

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.....	July 31, 2018
Number of Records in Report Set	50
Number of New Records in Report Set.....	19
Type of Records in Report Set	For each update, new records received at ASRS will displace a like number of the oldest records in the Report Set, with the objective of providing the fifty most recent relevant ASRS Database records. Records within this Report Set have been screened to assure their relevance to the topic.

National Aeronautics and
Space Administration

Ames Research Center
Moffett Field, CA 94035-1000



TH: 262-7

MEMORANDUM FOR: Recipients of Aviation Safety Reporting System Data

SUBJECT: Data Derived from ASRS Reports

The attached material is furnished pursuant to a request for data from the NASA Aviation Safety Reporting System (ASRS). Recipients of this material are reminded when evaluating these data of the following points.

ASRS reports are submitted voluntarily. 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

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: 1535684 *(1 of 50)*

Synopsis

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

ACN: 1533137 *(2 of 50)*

Synopsis

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

ACN: 1532610 *(3 of 50)*

Synopsis

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

ACN: 1523764 *(4 of 50)*

Synopsis

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

ACN: 1523092 *(5 of 50)*

Synopsis

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

ACN: 1521128 *(6 of 50)*

Synopsis

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

ACN: 1516729 *(7 of 50)*

Synopsis

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

ACN: 1516175 *(8 of 50)*

Synopsis

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

ACN: 1515991 *(9 of 50)*

Synopsis

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

ACN: 1512489 *(10 of 50)*

Synopsis

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

ACN: 1511632 *(11 of 50)*

Synopsis

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

ACN: 1507590 *(12 of 50)*

Synopsis

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

ACN: 1506429 *(13 of 50)*

Synopsis

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

ACN: 1504566 *(14 of 50)*

Synopsis

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

ACN: 1504384 *(15 of 50)*

Synopsis

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

ACN: 1504281 *(16 of 50)*

Synopsis

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

ACN: 1503650 *(17 of 50)*

Synopsis

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

ACN: 1503033 *(18 of 50)*

Synopsis

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

ACN: 1498775 *(19 of 50)*

Synopsis

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

ACN: 1447721 *(20 of 50)*

Synopsis

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

ACN: 1445019 *(21 of 50)*

Synopsis

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

ACN: 1444766 *(22 of 50)*

Synopsis

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

ACN: 1441571 *(23 of 50)*

Synopsis

B737 flight crew reported procedural errors caused by the late callout of a reserve First Officer .

ACN: 1436626 *(24 of 50)*

Synopsis

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

ACN: 1431311 *(25 of 50)*

Synopsis

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

ACN: 1428946 *(26 of 50)*

Synopsis

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

ACN: 1428180 *(27 of 50)*

Synopsis

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

ACN: 1425955 *(28 of 50)*

Synopsis

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

ACN: 1424221 *(29 of 50)*

Synopsis

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

ACN: 1424191 *(30 of 50)*

Synopsis

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

ACN: 1422137 *(31 of 50)*

Synopsis

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

ACN: 1421894 *(32 of 50)*

Synopsis

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

ACN: 1420514 *(33 of 50)*

Synopsis

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

ACN: 1420229 *(34 of 50)*

Synopsis

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

ACN: 1419067 *(35 of 50)*

Synopsis

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

ACN: 1418104 *(36 of 50)*

Synopsis

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

ACN: 1417108 *(37 of 50)*

Synopsis

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

ACN: 1417095 *(38 of 50)*

Synopsis

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

ACN: 1414879 *(39 of 50)*

Synopsis

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

ACN: 1414631 *(40 of 50)*

Synopsis

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

ACN: 1412767 *(41 of 50)*

Synopsis

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

ACN: 1412019 *(42 of 50)*

Synopsis

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

ACN: 1411815 *(43 of 50)*

Synopsis

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

ACN: 1411747 *(44 of 50)*

Synopsis

B767 Flight Crew reported exceeding 250 knots below 10000 feet during a late night arrival to LAX after several changes to their arrival and landing runway. Fatigue and distractions were cited as factors in the incident.

ACN: 1411085 *(45 of 50)*

Synopsis

B737-800 flight crew reported continuing to a landing after a leading edge slat transit light remained illuminated.

ACN: 1410042 *(46 of 50)*

Synopsis

Air carrier flight crew reported a mis-communication that led to a flap over speed after an ATC directed break out from the approach.

ACN: 1409916 *(47 of 50)*

Synopsis

A320 First Officer reported experiencing distracting headaches and fatigue from what he described as a continuous low frequency rumble from the engines in cruise flight.

ACN: 1409428 *(48 of 50)*

Synopsis

B777 flight crew reported an aircraft overspeed for 15-20 seconds while in cruise at FL410 due to a severe mountain wave encounter.

ACN: 1407596 *(49 of 50)*

Synopsis

B757-200 Captain reported fatigue was a factor in his approach that was flown below the glideslope to about 1200 feet AGL, 4 to 5 miles out.

ACN: 1405897 *(50 of 50)*

Synopsis

Air carrier Captain reported missing taxiway WH during night taxi at IAH. Captain stated signage lighting contributed to the event.

Report Narratives

Time / Day

Date : 201804
Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : WSSS.Airport
State Reference : FO
Relative Position.Angle.Radial : 023
Relative Position.Distance.Nautical Miles : 2
Altitude.AGL.Single Value : 1500

Environment

Flight Conditions : VMC
Light : Night

Aircraft : 1

Reference : X
ATC / Advisory.Tower : WSSS
Aircraft Operator : Air Carrier
Make Model Name : B767-300 and 300 ER
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Cargo / Freight
Nav In Use : FMS Or FMC
Flight Phase : Initial Climb
Route In Use.SID : VMR 5A

Aircraft : 2

Reference : Y
Make Model Name : Any Unknown or Unlisted Aircraft Manufacturer

Person : 1

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
Experience.Flight Crew.Total : 14900
Experience.Flight Crew.Last 90 Days : 40
Experience.Flight Crew.Type : 5900
ASRS Report Number.Accession Number : 1535684

Human Factors : Workload
Human Factors : Communication Breakdown
Human Factors : Fatigue
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : ATC
Analyst Callback : Attempted

Person : 2

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

Events

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

Assessments

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

Narrative: 1

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

turbulence a 2nd time.

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

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

Narrative: 2

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

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

We proceeded to select flaps up on schedule as normal with our airspeed increasing toward clean maneuvering speed of 226 knots, we then encountered wake turbulence a 2nd time. After it smoothed out, we again tried to reengage the A/P, but it disconnected or didn't engage, the Captain continued to fly the airplane. We then encountered wake turbulence a third time and a brief stick shaker occurred (1 sec) as we were approximately 10 knots under our clean maneuvering speed of 226 and attempting to accelerate to no greater than 230 knots per the SID. Of course there was also a lot going on with the A/P

disconnect warnings sounding twice, but the aircraft was under control, and I did not observe that we were too close to the Pilot Limit Indicator (PLI) until the shaker sounded. In fact, it seemed to me that the PLI disappeared at or near this point in the climb, and came back on simultaneously with the brief shaker - at least that's what I thought I saw.

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

Synopsis

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

Time / Day

Date : 201804

Local Time Of Day : 0001-0600

Environment

Light : Dawn

Aircraft

Reference : X

Make Model Name : No Aircraft

Flight Phase : Parked

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1533137

Human Factors : Fatigue

Events

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Deviation - Procedural : FAR

Detector.Person : Flight Crew

When Detected : Pre-flight

Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Procedure

Primary Problem : Procedure

Narrative: 1

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

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

Synopsis

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

Time / Day

Date : 201804

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.MSL.Single Value : 2000

Environment

Flight Conditions : IMC

Weather Elements / Visibility.Visibility : 10

Light : Daylight

Ceiling.Single Value : 500

Aircraft

Reference : X

ATC / Advisory.TRACON : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : Regional Jet 900 (CRJ900)

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Nav In Use : GPS

Flight Phase : Initial Approach

Route In Use : Vectors

Airspace.Class D : ZZZ

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Check Pilot

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Multiengine

ASRS Report Number.Accession Number : 1532610

Human Factors : Fatigue

Human Factors : Situational Awareness

Human Factors : Distraction

Person : 2

Reference : 2

Location Of Person.Aircraft : X

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

Events

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

Assessments

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

Narrative: 1

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

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

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

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

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

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

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

Time / Day

Date : 201803
Local Time Of Day : 0601-1200

Place

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

Environment

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

Aircraft

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

Component

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

Person : 1

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

Human Factors : Workload
Human Factors : Confusion

Person : 2

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

Events

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

Assessments

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

Narrative: 1

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

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

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

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

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

Time / Day

Date : 201803

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : IMC

Weather Elements / Visibility : Rain

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : B737 Undifferentiated or Other Model

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Parked

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Total : 20000

Experience.Flight Crew.Last 90 Days : 200

Experience.Flight Crew.Type : 10000

ASRS Report Number.Accession Number : 1523092

Human Factors : Other / Unknown

Human Factors : Fatigue

Events

Anomaly.Aircraft Equipment Problem : Less Severe

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Inflight Event / Encounter : Weather / Turbulence

Detector.Person : Flight Crew

When Detected : Pre-flight

Result.General : Release Refused / Aircraft Not Accepted

Result.General : Work Refused

Assessments

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

Narrative: 1

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

Synopsis

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

Time / Day

Date : 201802
Local Time Of Day : 0601-1200

Place

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

Environment

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

Aircraft : 1

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

Aircraft : 2

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

Person

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

Events

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

Assessments

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

Narrative: 1

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

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

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

Synopsis

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

Time / Day

Date : 201802

Environment

Light : Night

Aircraft

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

Person

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

Events

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

Assessments

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

Narrative: 1

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

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

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

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

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

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

Synopsis

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

Time / Day

Date : 201802

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : FNT.Airport

State Reference : MI

Altitude.MSL.Single Value : 3000

Environment

Flight Conditions : VMC

Weather Elements / Visibility : Snow

Weather Elements / Visibility : Turbulence

Light : Night

Aircraft

Reference : X

ATC / Advisory.TRACON : FNT

Aircraft Operator : Air Carrier

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

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Initial Approach

Airspace.Class C : FNT

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1516175

Human Factors : Training / Qualification

Human Factors : Workload

Human Factors : Fatigue

Human Factors : Situational Awareness

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

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

Events

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

Assessments

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

Narrative: 1

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

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

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

Narrative: 2

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

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

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

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

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

Synopsis

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

Time / Day

Date : 201802

Aircraft

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

Component

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

Person

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

Events

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

Assessments

Contributing Factors / Situations : Aircraft
Primary Problem : Aircraft

Narrative: 1

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

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

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

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

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

Synopsis

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

Time / Day

Date : 201801

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 1000

Environment

Flight Conditions : VMC

Light : Night

Aircraft

Reference : X

ATC / Advisory.Tower : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : B777 Undifferentiated or Other Model

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Final Approach

Airspace.Class B : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Total : 14388

Experience.Flight Crew.Type : 2413

ASRS Report Number.Accession Number : 1512489

Human Factors : Fatigue

Human Factors : Situational Awareness

Events

Anomaly.Inflight Event / Encounter : Unstabilized Approach

Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Executed Go Around / Missed Approach

Assessments

Contributing Factors / Situations : Human Factors

Primary Problem : Human Factors

Narrative: 1

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

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

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

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

Synopsis

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

Time / Day

Date : 201801

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ATL.Airport

State Reference : GA

Relative Position.Distance.Nautical Miles : 2

Altitude.AGL.Single Value : 500

Environment

Light : Daylight

Aircraft : 1

Reference : X

ATC / Advisory.Tower : ATL

Aircraft Operator : Air Carrier

Make Model Name : B737 Next Generation Undifferentiated

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Final Approach

Airspace.Class B : ATL

Aircraft : 2

Reference : Y

ATC / Advisory.Tower : ATL

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Flight Plan : IFR

Flight Phase : Final Approach

Airspace.Class B : ATL

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1511632

Human Factors : Distraction

Human Factors : Fatigue

Human Factors : Situational Awareness

Events

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

Assessments

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

Narrative: 1

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

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

Synopsis

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

Time / Day

Date : 201712

Aircraft

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

Person

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

Events

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

Assessments

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

Narrative: 1

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

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

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

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

Synopsis

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

Time / Day

Date : 201712

Local Time Of Day : 0001-0600

Environment

Light : Dawn

Aircraft

Reference : X

Make Model Name : No Aircraft

Flight Phase:Other

Person

Reference : 1

Location Of Person : Hangar / Base

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1506429

Human Factors : Communication Breakdown

Human Factors : Fatigue

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Other

Events

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Deviation - Procedural : FAR

Detector.Person : Flight Crew

Result.General : Flight Cancelled / Delayed

Assessments

Contributing Factors / Situations : Company Policy

Contributing Factors / Situations : Procedure

Primary Problem : Company Policy

Narrative: 1

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

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

Synopsis

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

Time / Day

Date : 201712

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : PHL.Airport

State Reference : PA

Altitude.AGL.Single Value : 0

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : B757-200

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Not Flying

Function.Flight Crew : Captain

Function.Ground Personnel : Other / Unknown

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1504566

Human Factors : Fatigue

Events

Anomaly.Deviation - Procedural : Other / Unknown

Detector.Person : Flight Crew

Were Passengers Involved In Event : N

When Detected.Other

Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Staffing

Primary Problem : Staffing

Narrative: 1

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

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

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

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

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

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

Synopsis

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

Time / Day

Date : 201712
Local Time Of Day : 0601-1200

Place

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

Environment

Light : Daylight

Aircraft

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

Person : 1

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

Person : 2

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

Events

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

Assessments

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

Narrative: 1

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

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

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

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

Time / Day

Date : 201712
Local Time Of Day : 1201-1800

Place

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

Environment

Light : Daylight

Aircraft

Reference : X
Aircraft Operator : Air Carrier
Make Model Name : EMB ERJ 170/175 ER/LR
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Flight Phase : Parked

Component

Aircraft Component : Safety Instrumentation & Information
Aircraft Reference : X
Problem : Malfunctioning

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1504281
Human Factors : Fatigue

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Person : Flight Crew
Were Passengers Involved In Event : N
When Detected : Aircraft In Service At Gate
Result.General : None Reported / Taken

Assessments

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

Narrative: 1

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

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

Synopsis

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

Time / Day

Date : 201712

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : RSW.Airport

State Reference : FL

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC

Light : Night

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Flight Phase : Landing

Route In Use.Other

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Not Flying

Function.Flight Crew : Captain

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1503650

Human Factors : Fatigue

Human Factors : Situational Awareness

Events

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

Anomaly.Deviation - Procedural : Published Material / Policy

Detector.Person : Flight Crew

When Detected : Aircraft In Service At Gate

Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Aircraft

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Procedure

Primary Problem : Human Factors

Narrative: 1

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

Synopsis

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

Time / Day

Date : 201712
Local Time Of Day : 0601-1200

Place

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

Environment

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

Aircraft

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

Component

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

Person : 1

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

Person : 2

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

Events

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

Assessments

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

Narrative: 1

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

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

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

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

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

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

Time / Day

Date : 201711

Local Time Of Day : 1201-1800

Place

Locale Reference.ATC Facility : ZZZ.ARTCC

State Reference : US

Altitude.MSL.Single Value : 38000

Environment

Flight Conditions : IMC

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Center : ZZZ

Aircraft Operator : Air Carrier

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

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Cruise

Airspace.Class A : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Type : 1300

ASRS Report Number.Accession Number : 1498775

Human Factors : Fatigue

Human Factors : Physiological - Other

Events

Anomaly.Flight Deck / Cabin / Aircraft Event : Illness

Detector.Person : Flight Crew

When Detected : In-flight

Result.General : Physical Injury / Incapacitation

Result.Flight Crew : Diverted

Assessments

Contributing Factors / Situations : Human Factors

Primary Problem : Human Factors

Narrative: 1

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

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

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

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

Synopsis

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

Time / Day

Date : 201705
Local Time Of Day : 1201-1800

Place

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

Environment

Flight Conditions : VMC
Light : Daylight

Aircraft

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

Component

Aircraft Component : ACARS
Aircraft Reference : X
Problem : Malfunctioning

Person : 1

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

Person : 2

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

Person : 3

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

Events

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

Assessments

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

Narrative: 1

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

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

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

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

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

Narrative: 2

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

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

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

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

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

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

Narrative: 3

[Report narrative contained no additional information.]

Synopsis

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

Time / Day

Date : 201704

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : SJC.Airport

State Reference : CA

Altitude.MSL.Single Value : 4200

Aircraft

Reference : X

ATC / Advisory.TRACON : NCT

Aircraft Operator : Air Carrier

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

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Nav In Use : GPS

Nav In Use.Localizer/Glideslope/ILS : Runway 30L

Flight Phase : Initial Approach

Route In Use.STAR : SILCN4

Airspace.Class C : SJC

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1445019

Human Factors : Fatigue

Human Factors : Situational Awareness

Human Factors : Time Pressure

Human Factors : Training / Qualification

Human Factors : Workload

Human Factors : Distraction

Events

Anomaly.ATC Issue : All Types

Anomaly.Deviation - Speed : All Types

Anomaly.Deviation - Track / Heading : All Types

Anomaly.Inflight Event / Encounter : Unstabilized Approach

Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Took Evasive Action

Result.Flight Crew : Executed Go Around / Missed Approach
Result.Air Traffic Control : Issued New Clearance

Assessments

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

Narrative: 1

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

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

Synopsis

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

Time / Day

Date : 201704

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZZ.Airport

State Reference : FO

Altitude.AGL.Single Value : 0

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : B737-800

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Taxi

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1444766

Human Factors : Distraction

Human Factors : Fatigue

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1444760

Human Factors : Distraction

Events

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

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Ground Event / Encounter : Other / Unknown

Detector.Person : Flight Crew

When Detected : Aircraft In Service At Gate

Result.Flight Crew : Overcame Equipment Problem

Assessments

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

Narrative: 1

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

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

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

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

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

Time / Day

Date : 201704

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Light : Dawn

Aircraft

Reference : X

ATC / Advisory.Ground : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : B737-700

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Taxi

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Last 90 Days : 169

ASRS Report Number.Accession Number : 1441571

Human Factors : Communication Breakdown

Human Factors : Confusion

Human Factors : Fatigue

Human Factors : Situational Awareness

Human Factors : Time Pressure

Human Factors : Workload

Human Factors : Distraction

Communication Breakdown.Party1 : Flight Crew

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

Qualification.Flight Crew : Air Transport Pilot (ATP)
Experience.Flight Crew.Last 90 Days : 85
ASRS Report Number.Accession Number : 1441832
Human Factors : Workload
Human Factors : Time Pressure
Human Factors : Situational Awareness
Human Factors : Confusion
Human Factors : Communication Breakdown
Human Factors : Distraction
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

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

Assessments

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

Narrative: 1

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

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

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

Narrative: 2

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

Scheduling should not move an assignment up earlier in the early morning for a reserve. That puts both of us in a bad spot. This forced me to do two jobs and forced him to rush to

work after being woken up two hours sooner than his alarm. Although I emphasized that we were not going to hurry, we still missed the clearance which led to missing putting the flaps out at the correct time.

Synopsis

B737 flight crew reported procedural errors caused by the late callout of a reserve First Officer .

Time / Day

Date : 201704

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Light : Night

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : B777 Undifferentiated or Other Model

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Parked

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1436626

Human Factors : Communication Breakdown

Human Factors : Fatigue

Communication Breakdown.Party1 : Flight Attendant

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Ground Personnel

Communication Breakdown.Party2 : Maintenance

Communication Breakdown.Party2 : Dispatch

Events

Anomaly.Aircraft Equipment Problem : Less Severe

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Deviation - Procedural : MEL

Detector.Person : Flight Crew

When Detected : Aircraft In Service At Gate

Result.General : Flight Cancelled / Delayed

Result.Flight Crew : Returned To Gate

Assessments

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

Narrative: 1

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

Synopsis

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

Time / Day

Date : 201703

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.MSL.Single Value : 18000

Environment

Flight Conditions : VMC

Light : Night

Aircraft

Reference : X

ATC / Advisory.Center : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : Regional Jet 200 ER/LR (CRJ200)

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Climb

Airspace.Class A : ZZZ

Component

Aircraft Component : Landing Gear

Aircraft Reference : X

Problem : Malfunctioning

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1431311

Human Factors : Fatigue

Human Factors : Time Pressure

Human Factors : Workload

Events

Anomaly.Aircraft Equipment Problem : Less Severe

Anomaly.Conflict : Ground Conflict, Less Severe

Anomaly.Deviation - Procedural : Published Material / Policy

Detector.Person : Flight Crew

Were Passengers Involved In Event : Y
When Detected : In-flight
Result.General : Maintenance Action
Result.Flight Crew : Returned To Departure Airport
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

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

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

and they gave us a new frequency, then metering said contact ramp for taxi, we contacted ramp and they informed us that we needed to start to taxi as two aircraft were waiting for us to move to get into the ramp area.

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

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

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

bridge to notify ramp personnel that we needed a chocks-in sign. We finally got this signal, and I notified the flight attendant "doors for arrival." She called me and mentioned that the ground personnel opened the door from the outside, and someone was waiting at the cockpit door waiting to talk with us. We then had someone banging on the cockpit door. I told the FO to slow down and complete the parking checklist, and then we would open the door.

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

I informed dispatch and the Dispatcher said he would transfer me to a supervisor. A supervisor answered and we were able to discuss logically the situation, and being in agreement we decided to remove us from the flight. I did ask to be connected to the Chief Pilot on duty to discuss the situation. The supervisor placed me on hold and to call the Chief Pilot. He returned to the line and said that a message was left for the Chief Pilot and they would call me back when both were on the line. I agreed, and at that time the FA entered and said that passengers were asking for an update. I asked, we still have passengers on board, I thought I told the [gate agent] that the passengers should deplane. The [gate agent] entered and mentioned that he just offered for them to deplane if they wanted. We still had the majority of the passengers on board. I said that I would make an announcement from the FA PA system and look the Passengers in the eye and give the information from me. I let them know that the plane needed to be inspected and that they should deplane and take all of their belongings with them. One woman asked me if they would get to ZZZ tonight. I replied that I did not know that information yet. As I was making the announcement my phone was ringing in my pocket, and I realized operations was calling me back. I re-entered the cockpit and answered another phone call from Operations. The Chief Pilot was on the line and everyone agreed that we should not take the flight to ZZZ this evening based on all of the issues, the late hour of the evening, the Warning Message situation, the ZZZ Weather, the Delay, and the expected return from ZZZ. The Chief Pilot agreed and so did Operations. We then called Crew Scheduling and they wanted us to say that we were Fatigued. We complied and they issued us a hotel.

After about 20 minutes on hold they issued us a hotel and gave us a number. The number was called and it was the hotel in ZZZ. We called back and placed on hold for another 10 minutes, got another number and called a hotel where we were. We waited over 50 minutes for a van and made 3 calls to confirm the specific hotel. Once the shuttle arrived it was full of the passengers from our flight that was delayed until the morning. Upon arrival at the hotel our names were nowhere to be found. All of the passengers were placed into rooms and we were still waiting as we called back Crew Scheduling, and were on hold for another 10 to 15 minutes. We finally entered our rooms at little while later.

Synopsis

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

Time / Day

Date : 201703

Local Time Of Day : 1801-2400

Place

Locale Reference.ATC Facility : SCT.TRACON

State Reference : CA

Aircraft

Reference : X

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

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 Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1428946

Human Factors : Fatigue

Human Factors : Situational Awareness

Events

Anomaly.Deviation - Speed : All Types

Anomaly.Deviation - Procedural : Published Material / Policy

Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Became Reoriented

Assessments

Contributing Factors / Situations : Human Factors

Primary Problem : Human Factors

Narrative: 1

First officer was hand flying and trying to slow the aircraft on a visual approach after being kept fast on arrival by ATC. Aircraft was at flaps 2, gear down and speed brakes out. First Officer went to retract speed brakes and mistakenly grabbed the flap handle bringing the flaps back up to 0. First thing I noticed as pilot monitoring was the aircraft speeding up and the VLS (lowest selectable speed) (hook) raising rapidly. That's when I said "your

speed brakes are still out" and brought the handle up. At that time he realized the mistake and said "I brought the flaps up by mistake." When I looked over the flap indicator appeared to be at 0, we got a quick "over speed" annunciation and I believe the airspeed was accelerating from 180 to approximately 210 (just at the bottom of the barber pole). Aircraft was reconfigured and remaining approach/landing was normal.

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

Synopsis

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

Time / Day

Date : 201702

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.MSL.Single Value : 24000

Environment

Flight Conditions : VMC

Light : Night

Aircraft

Reference : X

ATC / Advisory.Center : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : Regional Jet 200 ER/LR (CRJ200)

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Ferry

Nav In Use : GPS

Nav In Use : FMS Or FMC

Flight Phase : Cruise

Airspace.Class A : ZZZ

Component : 1

Aircraft Component : AC Generation

Aircraft Reference : X

Problem : Malfunctioning

Component : 2

Aircraft Component : APU

Aircraft Reference : X

Problem : Malfunctioning

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1428180

Human Factors : Distraction

Human Factors : Fatigue

Human Factors : Situational Awareness
Human Factors : Troubleshooting
Human Factors : Workload
Human Factors : Confusion

Events

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

Assessments

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

Narrative: 1

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

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

The Captain called for the IDG 2 QRH checklist. I completed the checklist, which directed me set GEN 2 to RESET/OFF, to confirm and disconnect IDG 2, and then to start the APU and turn on the APU GEN. I completed the checklist and reported the pertinent checklist notes to the Captain. At this point, we then ran the QRH checklists for trim and window/windshield heat messages, which all were resolved (I felt these messages all came

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

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

The Captain made two logbook entries: "IDG 2 master caution in cruise flight. Complied with QRH." and "APU OIL TEMP master caution while on one [engine] generator due to IDG 2 caution. Complied with QRH." The mechanics consulted with Maintenance Control and began inspecting the aircraft on the ramp. One of the mechanics relayed to me the status of the aircraft when I walked out to observe their work. He said the IDG on the right engine "was most likely shot" and pointed out the oil filter was in pressure bypass mode. He said he felt it would be unsafe to try and service the IDG, but rather that it needed to be replaced. There was no oil leak observed by myself or the mechanics inside the engine cowling. The mechanic then reported to me that he checked the APU oil level,

and that it was "very low." The mechanic reported there were no oil leaks observed inside the APU's titanium box. Upon further questioning by myself of how the low oil level occurred, the mechanic said he did not know. He remarked that APU oil levels should be regularly checked during CRJ-200 line/service checks. Ultimately, the mechanics deferred the IDG 2 and serviced and leak-checked the APU oil as the corrective actions for the two maintenance log entries. When I returned to the cockpit, the Captain informed me that Dispatch and Crew Scheduling had requested for us to take an FAR 117 flight duty period extension to complete the flight segment into our filed destination, to avoid it being cancelled. The Captain and I both agreed we were tired, and after a long sit at the previous airport and subsequent diversion, did not feel safe operating past the FDP limits. Thus, we rejected the extension. Crew Scheduling then provided all five of us (pilots, flight attendant, and mechanics) with hotel rooms. We were released from duty very late at night.

Day Two

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

I believe the biggest threat in this situation was the cascade of multiple system EICAS messages in a confined period of time. I feel that the Captain and I did a great job properly managing the workload and addressing the situation in a timely manner. Further, the Captain was quick to divide duties on the flight deck and ensure that one pilot was flying the aircraft and monitoring ATC, while the other pilot was able to perform troubleshooting and QRH duties. After the fact, I again reviewed the logbook for our aircraft. I was very surprised to find two entries a month earlier, which described almost word for word the scenario that we encountered. "In climb IDG DISC status message on number 2 engine." "After APU start - APU OIL TEMP caution." The aircraft appeared to have diverted following these issues, as both pages stated "ZZZ" as the station. The corrective action for the IDG 2 DISC message was a reset/could not duplicate, while the corrective action for the APU OIL TEMP message was adding 3/4 qt of oil to the APU. Of note, the next logbook described a replacement of the IDG 2 with a new unit. Thus, it appears that this aircraft encountered a very similar event less than a month ago. The IDG 2 was replaced, but it seems the corrective action for the APU being low on oil was simply to fill up the oil and sign off the logbook. Again, this is indicative of a "keep the airplane moving" mentality across our company. Given our APU was again low on oil, most likely there is a bigger problem with the APU on this specific aircraft that was never identified or purposefully ignored by our maintenance. Lastly, after the MEL 24-11-XX-XX was applied,

there appears to be no "check" in our system for dispatch to comply with the minimum flight weight of 38,500 LBS. If the Captain and I had not caught this error, we would have most likely been dispatched in a condition contrary to the MEL. Perhaps our Operations and dispatch need to develop some kind of performance check to ensure this limitation is automatically flagged on dispatch releases in the future.

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

Synopsis

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

Time / Day

Date : 201702

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC

Weather Elements / Visibility : Snow

Weather Elements / Visibility.Visibility : 1.5

Light : Daylight

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : Dash 8 Series Undifferentiated or Other Model

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Taxi

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Total : 22310

Experience.Flight Crew.Last 90 Days : 145

Experience.Flight Crew.Type : 7700

ASRS Report Number.Accession Number : 1425955

Human Factors : Fatigue

Events

Anomaly.Ground Excursion : Taxiway

Anomaly.Inflight Event / Encounter : Weather / Turbulence

Detector.Person : Flight Crew

When Detected : Taxi

Assessments

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

Narrative: 1

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

Causal factors: fatigue due to short sleep the night before, therefore I

- 1) Didn't recall we require taxiways plowed.
- 2) didn't fully gauge the level of fatigue
- 3) didn't stop the aircraft to either
 - a. have taxiways plowed
 - b. at least deliberately evaluate situation
 - c. bus pax to terminal
- 4) Multitasked when full attention should have been on taxiing.

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

Secondary causal factors.

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

Solutions:

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

Synopsis

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

Time / Day

Date : 201702

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ASE.Airport

State Reference : CO

Altitude.MSL.Single Value : 12600

Environment

Flight Conditions : Marginal

Weather Elements / Visibility : Fog

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.TRACON : ASE

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use.Localizer/Glideslope/ILS : Runway 15

Flight Phase : Initial Approach

Airspace.Class E : ASE

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1424221

Human Factors : Fatigue

Human Factors : Situational Awareness

Human Factors : Workload

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1424214

Human Factors : Situational Awareness
Human Factors : Training / Qualification

Events

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

Assessments

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

Narrative: 1

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

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

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

given us more time to set up and brief the approach again. I know ASE pretty well and I feel proficient flying in there. I was rushed with the airspace and I should have asked for more vectors for more time. I should have transferred the controls to the FO while I took care of the FMS and briefed the approach.

Narrative: 2

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

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

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

Synopsis

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

Time / Day

Date : 201702

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Light : Night

Aircraft

Reference : X

ATC / Advisory.Ramp : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : B737 Next Generation Undifferentiated

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Taxi

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Captain

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1424191

Human Factors : Fatigue

Human Factors : Situational Awareness

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1424193

Human Factors : Fatigue

Human Factors : Situational Awareness

Events

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

Assessments

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

Narrative: 1

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

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

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

Narrative: 2

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

Synopsis

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

Time / Day

Date : 201702
Local Time Of Day : 1201-1800

Place

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

Aircraft

Reference : X
ATC / Advisory.Tower : LAX
Aircraft Operator : Air Carrier
Make Model Name : Medium Transport, Low Wing, 2 Turbojet Eng
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Nav In Use.Localizer/Glideslope/ILS : Runway 24R
Flight Phase : Landing
Airspace.Class B : LAX

Component

Aircraft Reference : X

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Not Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1422137
Human Factors : Confusion
Human Factors : Fatigue
Human Factors : Workload
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : ATC
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.ATC Issue : All Types
Anomaly.Conflict : Airborne Conflict
Anomaly.Deviation - Altitude : Excursion From Assigned Altitude
Anomaly.Deviation - Speed : All Types
Detector.Person : Flight Crew
Were Passengers Involved In Event : N
When Detected : In-flight

Result.Flight Crew : Executed Go Around / Missed Approach
Result.Air Traffic Control : Issued New Clearance

Assessments

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

Narrative: 1

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

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

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

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

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

Synopsis

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

Time / Day

Date : 201702

Local Time Of Day : 0001-0600

Place

Locale Reference.ATC Facility : C90.TRACON

State Reference : IL

Altitude.MSL.Single Value : 13000

Aircraft

Reference : X

ATC / Advisory.TRACON : C90

Aircraft Operator : Air Carrier

Make Model Name : B737-800

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : GPS

Nav In Use : INS

Flight Phase : Initial Approach

Route In Use.STAR : BENKY 4

Airspace.Class E : C90

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Captain

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1421894

Human Factors : Fatigue

Human Factors : Situational Awareness

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1421908

Human Factors : Situational Awareness

Events

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

Assessments

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

Narrative: 1

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

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

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

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

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

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

Time / Day

Date : 201701

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 500

Environment

Flight Conditions : VMC

Light : Night

Aircraft

Reference : X

ATC / Advisory.Tower : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : Regional Jet 900 (CRJ900)

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Final Approach

Airspace.Class B : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Not Flying

Function.Flight Crew : Captain

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1420514

Human Factors : Fatigue

Human Factors : Situational Awareness

Events

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Inflight Event / Encounter : Unstabilized Approach

Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Became Reoriented

Assessments

Contributing Factors / Situations : Human Factors

Primary Problem : Human Factors

Narrative: 1

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

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

which took care of itself in our descent to the glide slope. As we caught the glide slope we slowed and flaps 30 was called for and selected. During all this we were handed off to Tower and cleared to land. I don't know how we skipped the flaps 45 on the Before Landing Checklist callout or the Stable at 1000 ft but we did. We had a lot going on in a short period of time and skipped the things we've done every flight for many years.

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

Synopsis

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

Time / Day

Date : 201701

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : VHHH.Airport

State Reference : FO

Relative Position.Distance.Nautical Miles : 10

Altitude.MSL.Single Value : 5000

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Center : VHHK

Aircraft Operator : Air Carrier

Make Model Name : MD-11

Crew Size.Number Of Crew : 3

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Cargo / Freight

Nav In Use : FMS Or FMC

Nav In Use : GPS

Flight Phase : Initial Climb

Route In Use.SID : PECAN1A

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Relief Pilot

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Total : 11623

Experience.Flight Crew.Last 90 Days : 150

Experience.Flight Crew.Type : 3118

ASRS Report Number.Accession Number : 1420229

Human Factors : Distraction

Human Factors : Human-Machine Interface

Human Factors : Situational Awareness

Human Factors : Fatigue

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain
Function.Flight Crew : Relief Pilot
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
Experience.Flight Crew.Total : 20000
Experience.Flight Crew.Last 90 Days : 130
Experience.Flight Crew.Type : 9000
ASRS Report Number.Accession Number : 1420870
Human Factors : Situational Awareness
Human Factors : Fatigue
Human Factors : Distraction
Human Factors : Human-Machine Interface

Events

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

Assessments

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

Narrative: 1

During the Pecan 1A departure from Hong Kong, just after we rolled out of the turn to RAMEN at 220 knots, the Captain (pilot flying) called for slats retract. The first officer (Pilot Monitoring) repeated the command and moved the flap/slat handle to the slats retract position. As soon as the handle was moved the stick shaker activated. The Captain called "slats extend", the first officer extended the slats and the stick shaker stopped. We lost several hundred feet of altitude during the recovery. I was the International Relief Officer (IRO) on this flight. I had been focusing on our ground track as the mandatory overflight of PORPA resulted in going a bit wide of the FMS generated ground track during the departure turn from PORPA to RAMEN. As we rolled out and I saw that we were correcting to track, I looked down at the SID depiction on my [Electronic Flight Bag (EFB)]. When I heard the slats retract call, I immediately looked up and saw that we were still several miles short of RAMEN with a 220 knot speed restriction there. I then looked at the airspeed indicator (thinking that maybe I missed a "high speed approved" call from ATC). We were still at 220 knots. The green slat retract (SR) on the airspeed indicator was obscured by the Gear Extend (GE) indication superimposed over it as the two speeds were almost identical. By the time I had processed this information and realized that we were still nearly 30 knots below slat retract speed (maybe 2 or 3 seconds), it was too late. The handle had been moved and the shaker was activated. Recommendations: First and foremost, this event illustrates the importance of the pilot monitoring verifying the limiting speed on the airspeed indicator before moving the flap/slat handle. This should continue to be discussed during recurring training. It is often said that the IRO has the best seat in the house when it comes to threat detection and mitigation as the IRO can devote 100% of his/her time to this activity. Obviously, I picked an unfortunate time to look down at my

[EFB]. That being said, could I have processed the position and airspeed information more quickly and possibly avoided this incident? Perhaps. At this point I should mention that this duty day followed two near minimum crew rests (for both me and the Captain). An international rest of 12 or 13 hours is simply not enough time to travel from the airport to (an often distant) hotel and back, check in and out of the hotel, eat at least once--often twice, plug in our required electronics (iPads and phones), sync our iPads, check our email for scheduling advisories, shower, shave and sleep eight hours. Something has to be sacrificed and it's almost always sleep. When you factor in the inevitable transportation issues (late bus, traffic congestion, etc.) and hotel issues (room key doesn't work, room smells like cigarette smoke, etc) even more sleep is lost. While sleeping only six or six and a half hours may not necessitate calling in fatigued, it definitely resulted in me performing at less than 100%. [The company] needs to do their part in the fatigue mitigation process. Minimum or near-minimum rest periods (less than 15 hours) should be minimized and back to back minimum or near-minimum rest periods should be prohibited.

Narrative: 2

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

Synopsis

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

Time / Day

Date : 201701

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : Mixed

Weather Elements / Visibility.Visibility : 10

Light : Night

Ceiling.Single Value : 5000

Aircraft

Reference : X

ATC / Advisory.Tower : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : B737 Next Generation Undifferentiated

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Mission : Passenger

Nav In Use : FMS Or FMC

Flight Phase : Takeoff

Airspace.Class B : ZZZ

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Last 90 Days : 183

ASRS Report Number.Accession Number : 1419067

Human Factors : Time Pressure

Human Factors : Distraction

Human Factors : Fatigue

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Last 90 Days : 232
ASRS Report Number.Accession Number : 1419373
Human Factors : Distraction
Human Factors : Fatigue

Events

Anomaly.Deviation - Procedural : Weight And Balance
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Became Reoriented

Assessments

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

Narrative: 1

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

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

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

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

Once airborne I discovered the error when I had a chance to look at the Release more carefully, and contacted Dispatch immediately. I tried to reach ZZZ Operations but no one

answered the radio. We determined the loading schedule was correct and landed uneventfully in ZZZ1. All I can say is I'm sorry. I have learned a lot from this flight and will be more diligent in the future, slow down, and try to minimize the risks of fatigue, multiple interruptions and changes to our normal flow.

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

Narrative: 2

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

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

Synopsis

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

Time / Day

Date : 201701

Local Time Of Day : 0601-1200

Place

Locale Reference.ATC Facility : ZME.ARTCC

State Reference : TN

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Center : ZME

Aircraft Operator : Air Carrier

Make Model Name : Widebody Transport

Crew Size.Number Of Crew : 3

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Cargo / Freight

Nav In Use : FMS Or FMC

Nav In Use.VOR / VORTAC : BWG

Flight Phase : Cruise

Airspace.Class A : ZME

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1418104

Human Factors : Situational Awareness

Human Factors : Workload

Human Factors : Distraction

Human Factors : Fatigue

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1418105

Human Factors : Workload
Human Factors : Fatigue
Human Factors : Distraction
Human Factors : Situational Awareness

Person : 3

Reference : 3
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Relief Pilot
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1418357
Human Factors : Situational Awareness
Human Factors : Fatigue
Human Factors : Distraction
Human Factors : Workload

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.Air Traffic Control : Provided Assistance

Assessments

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

Narrative: 1

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

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

Narrative: 2

[Report narrative contained no additional information.]

Narrative: 3

[Report narrative contained no additional information.]

Synopsis

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

Time / Day

Date : 201701

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : LGA.Airport

State Reference : NY

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC

Weather Elements / Visibility : Turbulence

Aircraft : 1

Reference : X

ATC / Advisory.Ground : LGA

Aircraft Operator : Air Carrier

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

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Taxi

Aircraft : 2

Reference : Y

ATC / Advisory.Ground : LGA

Aircraft Operator : Air Carrier

Make Model Name : A320

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Taxi

Aircraft : 3

Reference : Z

ATC / Advisory.Ground : LGA

Aircraft Operator : Air Carrier

Make Model Name : Airbus 318/319/320/321 Undifferentiated

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Taxi

Person : 1

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : First Officer
Function.Flight Crew : Pilot Not Flying
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
ASRS Report Number.Accession Number : 1417108
Human Factors : Fatigue
Human Factors : Distraction
Human Factors : Situational Awareness
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : ATC
Communication Breakdown.Party2 : Flight Crew

Person : 2

Reference : 2
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Instrument
Experience.Flight Crew.Total : 4000
ASRS Report Number.Accession Number : 1417111
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : ATC
Communication Breakdown.Party2 : Flight Crew

Events

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

Assessments

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

Narrative: 1

I was the First Officer (FO) on [the] flight. We landed on 31 from the expressway visual and made the T turnoff. Tower had said make the left turn off at T. I switched the radio to ground and the captain took the ground frequency while I called ramp to get clearance

into the gate. After I had come back to ground frequency the captain had not gotten a word in yet as the frequency was congested and there was a lot of traffic.

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

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

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

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

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

Narrative: 2

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

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

Once we receive word on who to wait for on the ramp the FO returns to VHF 1 and is able to get a word in with ground between the radio traffic and ground commands to "continue on B hold short of G." I move a short distance down B taxiway holding short of G, indicated by the 3 amber lights and was blocked by an A320 on G holding short of runway 4.

Landing traffic on 31 exits on S taxiway and an Airbus on A taxiway, Ground commands the Airbus on A taxiway to taxi on G and B in front of me but they wanted to give way to us. Ground commands us to taxi on B and hold short of F without delay. Once I set the parking brake ground asks about if we are cleared into the gate. The FO responds with what ramp stated, "One out cleared in" but we were both confused because another aircraft had pushed back into the alley, and we asked ramp to clarify if we were cleared in behind the last outbound which he did verify.

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

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

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

Synopsis

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

Time / Day

Date : 201701

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : LIT.Airport

State Reference : AR

Altitude.MSL.Single Value : 10000

Aircraft

Reference : X

ATC / Advisory.TRACON : LIT

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Initial Approach

Airspace.Class C : LIT

Airspace.Class E : LIT

Component

Aircraft Component : Radio Altimeter

Aircraft Reference : X

Problem : Improperly Operated

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1417095

Human Factors : Confusion

Human Factors : Fatigue

Human Factors : Training / Qualification

Events

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Inflight Event / Encounter : Weather / Turbulence

Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Executed Go Around / Missed Approach

Result.Flight Crew : Became Reoriented

Assessments

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

Narrative: 1

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

starting to set in. When the time came to brief the CAT II, I was getting very tired and when the FO challenged me on the DH setting, my judgment was not clear. I did not trust my instinct which told me that I was correct and instead I believed the FO. Since we had discussed the CAT II several times, I believed that we had the DH set correctly and since we were getting close to the airport, I did not ask to double check the setting with the example in the checklist. In the future, I will make sure that the DH setting is briefed as per the example provided and double check the setting if there is any question as to the correct setting.

Synopsis

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

Time / Day

Date : 201701

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ANC.Airport

State Reference : AK

Altitude.AGL.Single Value : 10000

Environment

Flight Conditions : IMC

Aircraft

Reference : X

ATC / Advisory.TRACON : A11

Aircraft Operator : Air Carrier

Make Model Name : Widebody Transport

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Flight Phase : Initial Approach

Airspace.Class C : ANC

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1414879

Human Factors : Distraction

Human Factors : Fatigue

Human Factors : Situational Awareness

Events

Anomaly.Aircraft Equipment Problem : Less Severe

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Inflight Event / Encounter : Weather / Turbulence

Anomaly.Inflight Event / Encounter : Unstabilized Approach

Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Became Reoriented

Assessments

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

Narrative: 1

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

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

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

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

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

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

Synopsis

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

Time / Day

Date : 201611

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.MSL.Single Value : 16000

Environment

Flight Conditions : VMC

Aircraft

Reference : X

ATC / Advisory.Center : ZZZ

Aircraft Operator : Air Carrier

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

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Nav In Use : FMS Or FMC

Flight Phase : Cruise

Airspace.Class E : ZZZ

Component

Aircraft Component : Autopilot

Aircraft Reference : X

Problem : Malfunctioning

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1414631

Human Factors : Fatigue

Events

Anomaly.Aircraft Equipment Problem : Less Severe

Anomaly.Inflight Event / Encounter : Weather / Turbulence

Detector.Person : Flight Crew

When Detected : In-flight

Result.General : Work Refused

Result.Flight Crew : Overcame Equipment Problem

Assessments

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

Narrative: 1

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

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

Synopsis

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

Time / Day

Date : 201612

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.MSL.Single Value : 25000

Environment

Flight Conditions : IMC

Light : Night

Aircraft

Reference : X

ATC / Advisory.Center : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : A300

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Cargo / Freight

Flight Phase : Climb

Airspace.Class A : ZZZ

Component : 1

Aircraft Component : Air Conditioning and Pressurization Pack

Aircraft Reference : X

Problem : Malfunctioning

Component : 2

Aircraft Component : APU Pneumatic System & Ducting

Aircraft Reference : X

Problem : Improperly Operated

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1412767

Human Factors : Fatigue

Human Factors : Physiological - Other

Human Factors : Troubleshooting

Person : 2

Reference : 2
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Pilot Flying
Function.Flight Crew : First Officer
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1412748
Human Factors : Physiological - Other
Human Factors : Fatigue
Human Factors : Troubleshooting

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.Flight Crew : Overcame Equipment Problem
Result.Aircraft : Equipment Problem Dissipated

Assessments

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

Narrative: 1

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

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

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

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

Time / Day

Date : 201612

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : CLT.Airport

State Reference : NC

Environment

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Tower : CLT

Aircraft Operator : Air Carrier

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

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Flight Phase : Initial Climb

Airspace.Class B : CLT

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1412019

Human Factors : Confusion

Human Factors : Fatigue

Human Factors : Situational Awareness

Events

Anomaly.ATC Issue : All Types

Anomaly.Deviation - Track / Heading : All Types

Anomaly.Deviation - Procedural : Clearance

Anomaly.Deviation - Procedural : Published Material / Policy

Detector.Person : Air Traffic Control

When Detected : In-flight

Result.Flight Crew : Returned To Clearance

Result.Flight Crew : Became Reoriented

Assessments

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

Narrative: 1

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

Why:

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

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

Next Time:

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

What [the company] could do better:

SCHEDULES:

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

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

Synopsis

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

Time / Day

Date : 201612

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC

Weather Elements / Visibility : Icing

Light : Night

Aircraft

Reference : X

ATC / Advisory.CTAF : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : Regional Jet 200 ER/LR (CRJ200)

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Landing

Flight Phase : Taxi

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1411815

Human Factors : Fatigue

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1411814

Human Factors : Fatigue

Events

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

Assessments

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

Narrative: 1

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

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

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

anything associated with it from now on. All of this could have been avoided if people were honest.

Narrative: 2

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

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

Synopsis

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

Time / Day

Date : 201612

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : LAX.Airport

State Reference : CA

Altitude.MSL.Single Value : 9000

Environment

Flight Conditions : IMC

Weather Elements / Visibility : Icing

Weather Elements / Visibility : Turbulence

Light : Night

Aircraft

Reference : X

ATC / Advisory.TRACON : SCT

Aircraft Operator : Air Carrier

Make Model Name : B767-300 and 300 ER

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Cargo / Freight

Nav In Use : FMS Or FMC

Flight Phase : Descent

Route In Use.STAR : BASET4

Airspace.Class B : LAX

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 : Pilot Not Flying

Function.Flight Crew : First Officer

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1411747

Human Factors : Distraction

Human Factors : Fatigue

Person : 2

Reference : 2
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1411878
Human Factors : Distraction
Human Factors : Fatigue

Events

Anomaly.ATC Issue : All Types
Anomaly.Deviation - Speed : All Types
Anomaly.Deviation - Procedural : FAR
Detector.Person : Flight Crew
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
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

We were descending to cross KONZL at 17000 ft as briefed and instructed on our arrival into LAX, expecting to continue via our filed/briefed STAR and a south complex runway (indicated as available on ATIS). Approach issued a change of arrival (BASET4 instead of the RDEYE2), direct to a fix on the arrival (BASET), different runway than expected (6L instead of 7R), "Descend via" clearance on the new arrival, and the ACARS chimed with a "Call Crew Schedules on arrival" all at about the same time.

As we tried to type/reconcile/brief, we got caught up in what appeared to be a discrepancy between the FMS database STAR and the chart. The BASET4 chart illustrates a descent to cross REEDR at/above 9000 followed by a 210 degree heading. Lined up with that heading (on the chart) is "ZUSGI", annotated with at/above 8000. The FMS database routing showed the turn at REEDR, subsequent heading, and a REEDR crossing altitude of 9000 ft. As we had been cleared to 'descend via' the BASET, the last applicable altitude was the item we were paying lots of attention to but as tired as we were, it didn't make sense. We were almost caught up again when we were given direct SMO with instructions to depart SMO on a 250 degree heading and descend to 8000 ft, and told to expect 7R. With all the mode changes, typing, button pushing, briefing, and radio calls crammed into a couple short minutes, neither of us noticed the speed window was open as we approached 10000 ft. The Captain caught it at about 9000 ft and immediately leveled to slow. I looked up and saw 290 kias. The airplane slowed rapidly to 250 and we continued our descent.

No comment was made by approach and we made it to the gate without any further incident (to the best of our knowledge). The simplest explanation is that the speed window was open in a VNAV descent and we didn't notice. More directly, though, I should have kept our current lateral and vertical modes in my scan each time I transitioned to/from

heads-down and typing. While I was programming the FMS, I neglected to serve adequately in my role as Pilot Monitoring. Increased scan, slowing down, and backing each other up in a more positive manner.

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

B767 Flight Crew reported exceeding 250 knots below 10000 feet during a late night arrival to LAX after several changes to their arrival and landing runway. Fatigue and distractions were cited as factors in the incident.

Time / Day

Date : 201612

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 1000

Environment

Light : Night

Aircraft

Reference : X

ATC / Advisory.Tower : 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 : Landing

Airspace.Class B : ZZZ

Component

Aircraft Component : Flap/Slat Indication

Aircraft Reference : X

Problem : Malfunctioning

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Captain

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1411085

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 : 1411390
Human Factors : Fatigue
Human Factors : Situational Awareness

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Deviation - Procedural : Published Material / Policy
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 : Aircraft

Narrative: 1

We had been cleared to land. The visibility was good with the airport in sight. Above 1000 feet on short final I called for flaps 30 to complete the final aircraft landing configuration. The landing check was also called for at this time. During the landing checklist we did not get the "green light" for the flaps. We discovered that the #6 leading edge slat transit light was illuminated. However, a visual check of the leading edge flaps confirmed to us that all the slats appeared to be extended to the full position. The autopilot was not engaged and the aircraft showed no rolling tendency. I increased the airspeed slightly. The aircraft felt stable. We talked briefly about our situation and felt that it was safe to land. We continued to a normal landing.

First, after thinking about the event and reviewing the QRH, I now believe that we should have abandoned the landing and gone missed approach. We could have then reviewed the procedures more thoroughly and perhaps considered a flaps 15 landing. This would have been the most prudent way to go. It would have been a better decision and the right way to address the situation.

Second, I think that since the aircraft appeared to be functioning properly, continuing to a landing just felt right at the time. Everything outside appeared normal and the runway was just right there. There was definitely some expectation bias that took place.

Other elements that may have had a part in this scenario are:

- We didn't have much time to make a decision. By the time we figured out our situation we were very close to the runway.
- We received the aircraft two hours late, so we already were well behind schedule.
- We were flying the all-nighter and although I had slept for over 5 hours that evening and felt well rested before heading for the airport shuttle, it is not a part of my normal biorhythms to be awake during those hours of the day. At the time of the event, even though I felt alert, I may not have been at my best.

Each of these additional conditions were not at the forefront of my thoughts, but may have subconsciously effected my decision making.

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

B737-800 flight crew reported continuing to a landing after a leading edge slat transit light remained illuminated.

Time / Day

Date : 201612

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.MSL.Single Value : 3000

Environment

Flight Conditions : IMC

Weather Elements / Visibility : Cloudy

Light : Daylight

Ceiling.Single Value : 1100

Aircraft

Reference : X

ATC / Advisory.TRACON : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : B787-800

Crew Size.Number Of Crew : 4

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

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 Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Total : 21600

ASRS Report Number.Accession Number : 1410042

Human Factors : Confusion

Human Factors : Fatigue

Human Factors : Human-Machine Interface

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 : Relief Pilot
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1410460
Human Factors : Human-Machine Interface
Human Factors : Confusion
Human Factors : Communication Breakdown
Human Factors : Fatigue
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Person : 3

Reference : 3
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : First Officer
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1410030
Human Factors : Human-Machine Interface
Human Factors : Fatigue
Human Factors : Communication Breakdown
Human Factors : Confusion
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Deviation - Speed : All Types
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : FLC Override Automation
Result.Flight Crew : Executed Go Around / Missed Approach
Result.Flight Crew : Regained Aircraft Control

Assessments

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

Narrative: 1

On arrival, the First Officer (FO) asked me if he could hand fly from 10,000 feet down to landing. He has been off on a medical. He is fully qualified, so I said yes. Everything was normal until we intercepted the LOC XYL. We were at 190 Knots and ATC asked us to slow to 170 Knots. Configuration was gear up and flaps 15. We had just intercepted the GS at approximately 5000 feet and not slowing. I told the FO that this airplane was hard to slow, so we put the gear down. ATC asked us to slow to 160 Knots and we selected flaps 20. At approximately 4000 feet, ATC said we were too close to traffic ahead and needed to break us out. He said maintain 3000 feet and turn left to 270. At this point, I used some poor phraseology. I said let's treat this like a GO AROUND. I was thinking, gear up, set missed

approach altitude (3000), heading select 270, Set Speed, and clean up on schedule. I should have said, level at 3000, and turn to 270. The FO heard GO AROUND and pushed to Take Off Go Around button hand flying in a descent. The jet accelerates very fast at GO AROUND thrust in a descent. I put the gear up and went to flaps 5, 1, up. The [relief pilots] and I were saying "SPEED". We had a flap over speed of 262 knots from flaps 1 to 0. I took control of the plane and slowed to 250 and turned on the Auto Pilot. Landed on XYL. Made a logbook entry about the Flap Over Speed.

Narrative: 2

[Report narrative contained no additional information.]

Narrative: 3

[Report narrative contained no additional information.]

Synopsis

Air carrier flight crew reported a mis-communication that led to a flap over speed after an ATC directed break out from the approach.

Time / Day

Date : 201612

Local Time Of Day : 1201-1800

Place

Locale Reference.ATC Facility : ZZZ.ARTCC

State Reference : US

Environment

Flight Conditions : VMC

Aircraft

Reference : X

ATC / Advisory.Center : ZZZ

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 : Cruise

Airspace.Class A : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1409916

Human Factors : Distraction

Human Factors : Fatigue

Human Factors : Physiological - Other

Events

Anomaly.Aircraft Equipment Problem : Less Severe

Detector.Person : Flight Crew

When Detected : In-flight

Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Aircraft

Primary Problem : Aircraft

Narrative: 1

During cruise we noticed an annoying noise in the cockpit that only occurred after the aircraft leveled off in cruise flight and the auto thrust retards the thrust from climb to cruise thrust, the sounds a normal 320 engine [type] aircraft retarding the engine thrust to idle when the fans rumble temporarily.

However on [this aircraft] the rumble of the unsynced fans is continuous and low frequency to the point where you feel it internally. When the [other type] engines are at full power there is no low frequency rumble, [and] when the engines are at idle, there is no low frequency rumble. But when the engines are in cruise thrust, there is a constant low frequency rumble that constantly comes in and out [and can be] heard/felt in the cockpit.

When I stepped outside the cockpit to use the lavatory, both the Captain and I noticed that you cannot hear the fan rumble in the passenger cabin (or at least in the forward galley/forward lav area). Upon returning to the cockpit after a lavatory break, we were subjected to the unsynced fans again.

We didn't notice it during the [first] leg, but it was becoming annoying by the [second] leg and by the time we were flying [the last leg] I had a throbbing headache and I found it difficult to perform my pilot duties and concentrate on the tasks at hand.

I also submitted an accompanying company fatigue report. Investigate the low frequency unsynced fan harmonics on the engines. Limit number of legs crew fly [this] aircraft.

Synopsis

A320 First Officer reported experiencing distracting headaches and fatigue from what he described as a continuous low frequency rumble from the engines in cruise flight.

Time / Day

Date : 201612

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.MSL.Single Value : 41000

Environment

Light : Night

Aircraft

Reference : X

ATC / Advisory.Center : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : B777-200

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 Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1409428

Human Factors : Fatigue

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 : Relief Pilot

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1409712

Human Factors : Distraction

Human Factors : Confusion
Human Factors : Situational Awareness

Events

Anomaly.Deviation - Speed : All Types
Anomaly.Inflight Event / Encounter : Weather / Turbulence
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Requested ATC Assistance / Clarification
Result.Flight Crew : Regained Aircraft Control
Result.Flight Crew : FLC Override Automation
Result.Air Traffic Control : Issued New Clearance

Assessments

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

Narrative: 1

At FL410, initially at Mach .834 with 80 kts of steady-state tailwind, we encountered a severe mountain wave: airspeed increased 25 kts within 5 seconds. As the PF, I rapidly went full idle and then deployed full speed brakes as it continued to accelerate. The aircraft sped into the barber pole with full idle and boards by 15 kts and remained there for 15-20 seconds before decelerating to within limits. Now on the performance decreasing side of the wave and in moderate turbulence, we asked for and were given a descent to FL390 with airspeed above the lower barber pole but within the amber foot. I achieved normal range airspeed in the descent and ascertained that there were no injuries in the cabin from the abrupt turbulence.

These mountain waves are not uncommon with a strong tailwind eastbound from the Rocky Mountain Range and are normally easily handled with throttle reduction below Mach .84, but this one was very severe and could not be prevented even with an expeditious reaction. While the acceleration was adequately handled, little sleep on a turbulent night may have been a factor with me not better catching the deceleration on the performance decreasing side of the mountain wave and allowing the airspeed to enter the amber foot. Additionally, I was slow to catch the fact that the Autothrottles had entered the "HOLD" mode vs a speed mode from the initial throttle reduction, and that confusion caused a slower acceleration back to normal parameters than what I would be proud of, as I hand-flew the aircraft through the descent to FL390. It was safe, but could have been flown better. The FB (in the PM role) did an outstanding job of assisting me through the event.

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

B777 flight crew reported an aircraft overspeed for 15-20 seconds while in cruise at FL410 due to a severe mountain wave encounter.

Time / Day

Date : 201612
Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZZ.Airport
State Reference : FO
Altitude.AGL.Single Value : 1200

Environment

Flight Conditions : VMC

Aircraft

Reference : X
ATC / Advisory.Tower : ZZZZ
Aircraft Operator : Air Carrier
Make Model Name : B757-200
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Flight Phase : Initial Approach

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Pilot Flying
Function.Flight Crew : Captain
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1407596
Human Factors : Situational Awareness
Human Factors : Fatigue

Events

Anomaly.Deviation - Altitude : Overshoot
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : Clearance
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Anomaly.Inflight Event / Encounter : CFTT / CFIT
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Returned To Clearance
Result.Flight Crew : Became Reoriented

Assessments

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

Narrative: 1

These recollections are made after getting about 5 hours of sleep after arrival. The essence of the incident is that we ended up stabilizing on the glide slope late. Here is how it unfolded.

It was the First Officer's (FO) leg, number 4, and the last leg in the trip pairing. We had initially flown an am leg, followed by day crew rest that was a poor one for both crew members, due to the 2.5 hour drive to the hotel. (There was a wreck on the [road]). When we met to begin our night duty period to fly, we both related that sleep did not come easily, having arrived at the hotel so late in the day. We proceeded uneventfully to [first destination]. At the hub, we each tried to get some rest in a sleep room-I dozed fitfully, and the FO mentioned during our following flight planning that she had not been able to sleep.

We proceeded to [next destination], and after blocking in, while discussing the current and forecast weather for our final leg, discussed the possible need for me to make a Cat II auto land approach at ZZZZ, but would make that decision enroute. It was the FO's leg, and she was Pilot Flying until we determined that although ZZZZ visibility was reported well above Cat I minimums, the variable thin broken cloud report of varying between 200 and 2000 feet lead us to conclude that a Cat II Auto land approach would be prudent. We completed the Approach checklist and exchanged roles on radar downwind. During the remainder of the radar pattern, we had consecutive reductions in altitude such that we never leveled off until reaching the assigned 2000 feet altitude for glide slope intercept. As the airplane leveled off on autopilot, I noticed that for some reason, we were a little above 2000 feet, so I selected a Vertical speed descent of a few hundred feet per minute to get us down. About this time, we were distracted by switching to tower, and continued a slow descent while cleared for the approach to what was in fact below 2000, although we did not realize it. Monitoring my radio altimeter, I could not understand why the Glide Slope Indicator had not come alive, and was about to initiate a go-around and try to figure it out later. About this time the FO said something like "we are below glide slope," so I leveled off, and we intercepted the glide slope from below, and continued the approach. During this phase, we were VMC, and could actually see the ground, but did not have slant range visibility to the runway-due to low broken clouds.

After landing and debriefing, we questioned the correctness of my altimeter setting, and only after some sleep and further thought, have I pieced together what I think happened. Going back to the arrival sequence, since it had been the FO's leg, the Right Autopilot was in command. Due to consecutively lower altitude assignments, we never actually leveled off until the 2000 feet assignment, which, as I mentioned above, we did not descend to without engaging Vertical Speed. The only explanation for this that I can come up with is that my altimeter was somehow still in Standard versus set to QNH. I had completed the Approach check, and was sure that at one time I saw the local altimeter setting, but until I selected the Approach tile on the radar dogleg, which engaged all 3 autopilots, the Right autopilot remained in command, reflecting the FO's correct altimeter setting. That fact, combined with consecutive lower altitude assignments that precluded level off until final, masked the error.

The net result was that we paralleled the glide slope just below it, intercepted the glide slope late, and pushed stabilized approach criteria. I estimate we were 4-5 miles out when all this took place, and about 1200 feet or so AGL. The reason it seemed so comfortable to continue is that we were actually VMC, and could see the ground below us.

In retrospect, a better decision would have been to go around when I was initially inclined to do so, figure out exactly what was not right, and shoot another approach. It has taken some hours of recollection and thought to piece together what happened, time not available when it happened. Factors contributing were: third leg of an all-night duty period, challenging weather, and fatigue. Both crew members had not slept well, and I am shocked at the insidious onset of dull thought leading to poor decision making in my own case brought on by fatigue.

For me, avoid hub turns. I do not sleep well during the day, and so must simply avoid the need to do so. In flight, go around when you determine things are not right.

Synopsis

B757-200 Captain reported fatigue was a factor in his approach that was flown below the glideslope to about 1200 feet AGL, 4 to 5 miles out.

Time / Day

Date : 201612

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : IAH.Airport

State Reference : TX

Altitude.AGL.Single Value : 0

Environment

Light : Night

Aircraft

Reference : X

ATC / Advisory.Ground : IAH

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 : Cargo / Freight

Flight Phase : Taxi

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1405897

Human Factors : Confusion

Human Factors : Fatigue

Human Factors : Situational Awareness

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : ATC

Events

Anomaly.ATC Issue : All Types

Anomaly.Deviation - Procedural : Clearance

Anomaly.Ground Incursion : Taxiway

Detector.Person : Flight Crew

When Detected : Taxi

Result.Flight Crew : Took Evasive Action

Result.Flight Crew : Requested ATC Assistance / Clarification

Result.Flight Crew : Became Reoriented

Result.Air Traffic Control : Provided Assistance

Assessments

Contributing Factors / Situations : Airport

Contributing Factors / Situations : Environment - Non Weather Related

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Procedure

Primary Problem : Airport

Narrative: 1

After landing at IAH Runway 27, Ground initially gave us incomplete instructions to taxi to the ramp. Our instructions ended at Taxiway RA, when we approached Taxiway WB, the FO queried Ground to ensure that we should taxi WB to WH to the ramp. As we taxied south on WB, we were looking for the ramp and Taxiway WH. We never saw a sign for WH, but I recognized the ramp 10 feet after we passed the taxiway. I immediately stopped the aircraft. When we talked to Ground, he apologized that the lights were out on the signage, but thought we were familiar. We eventually taxied further down to turn around to the ramp.

[Caused by] no NOTAM for the inoperative lighting on the signage and my own fatigue from several circadian rhythm changes in the proceeding 3 days.

Synopsis

Air carrier Captain reported missing taxiway WH during night taxi at IAH. Captain stated signage lighting contributed to the event.