order in for 34 gallons a side and did not receive it. We then proceeded to taxi and take off with enough fuel for one way but with the prevailing headwinds it would not have been enough to make it to our alternate if needed so we both decided to return to [the departure airport].

Synopsis
The pilots of a small transport aircraft reported departing in a time pressure condition only to discover that the requested fuel load had not been added. This resulted in a return to the departure airport.
ACN: 1325157 (42 of 50)

Time / Day
- Date: 201601
- Local Time Of Day: 0001-0600

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

Environment
- Flight Conditions: VMC
- Light: Night

Aircraft
- Reference: X
- 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: Climb
- Airspace: Class A: ZZZ

Component
- Aircraft Component: Hydraulic System
- 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: Pilot Flying
- Function: Flight Crew: Captain
- Qualification: Flight Crew: Air Transport Pilot (ATP)
- Experience: Flight Crew: Last 90 Days: 210
- Experience: Flight Crew: Type: 741
- ASRS Report Number: Accession Number: 1325157
- Human Factors: Communication Breakdown
- Human Factors: Confusion
- Human Factors: Fatigue
- Human Factors: Time Pressure
- Human Factors: Distraction
- Communication Breakdown: Party1: Flight Crew
- Communication Breakdown: Party2: Ground Personnel
- Communication Breakdown: Party2: Dispatch

Events
Anomaly: Aircraft Equipment Problem : Less Severe
Anomaly: Deviation - Procedural : FAR
Anomaly: Deviation - Procedural : Published Material / Policy
Detector: Person : Flight Crew
When Detected : In-flight
Result: Flight Crew : Diverted
Result: Flight Crew : Landed As Precaution

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

Narrative: 1

We were on the second duty day of a trip. The pick up at our hotel was at XA:50 local time. We flew [the] flight prior to ZZZ.

On the second leg, we had a HYD YELLOW RSVR LO ECAM right after takeoff. The Yellow system hydraulic fluid was completely lost and empty. We performed the ECAM and the checklist. Although I wanted to return, after consulting the Company and my First Officer (FO) (who had recently experienced the same problem) they all recommended that we continue (3+ hours left in the flight). According to them, that recommendation was made based on: the remaining system was operating normally; QRH does not call for "land(ing) at the nearest suitable"; and QRH is "controlling". Although I felt somewhat uncomfortable continuing the flight with the loss of a major hydraulic system, especially on a dark night, I agreed with the recommendation to continue. Soon into the cruise, I reviewed both the "Yellow & Green HYD System Loss" checklists, just in case we also lost the Green system, which I thought, would put us in a challenging situation for sure. Plus, I was still feeling that we were in a state where "A critical system redundancy is lost." So, I reestablished the radio conference. After a careful review, they now all agreed with me that we should divert instead of continuing. We diverted to ZZZ1. The flight landed overweight and completed the loss of Accumulator pressure on approach.

We were not even at the gate when the station was calling us on the radio to see if we would agree to continue the flight to ZZZ2. Immediately after completing the flight, both a mechanic and station personnel came on board asking about continuing the flight. I had not even had a chance to talk with Dispatch or Scheduling, when people started bombarding me with questions. I asked them to give me a chance to talk with the company. I next had a talk with Maintenance, the Station Manager, Dispatch, and the Ops Manager. He asked me to waive the 30 min duty extension to continue the flight to ZZZ2. He told me the new plane would arrive in time for an XB:15 departure and I agreed to extend.

Soon after that conversation, I received information that the arrival of the plane would not be until after XB:04. I called back only the Operations Manager had already gone home. Now I was on the phone with another Operations manager who told us that he needed a 2 hour extension. I couldn't tell the passengers that we wouldn't be flying the flight just a few minutes after announcing the flight would continue based on the 30 minute extension. For the sake of our customers, we decided to press on and reluctantly agreed to extend. FO confirmed with me several times that the Crew Critical Off time (CCO) time was now XH:57 even though an ACARS message said XH:00. He "updated" the CCO and we
received the revised ACARS message of XH:57. During the climb we received the ACARS message "Extension not available. Must return to the gate." Dispatch stated that we had exceeded the CCO time of XH:05 when we took off at XH:06. This CCO time of XH:05 was never addressed before. I asked what they wanted us to do at that point. Dispatch was consulting with the FAR 117 desk and Ops Manager. It took a while for them to respond and when they did, Dispatch informed us that if we expedited the taxi after landing in ZZZ1, we should be okay. I further asked Dispatch if we had in fact exceeded the CCO time or not. Dispatch said they were reviewing the information to find the answer. After some wait, the Ops Manager sent us an ACARS message saying we had not exceeded the FAA time but the company CCO time. I do not have full confidence in that explanation. If we were okay, then why had they sent us the "must return to the gate" message to begin with? The flight continued and landed normally in the very early hours of the morning.

Synopsis

The A320 lost the yellow hydraulic system and diverted, which put them in a confusing FAR 117 situation.
**ACN: 1324319 (43 of 50)**

**Time / Day**
- Date: 201601
- Local Time Of Day: 0601-1200

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

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

**Aircraft**
- Reference: X
- 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
- 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)
- Experience.Flight Crew.Last 90 Days: 169
- Experience.Flight Crew.Type: 11000
- ASRS Report Number.Accession Number: 1324319
- Human Factors: Fatigue
- Human Factors: Situational Awareness
- Human Factors: Distraction

**Person: 2**
- Reference: 2
- Location Of Person.Aircraft: X
- Location In Aircraft: Flight Deck
- Reporter Organization: Air Carrier
- Function.Flight Crew: First Officer
- Qualification.Flight Crew: Air Transport Pilot (ATP)
- Experience.Flight Crew.Last 90 Days: 158
- ASRS Report Number.Accession Number: 1324307
- Human Factors: Fatigue
Human Factors: Distraction
Human Factors: Situational Awareness

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

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

**Narrative: 1**

Pushback from Gate; leg 2; first leg involved a 0315 body clock lobby. I felt fine before push and in no way thought I was fatigued. On pushback, the gate to our immediate right commenced push before we had unhooked from the tug. We were watching them closely as we required a left 270 degree turn in order to clear them, which we did. I felt the flow on the flight deck was unhurried and normal.

On taxi, we noticed that we’d not placed the transponder to TA/RA (at this point we should have expanded our SA). When I performed the throttle check, we found that the flaps were still up. We placed them to 1, completed the Before Taxi Checklist (again? for the first time?) and took off.

During the climb to cruising altitude, there were a couple of minor mistakes made (switch to a new frequency and fail to check in, 10,000 feet callouts/items performed late) that indicated that both of us may not have been as sharp as we felt we were. Neither of us is certain if the Before Taxi Checklist was completed (the First Officer believes maybe; I do not remember it at all).

It is possible that in our desire to not taxi into the pushback aircraft, I started to taxi without calling for the checklist. I do remember asking the First Officer to watch my wing all the way through the turn. It is also possible that I called for the checklist before the First Officer had called "standing by flaps" and we compounded that by failure to verify the steps of the checklist.

I can state without reservation that failure to put the flaps down, regardless of error trapping, is fairly egregious error. I’ve never done this before and feel that I am diligent in my checklist discipline. It is inexcusable regardless of the distractions encountered, but interesting (and significant) that we would both miss it simultaneously. I am relieved that the built-in error traps caught the mistake before we made it to the takeoff run up. Before today I would have thought it very unlikely that I would get caught in this particular event chain. Cheap lesson learned with nothing more than an ego hit. Having said that, and not taking any culpability off my shoulders, it is my belief that this was made possible in no small part by scheduling practices. Red-eye flying can be done safely, but requires a bit more planning and lead-in rest than we are currently devoting to it. Knowing this, it is incumbent on me to be the last link in the safety chain and be a bit more mindful when the schedule puts us at increased risk of a similar event again.

**Narrative: 2**
[Report narrative contained no additional information.]

**Synopsis**

B737 flight crew forgot to set the flaps before taxi, but discovered the mistake during the throttle check while taxiing out. Fatigue and distractions during pushback reportedly played a role in the mistake.
**ACN: 1323105** (44 of 50)

**Time / Day**
- Date: 201601
- Local Time Of Day: 0001-0600

**Place**
- Locale Reference: Airport: ZZZ.Airport
- State Reference: US
- Altitude.MSL.Single Value: 14000

**Environment**
- Light: Night

**Aircraft**
- Reference: X
- ATC / Advisory.Center: ZZZ
- Aircraft Operator: Air Carrier
- Make Model Name: Large Transport, Low Wing, 2 Turbojet Eng
- Crew Size.Number Of Crew: 2
- Operating Under FAR Part: Part 121
- Flight Plan: IFR
- Mission: Passenger
- Flight Phase: Climb
- Airspace.Class E: ZZZ

**Component**
- Aircraft Component: AC Generation
- 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: 1323105
- Human Factors: Distraction
- Human Factors: Fatigue
- Human Factors: Human-Machine Interface
- Human Factors: Situational Awareness
- Human Factors: Communication Breakdown
- 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: First Officer
Function.Flight Crew: Pilot Flying
Qualification.Flight Crew: Air Transport Pilot (ATP)
ASRS Report Number.Accession Number: 1323106
Human Factors: Situational Awareness
Human Factors: Human-Machine Interface
Human Factors: Distraction
Human Factors: Communication Breakdown
Human Factors: Fatigue
Communication Breakdown.Party1: Flight Crew
Communication Breakdown.Party2: Flight Crew

Events
Anomaly.Aircraft Equipment Problem: Less Severe
Anomaly.Deviation - Procedural: Published Material / Policy
Detector.Person: Flight Crew
Were Passengers Involved In Event: N
When Detected: In-flight
Result.Flight Crew: Overcame Equipment Problem
Result.Aircraft: Equipment Problem Dissipated

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

Narrative: 1
On climbout from ZZZ passing 14000 ft my first officer noticed that the generators were not connected to the electrical system. I connected the generators and ran the after start check list, the flight proceeded normally.

It was the last flight using the old procedures and we were studying the new procedures. I got out of sequence and forgot the after start procedure and the call for the after start checklist.

Narrative: 2
Congested ramp during push back. Delayed starting engine 1 for confusion over traffic in ramp. Finished push and engine 1 and 2 were normal starts. Taxied out to a normal take off. Weather in area and icing. After takeoff had to confirm climb clearance because First Officer (FO) and Captain (CA) heard different clearances. Lots of ATC handling. Around 13,000 feet FO engaged autopilot. Around 14,000 feet FO reached up to turn up the heat in passenger cabin. That is when FO noticed the blue GEN OFF BUS lights were illuminated. FO brought this to the CA’s attention. CA put the generators on bus, rechecked all overhead switches while FO watched and re-engaged autopilot. A lot more ATC handling. Once at cruise FO and CA discussed what happened and came to the conclusion that the After Start Checklist was not accomplished, as well as the CA’s after start flow. CA and FO continued to triple check all remaining flows and duties and landed without incident at destination.
Fatigue played a factor in that the crew had a very long first day of the trip with an early wake up. Crew commented at destination that they were exhausted and that it was a really long day (about 8.5 flying and 12 hours of duty). Shorter layover for ZZZ. I (FO) planned on getting up a lot earlier than I did in ZZZ to have a leisurely morning, but I couldn't get out of bed. So instead I slept off and on and finally got up in time for a quick workout and a take-out breakfast from the grocery store. Felt fine leaving ZZZ. We had a 2 hour sit in ZZZ1 before the ZZZ2 leg. Now people are starting to show signs of fatigue like yawning. But we felt good to fly and reported for the flight. This was our last leg before our new procedures were to take effect; changing flows and checklists. This was definitely on our minds as we had been talking about it the last day or 2. Before, when CA's started engines I used to hold the checklist in my hands to remember to accomplish said checklist, but now with FO's starting the engines I have to put it down. Before that would have trapped the error of not doing the checklist, but now it didn't and I honestly don't have another reminder yet. I should have noticed the GEN OFF BUS lights at the 10,000 feet pressurization check but I do not know why I didn't catch it then...it just didn't register, which is why I think fatigue was a factor. The distraction of the new procedures was definitely on our minds and also attributed to the mistake.

**Synopsis**

Flight crew neglected to connect the generators due to not completing the checklist properly. Transitioning from old procedures to new procedures caused the flight crew to get out of sequence while accomplishing the checklist.
**Time / Day**
- Date: 201601
- Local Time Of Day: 1201-1800

**Place**
- Locale Reference.Airport: ZZZ.Airport
- State Reference: US
- Altitude.MSL.Single Value: 1000

**Environment**
- Flight Conditions: IMC
- Weather Elements / Visibility: Cloudy
- Weather Elements / Visibility.Visibility: 3
- Light: Daylight
- Ceiling.Single Value: 500

**Aircraft**
- Reference: X
- ATC / Advisory.Tower: ZZZ
- Aircraft Operator: Air Carrier
- Make Model Name: B737 Undifferentiated or Other Model
- Crew Size.Number Of Crew: 2
- Operating Under FAR Part: Part 121
- Flight Plan: IFR
- Mission: Passenger
- Flight Phase: Initial Approach
- 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: Pilot Not Flying
- Function.Flight Crew: First Officer
- Qualification.Flight Crew: Air Transport Pilot (ATP)
- Experience.Flight Crew.Last 90 Days: 144
- ASRS Report Number.Accession Number: 1322997
- Human Factors: Confusion
- Human Factors: Fatigue
- Human Factors: Communication Breakdown
- 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
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
Experience.Flight Crew.Last 90 Days : 125
Experience.Flight Crew.Type : 12000
ASRS Report Number.Accession Number : 1324825
Human Factors : Fatigue
Human Factors : Communication Breakdown
Human Factors : Confusion

Events
Anomaly.ATC Issue : All Types
Anomaly.Deviation - Altitude : Overshoot
Anomaly.Deviation - Track / Heading : All Types
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Detector.Automation : Aircraft Other Automation
Detector.Person : Flight Crew
Detector.Person : Air Traffic Control
Were Passengers Involved In Event : N
When Detected : In-flight
Result.Flight Crew : Regained Aircraft Control
Result.Flight Crew : Became Reoriented

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

Narrative: 1
This was the last leg of a four-day for me and I was flying with an older, senior Captain that I had never flown with before. I was the Pilot Monitoring and was a little tired after flying the last four days. I was ready to be done. The Captain was the Pilot Flying (PF). We got along great during the flight, but I guess I felt somewhat intimidated. The weather was IFR when we shot the ILS to Runway 4. I think the ceiling was reported at 500 ft OVC and 3 RA. The Approach Controller gave us a bad vector which put us through the LOC. He gave us another to rejoin. I think this put the Captain behind the airplane. I do not think we were fully configured or on speed at the FAF. I think the Captain missed pressing APP and we did not capture the G/S (Glideslope). He proceeded to chase it by Vert speeding down for the G/S. We were inside the FAF at this point.

I definitely should have called go-around at this point, but at the time, I thought that the Captain could get it all back together. He started to deviate from the LOC as well. I think we got a sink rate and two glideslope aural warnings, but I do not remember a pull-up command. The whole time I was thinking I should say go around, but my mouth was frozen shut. I was along for the ride at this point.

The Captain missed his FAF callout and the 1000 foot callout. I was fixated on willing him to get back on LOC and G/S and missed my callouts as well. We broke out and the runway was to the left of the nose and we were low. The Captain corrected and we landed without incident and he made our planned turnoff. I am very upset with myself for not being more assertive and calling go-around when my gut was telling me to. I have learned from my
mistake and will never let this situation happen again. From now on, if I think go-around, I will say go-around.

**Narrative: 2**

[Report narrative contained no additional information.]

**Synopsis**

On approach in a B737, ATC issued an improper vector which sent the flight crew through the localizer. While attempting to recapture the localizer and glideslope the flight crew began to fall behind the aircraft resulting in breaking out of the clouds to the right of the runway.
ACN: 1322034 (46 of 50)

Time / Day
Date : 201512
Local Time Of Day : 0601-1200

Place
Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.MSL.Single Value : 400

Environment
Flight Conditions : VMC
Light : Daylight

Aircraft
Reference : X
ATC / Advisory.Tower : 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 : Initial Climb
Airspace.Class C : 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 : 197
Experience.Flight Crew.Type : 10200
ASRS Report Number.Accession Number : 1322034
Human Factors : Fatigue
Human Factors : Situational Awareness
Human Factors : Distraction

Person : 2
Reference : 2
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : First Officer
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
Experience.Flight Crew.Last 90 Days : 234
Experience.Flight Crew.Type : 7080
ASRS Report Number.Accession Number : 1320990
Human Factors : Situational Awareness
Human Factors : Distraction

Events

Anomaly.Deviation - Speed : All Types
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Regained Aircraft Control

Assessments

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

Narrative: 1
On climb out, we received an "Airspeed Low" alert twice. Initially, we thought we may have taken off without flaps (1) extended. However, what we deduced was that I (PM) retracted the flaps when the FO called for "Gear Up". There were several additive conditions that probably contributed to my fault. First was fatigue. This was the first flight of the day with a relatively early start time for a PM trip. The overnight was short. For me, the room temperature was very warm and uncontrollable (central heat) providing for less than optimal sleeping conditions. The prior night was even worse, the crew hotel was host to a very large youth event and the kids were running all over the hotel at all times of the day and night. Second, the radar would not test properly and required us to troubleshoot with Maintenance. Third, our departure runway was changed immediately after pushback. Nevertheless, I did not feel rushed, and we completed the information only write up and departure plan review in a timely fashion. The taxi out and takeoff roll were uneventful. I don't remember the FO calling for gear retraction; I don't remember moving the flap handle either. Up to the point of the "Airspeed Low" alert, it was a very quiet, systematic and normal takeoff. With the annunciation of the "Airspeed Low" alert, I immediately looked at our airspeed. Initially, I was confused why the low airspeed caution band was "higher" than what I would have expected, but the speed was as expected for that phase of flight in those conditions, we were accelerating normally, the pitch of the aircraft was normal as expected; and the power was normal and as expected. The alert soon dissipated and we began to analyze what had happened.

I realize (with hindsight) that we could have added power since it had been a reduced thrust takeoff. Nevertheless, the FO (PF) continued to fly the aircraft through the whole incident. We immediately noticed that the flaps were in the up position and initially thought we had taken off without flaps. This led me to question myself, "how this could have happened", given all the procedures we would have had to miss. I then noticed that the gear was still down and then reached over to retract the gear. I don't know if I moved the flap handle when the FO called for gear up. I don't know if the FO incorrectly called for flaps up and I blindly complied. In either case, I failed to be an effective PM. I would hope that this event has forever elevated my awareness of my duties as a PM, especially during critical phases of flight.

Narrative: 2
The flight was the first flight of the day, which was the third day of a three-day trip. The preceding two days were uneventful, and I felt that the Captain and I were communicating
and working well together as a team. We had a relatively short overnight, which was compounded by a 50 minute delay, but I felt well rested and ready for the challenging day. The weather was clear, with light winds. The preflight briefings, before start originating and before pushback checklists were completed, based on a Runway 32L departure. During pushback, Ground advised that 32R was now the active runway. After pushback, we computed takeoff data for the new runway, and completed the departure briefing. Takeoff computations called for a flaps 1, reduced thrust takeoff. I would have preferred to complete departure brief after the before taxi checklist, but the Captain called for the briefing before we performed the after push flows. After the departure brief was completed, we ran through the after push flows and before taxi checklist. We taxied to Runway 32R, and completed the before takeoff checklist as we crossed the hold short line for Runway 32R. The takeoff roll was uneventful, as were rotation and initial climb. Once a positive rate of climb was established, I called "Landing Gear Up." Approximately 10 seconds after I called for landing gear up, I heard the annunciation "Airspeed Low, Airspeed Low." I glanced down at the Primary Flight Display (PFD), and noted that the airspeed was now about 10 knots below the Minimum Maneuver Speed (amber) bar. Initially, both the Captain and I were unsure as to why we were hearing the caution, and why we were now below minimum maneuvering speed. Rather than discuss it then, I lowered the nose and reduced my rate of climb until the airspeed was above flaps up speed. Initially, both the Captain and I suspected that we had inadvertently performed a flaps up takeoff, but I was certain we positioned the flaps properly (flaps 1), having recalled waiting for the flaps to position during the before taxi checklist. Also, we checked flap position twice during the previous checklist, and we never experienced a takeoff warning annunciation during the takeoff roll. After discussing it with the Captain, he admitted that "I think I raised the flaps instead of the gear." He also stated that when he looked up at the gear while we were accelerating, he noted it was still down, when he expected it to have already been raised. The remainder of the flight was uneventful.

This seems to be a clear case of pilot error caused by inattention. We debriefed the event extensively, and for what it's worth, the Pilot Monitoring (Captain) was mortified at his actions. He could give no explanation as to why he raised the flaps instead of the landing gear handle. Obviously, had I been watching the actions of the Pilot Monitoring, I would have caught the error, but that would have been difficult at such a crucial phase of flight (rotation and establishment of a stable climb). I'm not sure what else could be done to prevent this event from happening again, other than paying closer attention to what he/she is doing.

Synopsis

After takeoff, B737 crew raised the flaps from flaps 1 to up prior to reaching the minimum cleanup altitude or attaining minimum maneuvering speed for flaps up. Crew received an "Airspeed Low, Airspeed Low" aural alert and reacted by lowering the nose and quickly gaining sufficient airspeed.
**ACN: 1321489** (47 of 50)

**Time / Day**
- Date: 201512
- Local Time Of Day: 0601-1200

**Place**
- Locale Reference.Airport: SFO.Airport
- State Reference: CA
- Altitude.MSL.Single Value: 1000

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

**Aircraft**
- Reference: X
- ATC / Advisory.Tower: SFO
- Aircraft Operator: Air Carrier
- Make Model Name: Widebody, Low Wing, 2 Turbojet Eng
- Crew Size.Number Of Crew: 2
- Operating Under FAR Part: Part 121
- Flight Plan: IFR
- Mission: Passenger
- Nav In Use: FMS Or FMC
- Nav In Use.Localizer/Glideslope/ILS: Runway 28L
- Flight Phase: Final Approach
- Route In Use: Visual Approach
- Airspace.Class B: SFO

**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.Last 90 Days: 66
- Experience.Flight Crew.Type: 5954
- ASRS Report Number.Accession Number: 1321489
- Human Factors: Fatigue
- Human Factors: Human-Machine Interface
- Human Factors: Situational Awareness
- Human Factors: Training / Qualification
- Human Factors: Confusion

**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  
Result.Flight Crew : FLC Overrode Automation  
Result.Flight Crew : Became Reoriented

Assessments

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

Narrative: 1

On flight to SFO. During the approach and landing phase the aircraft descended below 1000 ft and close to full scale deflection on the GS during VMC daylight conditions while on the FMS Bridge Visual to 28R. I was flying pilot and following the FD while slowing to 160kts and trying to maintain a position behind an aircraft on approach to 28L. I stopped the descent and climbed to about 1000ft making positive adjustments per SOP. At this point we received one GS aural warning. I then intercepted the GS and proceeded to land uneventfully.

Several factors contributed to this undesired state:
1. The previous three days were single assignments starting early on the 28th, late on the 29th finishing early on the 30th, and then starting early on the 31st. All while maintaining long call reserve in-between and not knowing how to prepare in advance for the next day's assignment. Fatigue was an issue as I was not able to fully recover from switching duty periods almost 12 hours different for the previous 3 days.
2. Being new to the fleet, but being comfortable in the aircraft previously. Having the AP not intercepting the GS before intercepting the Localizer is new to me and the aircraft contributed to this state. I do not know why the FD guidance guided me to this state as I was locked on and relying on it for guidance while focusing on the aircraft on 28L.

This was a combination of fatigue, first time experiencing the GS not intercepting before the LOC, and high work load environment on parallel approaches.

Synopsis

Air carrier Captain on visual approach to SFO descended below glideslope by following incorrectly programmed FD bars. Fatigue was listed as a contributing factor.
**ACN: 1321321 (48 of 50)**

**Time / Day**
- Date: 201512
- Local Time Of Day: 0601-1200

**Place**
- Locale Reference: Airport: IAD.Airport
- State Reference: DC
- Altitude.AGL.Single Value: 400

**Environment**
- Flight Conditions: IMC
- Weather Elements / Visibility: Rain
- Light: Daylight
- Ceiling.Single Value: 600
- RVR.Single Value: 6000

**Aircraft**
- Reference: X
- ATC / Advisory: Tower: IAD
- Aircraft Operator: Air Carrier
- Make Model Name: B737 Undifferentiated or Other Model
- Crew Size.Number Of Crew: 2
- Operating Under FAR Part: Part 121
- Flight Plan: IFR
- Mission: Passenger
- Nav In Use.Localizer/Glideslope/ILS: Runway 19C
- Flight Phase: Final Approach
- Airspace.Class B: IAD

**Person**
- Reference: 1
- Location Of Person.Aircraft: X
- Location In Aircraft: Flight Deck
- Reporter Organization: Air Carrier
- Function.Flight Crew: Captain
- Function.Flight Crew: Pilot Flying
- Qualification.Flight Crew: Air Transport Pilot (ATP)
- Experience.Flight Crew.Total: 14900
- Experience.Flight Crew.Last 90 Days: 140
- Experience.Flight Crew.Type: 3000
- ASRS Report Number.Accession Number: 1321321
- Human Factors: Situational Awareness
- Human Factors: Fatigue

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

Assessments

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

Narrative: 1
On glide slope ILS Runway 19C IAD, configured, everything normal. Weather 600 OVC RVR 6000+. Autopilot turned off about 1000 AGL, auto throttle still on. Approach was completely normal and stable until at 700 MSL (about 400 feet AGL) all at once the Captain's side (mine) flight director disappeared, FO's still visible, FO called Rwy in sight, I disconnected auto throttles, and the GPWS called glide slope, airspeed showed 8 kts slow, I added plenty of power to correct, we made an adequate and safe landing. But what happened when the FD disappeared? Instantly we were low and slow yet I remember changing nothing. One second everything was normal and stable and the next instant we were low and slow. I don't know what happened to cause the FD to disappear and the GS to go haywire (interference in the critical area?). There was no wind shear to explain away the airspeed loss. Pilot error? I don't know what I did since it was stable the whole way down and required little input. Yes I was ridiculously tired today but neither the FO nor I noticed any radical changes made by me. It was recovered safely and otherwise no big deal except the GPWS GS warning.

Synopsis
B737 Captain reported a low altitude unstable condition occurred rapidly and without obvious cause on an approach to IAD.
**Time / Day**
- Date: 201512
- Local Time Of Day: 1201-1800

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

**Environment**
- Flight Conditions: IMC
- Weather Elements / Visibility: Visibility: 0.5
- Light: Night
- Ceiling: Single Value: 200

**Aircraft**
- Reference: X
- Aircraft Operator: Air Carrier
- Make Model Name: Commercial Fixed Wing
- Crew Size: Number Of Crew: 2
- Operating Under FAR Part: Part 121
- Flight Plan: IFR
- 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)
- Experience.Flight Crew.Last 90 Days: 197
- ASRS Report Number.Accession Number: 1320299
- Human Factors: Distraction
- Human Factors: Fatigue

**Events**
- Anomaly.Flight Deck / Cabin / Aircraft Event: Other / Unknown
- Anomaly.Deviation - Procedural: Published Material / Policy
- Detector.Person: Flight Crew
- When Detected: Aircraft In Service At Gate
- Result.General: None Reported / Taken

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

**Narrative: 1**

I was flying the last day of a three-day. That last day involved four legs. Three of those airports involved approaches to minimums as a bonus, LGA in the pouring rain. That day, I experienced the worst weather, I've seen this entire year. Approaches to low visibility, turbulence, holding and high winds were abundant.

We reported in at XA20. We finished at XO10. That is a 13 hour and 50 minute Duty Day. It was a very long day. On the first flight of the morning, after we barely got into [the airport], we then had to swap aircraft, ground time. We flew [the next leg], shot the approach, landed and then learned of our three-hour delay to LGA.

My First Officer stated to me "I don't think I'm going to make it if we get that late". I actually felt fine at that time and hoped we could continue past LGA. We were concerned that we would in fact be too tired, exhausted, whipped, beat or sorry "fatigued", to complete final leg of the trip LGA-ZZZ. I called Crew Scheduling as we were concerned about NOT being able to complete the trip past LGA. A Scheduler (unknown) had put max block in time under the remarks section of our schedule of XO50. This time was totally false, wrong; I find it ridiculous, that we get false information from folks sitting in front of a computer in an office, while we hang out in a terminal counting duty time on our fingers.

By the way, I find the paperwork given to us at block-out with Tables giving worthless information and presented in a horrible format, as Company will push every Crew they can to the federal limit. Why waste time with all these tables when Scheduling will "sell" the federal limit?

Back to my ASAP event, I told the Scheduler on the phone I was concerned about the trend of our day and asked him about this bogus "MAX BI XO50" on our board. He was great and corrected it he stated our max block in time under the remarks section of our schedule of XM20, and XO50 if we accepted extension. It should have been correct the first time. Pilots should have correct information.

Landing in LGA. During that flight, holding to a near divert then an approach to minimums in pouring rain. We arrived at the gate in LGA, took a deep breath and both of us were not sure if we were fit to fly, tired, whipped, exhausted, beat or sorry "fatigued" for the next leg. We were 10:36 hours into our duty day. I walked off to get coffee for both of us. I returned and we talked about the next leg to ZZZ, through weather, if wheels up time could be met, any delays and arrival time could be met. We were bombarded with no less than three calls from Scheduling, which I did not answer as I didn't want any additional pressures added to us.

The aircraft was loading up fast with Passengers; nothing was said to us by the Agent. In fact, I think he knew nothing of how close we were to timing out. The flight was not going unless we accepted the extension. Operational pressures.

We tried to manage our expectations of get home-itis, finish the task, getting home, or letting down 143 Passengers. I wanted to make the right decision and limit influence from anybody outside of the First Officer and me. After we talked a few minutes we both decided that we could accept our extensions and fly the final leg to ZZZ.

I picked up the phone and called scheduling back, as they had left three messages on my
phone. It's almost as if they thought we would sneak away. I started talking to a Scheduler who answered the phone. I asked if they had been looking for us. This Scheduler informed me of a JA (Junior Available) trip that I have been assigned for the next day. I am suddenly, shocked, blindsided, sad, mad and in disbelief. I informed the Scheduler that we hadn't even made it back into ZZZ yet. Due to the weather in between LGA-ZZZ, who knows? I basically argued with her over a trip assigned to me, for the next day. Unbelievable.

The flight was going to be challenging enough, I did not need the Company adding distractions to me. The FAA has an "I'm Safe" self-check. Company doesn't agree. You are either sick or fatigued and make sure you say the correct term. Company has Green, Yellow and Red with the goal of staying in the Green and how to notice the effects/symptoms of leaving the Green. In this case Company had just added a bunch of stress to my life and pushed me into the Yellow.

Only after arguing with me over, my new scheduler shifted gears and wanted to talk about our ZULU BI (Block In) time. I informed her that we understand. We are asked if we are going to push the button to extend our day. I don't remember what I said, maybe yeah or we will. She stated, "I'll show you notified for your trip tomorrow". I say "No, I'm not notified and I will call you in ZZZ, and I would talk to a Supervisor, I have a flight to fly". I hung up the phone and was extremely upset, so much that my flying partner noticed it, he brought my focus back to the task at hand, and asked if I was ok, he told me to take my time and asked if I thought I could fly the leg.

Then the Agent came into cockpit and told me Scheduling was on the phone in the jet way, really! Just someone else trying to tell us about ZULU BI time or pushing the button, I said, "I've already talked to them!" We took off and flew to ZZZ. I tried to limit the effects of the distractions that had just been introduced unnecessarily by my Company. I tried my best, but I can't help but think about my disappointment and Family the entire flight time, this is not safe.

In hindsight, I should have walked off the aircraft in LGA. It would have been because the distraction introduced onto me by the Company Schedulers. Looking back, I thought I could block it out of my mind, but I was unable to. It's not worth making a mistake I can't take back.

Although, I am extremely upset about being forced to work on my days off, I'm more upset on the timing of the JA assignment (before, I was to finish a 13h 50m day). I find, bad math (BI Time), multiple calls from Scheduling, fast loading of the aircraft and JA assignment all added pressures by my Company that I don't appreciate, one bit. I felt once I was assigned JA trip, any decision I made would be under a microscope and I might end up being Monday-Morning Quarterbacked by someone. It will not happen again to this Pilot!

Scheduling could have JA'd me on my arrival into ZZZ. I'd still be angry but it wouldn't be as distracting as flying a leg after receiving bad news. My Passengers deserve my full attention and my Company needs to practice what they preach.

Synopsis

B737 Captain laments a grueling duty day, in bad weather, during which he is badgered by scheduling to accept a duty day extension and a trip assignment on his day off as the junior Captain available.
**ACN: 1320218 (50 of 50)**

**Time / Day**
Date: 201512
Local Time Of Day: 1801-2400

**Place**
Locale Reference, ATC Facility: ZZZ.TRACON
State Reference: US

**Environment**
Weather Elements / Visibility: Thunderstorm
Weather Elements / Visibility: Turbulence
Weather Elements / Visibility: Windshear
Weather Elements / Visibility: Visibility: 5
Ceiling: Single Value: 1500

**Aircraft**
Reference: X
ATC / Advisory, TRACON: ZZZ
Aircraft Operator: Air Carrier
Make Model Name: B737 Undifferentiated or Other Model
Crew Size, Number Of Crew: 2
Operating Under FAR Part: Part 121
Flight Plan: IFR
Mission: Passenger
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, Total: 22000
Experience, Flight Crew, Last 90 Days: 200
Experience, Flight Crew, Type: 4500
ASRS Report Number, Accession Number: 1320218
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)
Events
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 : Executed Go Around / Missed Approach
Result.Flight Crew : Diverted

Assessments
Contributing Factors / Situations : Weather
Primary Problem : Weather

Narrative: 1
Flight had to hold a short period due to thunderstorms near the area. Released from holding after three other arrivals were issued STARS. Got vectored for an ILS. On approach experienced a 50 knot tailwind which made the approach unstable so we went around.

Got ATC vector for a different runway where Approach Control had two other aircraft approaching. All three of us went around because of impending wind shear. Now getting near min fuel so we diverted to a nearby airport and got vectored for an ILS. Tower advised us of a headwind. We had a strong headwind on final until 200 feet AGL. I looked at my primary flight display and noticed a quartering tailwind at 16 knots. We landed uneventfully, but suspected we were approximately 2 to 4 knots over our tailwind limitation.

Narrative: 2
[Report narrative contained no additional information.]

Synopsis
Due to adverse winds on approach, flight executed a go around. Due to low fuel amounts then diverted to another airport.