

ASRS Database Report Set

Cockpit Resource Management (CRM) Issues

Report Set Description.....Crew Resource Management (CRM) inflight situations
(conflicts, NMACs, and emergencies).

Update Number31

Date of UpdateMarch 24, 2022

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

Records within this Report Set have been screened to assure their relevance to the topic.



TH: 262-7

MEMORANDUM FOR: Recipients of Aviation Safety Reporting System Data

SUBJECT: Data Derived from ASRS Reports

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

ASRS reports are submitted voluntarily. Such incidents are independently submitted and are not corroborated by NASA, the FAA or NTSB. The existence in the ASRS database of reports concerning a specific topic cannot, therefore, be used to infer the prevalence of that problem within the National Airspace System.

Information contained in reports submitted to ASRS may be clarified by further contact with the individual who submitted them, but the information provided by the reporter is not investigated further. Such information represents the perspective of the specific individual who is describing their experience and perception of a safety related event.

After preliminary processing, all ASRS reports are de-identified and the identity of the individual who submitted the report is permanently eliminated. All ASRS report processing systems are designed to protect identifying information submitted by reporters; including names, company affiliations, and specific times of incident occurrence. After a report has been de-identified, any verification of information submitted to ASRS would be limited.

The National Aeronautics and Space Administration and its ASRS current contractor, Booz Allen Hamilton, specifically disclaim any responsibility for any interpretation which may be made by others of any material or data furnished by NASA in response to queries of the ASRS database and related materials.

A handwritten signature in blue ink, appearing to read "B. Hooey".

Becky L. Hooey, Director
NASA Aviation Safety Reporting System

CAVEAT REGARDING USE OF ASRS DATA

Certain caveats apply to the use of ASRS data. All ASRS reports are voluntarily submitted, and thus cannot be considered a measured random sample of the full population of like events. For example, we receive several thousand altitude deviation reports each year. This number may comprise over half of all the altitude deviations that occur, or it may be just a small fraction of total occurrences.

Moreover, not all pilots, controllers, mechanics, flight attendants, dispatchers or other participants in the aviation system are equally aware of the ASRS or may be equally willing to report. Thus, the data can reflect **reporting biases**. These biases, which are not fully known or measurable, may influence ASRS information. A safety problem such as near midair collisions (NMACs) may appear to be more highly concentrated in area “A” than area “B” simply because the airmen who operate in area “A” are more aware of the ASRS program and more inclined to report should an NMAC occur. Any type of subjective, voluntary reporting will have these limitations related to quantitative statistical analysis.

One thing that can be known from ASRS data is that the number of reports received concerning specific event types represents the **lower measure** of the true number of such events that are occurring. For example, if ASRS receives 881 reports of track deviations in 2010 (this number is purely hypothetical), then it can be known with some certainty that at least 881 such events have occurred in 2010. With these statistical limitations in mind, we believe that the **real power** of ASRS data is the **qualitative information** contained in **report narratives**. The pilots, controllers, and others who report tell us about aviation safety incidents and situations in detail – explaining what happened, and more importantly, **why** it happened. Using report narratives effectively requires an extra measure of study, but the knowledge derived is well worth the added effort.

Report Synopses

ACN: 1822878 *(1 of 50)*

Synopsis

Air carrier flight crew reported a taxiway incursion and ground conflict resulted from receiving ATC taxi instructions during a high workload landing roll and not being able to clarify with Ground Control.

ACN: 1821911 *(2 of 50)*

Synopsis

Air Carrier flight crew reported Dispatch notification during cruise of incorrect amount of dry ice weight information provided to flight crew at departure.

ACN: 1817229 *(3 of 50)*

Synopsis

B737-800 flight crew reported a clearance deviation due to automation mismanagement and CRM issues.

ACN: 1816084 *(4 of 50)*

Synopsis

Flight crew reported a NMAC with a glider while they were on a STAR inbound to SNA.

ACN: 1814363 *(5 of 50)*

Synopsis

Air Carrier First Officer reported an unstable approach and non compliance with SOP's. The aircraft touched down and the "GO Around" call happened almost simultaneously, creating a CRM discussion at the arrival gate.

ACN: 1811182 *(6 of 50)*

Synopsis

First Officer reported engine failure on departure caused a return to the airport and a safe landing but the Captain did not comply with established procedures.

ACN: 1805744 *(7 of 50)*

Synopsis

First Officer Pilot Monitoring reported the Pilot Flying flew too low on a Visual Approach and did not respond to his instructions to climb to avoid terrain until ATC also instructed them to climb.

ACN: 1805214 *(8 of 50)*

Synopsis

Corporate aircraft Captain reported overshooting assigned altitude during departure due to a late ATC Clearance. Captain also cited lack of flying as a contributing factor.

ACN: 1804019 *(9 of 50)*

Synopsis

Instructor and student reported descending below Minimum Descent Altitude, which they attributed to an incorrect altimeter setting, and turbulence.

ACN: 1802319 *(10 of 50)*

Synopsis

Air carrier flight crew reported an altitude and track heading deviation during approach to an international airport. The crew stated this sequence of flights, since the COVID-19 pandemic started, are very long and fatiguing which may have been a factor in the event.

ACN: 1802287 *(11 of 50)*

Synopsis

Air carrier First Officer reported a CFIT event during approach under Approach Control which was followed by an uneventful visual landing.

ACN: 1797204 *(12 of 50)*

Synopsis

Flight Attendant reported misgivings over Crew Coordination and Communication over compressor stalls during this and other flights, including ETOPS.

ACN: 1796734 *(13 of 50)*

Synopsis

Air Carrier Flight Attendant reported physiological symptoms from intermittent cabin fumes which were also reported by passengers.

ACN: 1795884 *(14 of 50)*

Synopsis

Air carrier flight crew reported missing re-setting the auto-brake system before takeoff and cited dealing with a passenger not complying with face mask policy as a contributing factor.

ACN: 1792528 *(15 of 50)*

Synopsis

Air carrier flight crew reported that during arrival into BUR airport they had experienced an RA and later had a terrain warning caused by passing over a mountain peak at a high rate of descent.

ACN: 1790605 *(16 of 50)*

Synopsis

Learjet First Officer reported receiving a low altitude alert from ATC after descending early on a cleared instrument approach.

ACN: 1789180 *(17 of 50)*

Synopsis

A321 flight attendants reported a communication breakdown with the Captain regarding cabin odor during boarding.

ACN: 1786404 *(18 of 50)*

Synopsis

Air carrier Captain reported that an airspeed exceedance and altitude excursion occurred when the aircraft encountered a mountain wave.

ACN: 1784953 *(19 of 50)*

Synopsis

Air Carrier First Officer reported poor CRM with the Lead FA regarding the company face mask policy on the Flight Deck.

ACN: 1781107 *(20 of 50)*

Synopsis

Flight Attendant reported the FA crew were unwilling to enter the flight deck because the First Officer would not wear a face mask.

ACN: 1780384 *(21 of 50)*

Synopsis

LR-40 Captain reported a critical Ground conflict during takeoff roll with a runway incursion aircraft at far end of departure runway.

ACN: 1772774 *(22 of 50)*

Synopsis

Air Carrier First Officer reported an altitude deviation during departure and cited poor CRM and lack of flying as contributing factors.

ACN: 1770347 *(23 of 50)*

Synopsis

Corporate Captain reported poor judgment resulted in flying VFR into IMC. Captain reported outside pressures to depart contributed to the event.

ACN: 1768450 *(24 of 50)*

Synopsis

Air carrier flight crew reported an overweight landing.

ACN: 1766003 *(25 of 50)*

Synopsis

G280 Captain reported deviating from the ATC clearance due to receiving an RA.

ACN: 1765743 *(26 of 50)*

Synopsis

Air carrier Flight Crew reported Flight Management Computer Database was out of date.

ACN: 1764793 *(27 of 50)*

Synopsis

Air carrier flight crew reported executing a go-around due to a ground proximity warning.

ACN: 1763155 *(28 of 50)*

Synopsis

Pilot reported being under pressure and flew a ferry flight without proper documentation.

ACN: 1761850 *(29 of 50)*

Synopsis

Air Carrier Captain reported an unstable approach due to poor CRM and lack of flying.

ACN: 1761773 *(30 of 50)*

Synopsis

Air Carrier Captain reported a track deviation during approach and cited fatigue and low flight time during the pandemic as contributing factors.

ACN: 1758896 *(31 of 50)*

Synopsis

Pilot reported flying approaches into FWS airport entered NFW Class D airspace without clearance and cited FAA charting issues as a contributing factor.

ACN: 1758346 *(32 of 50)*

Synopsis

Flight Attendant reported a passenger was non compliant with face mask policy during flight. Reporter stated the passenger said he had a medical condition, but it was not noted in the crew's records.

ACN: 1757150 *(33 of 50)*

Synopsis

B757 flight crew reported accidental depressurization in cruise when troubleshooting a pack malfunction.

ACN: 1754416 *(34 of 50)*

Synopsis

Captain reported a GA aircraft departed in opposite direction while they were on the runway ready for takeoff. The Tower was closed at the time of the event.

ACN: 1751568 *(35 of 50)*

Synopsis

Air carrier First Officer reported they had numbers for a full runway takeoff, but were given and executed an intersection takeoff.

ACN: 1750466 *(36 of 50)*

Synopsis

Air carrier flight crew reported receiving a windshear warning on takeoff and failing to perform the Wind Shear Maneuver.

ACN: 1747275 *(37 of 50)*

Synopsis

A pilot practicing approaches reported executing a go-around after the flight crew descended below a crossing restriction and received a low altitude alert from ATC.

ACN: 1746738 *(38 of 50)*

Synopsis

Air carrier flight crew reported experiencing an unstabilized approach and setting up to land on a closed runway with anticipation of changing to landing runway later.

ACN: 1744573 *(39 of 50)*

Synopsis

Flight Attendant reported that another Flight Attendant refused to wear a mask during boarding and throughout the flight. Reporter expressed concern that the health of passengers and other cabin crew were put at risk.

ACN: 1743749 *(40 of 50)*

Synopsis

Corporate pilot reported having an altitude deviation while hand-flying the aircraft and attributed it to lack of flying due to the COVID-19 slow down.

ACN: 1743683 *(41 of 50)*

Synopsis

B747 flight crew reported that ATC instructed them to maintain greater than 250 kts. airspeed below 10,000 ft.

ACN: 1742866 *(42 of 50)*

Synopsis

Air carrier Captain reported experiencing an unstabilized approach in which they should have executed a go-around but decided to continue and stabilized at 500 feet. Captain reported rustiness from lack of flying contributed to the event.

ACN: 1742825 *(43 of 50)*

Synopsis

Air carrier Captain reported operating flights with an incorrect MEL applied. The flight deck sanitizing process was cited as a reason for not closely reviewing the logbook and MEL.

ACN: 1740453 *(44 of 50)*

Synopsis

Air Carrier flight crew reported receiving a GPWS terrain alert on a visual approach to ITO.

ACN: 1739626 *(45 of 50)*

Synopsis

ERJ145 Captain reported the parked aircraft began rolling on the ramp and the First Officer put the brakes on and the parking brake causing an abrupt stop injuring a Flight Attendant.

ACN: 1737621 *(46 of 50)*

Synopsis

Air carrier flight crew reported having an aircraft pressurization problem thinking it was an equipment problem but the Packs were not turned on.

ACN: 1736305 *(47 of 50)*

Synopsis

Flight Attendants reported concerns about a sick passenger in their flight.

ACN: 1733955 *(48 of 50)*

Synopsis

Flight attendant reported a CRM issue developed with the flight deck crew after reporting there was a minor maintenance issue with an aircraft door.

ACN: 1731353 *(49 of 50)*

Synopsis

CRJ-200 Captain reported landing safely after experiencing multiple electrical and autoflight anomalies.

ACN: 1726381 *(50 of 50)*

Synopsis

Corporate jet SIC reported that during a circle to land maneuver at night, the PIC lined up with the wrong runway, allowed airspeed to decay, and did not execute an ATC-commanded go-around. The PIC did not respond to the SIC's guidance and CRM was compromised.

Report Narratives

Time / Day

Date : 202107

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC

Aircraft : 1

Reference : X

ATC / Advisory.Ground : ZZZ

ATC / Advisory.Tower : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : B737 Undifferentiated or Other Model

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Taxi

Aircraft : 2

Reference : Y

Make Model Name : Medium Transport

Crew Size.Number Of Crew : 2

Flight Phase.Other

Person : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Total : 3778

Experience.Flight Crew.Last 90 Days : 164

Experience.Flight Crew.Type : 3778

ASRS Report Number.Accession Number : 1822878

Human Factors : Communication Breakdown

Human Factors : Workload

Human Factors : Situational Awareness

Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : ATC

Person : 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 : Multiengine
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Air Transport Pilot (ATP)
Experience.Flight Crew.Total : 2729
Experience.Flight Crew.Last 90 Days : 230
Experience.Flight Crew.Type : 2729
ASRS Report Number.Accession Number : 1822880
Human Factors : Communication Breakdown
Human Factors : Workload
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : ATC

Events

Anomaly.ATC Issue : All Types
Anomaly.Conflict : Ground Conflict, Less Severe
Anomaly.Deviation / Discrepancy - Procedural : Clearance
Anomaly.Ground Incursion : Taxiway
When Detected : Taxi
Result.Flight Crew : Requested ATC Assistance / Clarification
Result.Air Traffic Control : Provided Assistance

Assessments

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

Narrative: 1

During landing roll out, using max autobrake, transfer of control, stowing the thrust reversers, at a relatively high speed, Tower issued taxi instruction of turn left on Taxiway 1 hold short of Taxiway 2. As I was concentrating on flying the airplane (decelerating on landing rolling out) I only heard Left on 1 and 2. As I vacated the runway on Taxiway 1 Ground called us but was stepped on and was unreadable. When vacating taxiway 1 and clearing the hold short line for the runway there is barely room to even hold short of taxiway 2 thus, I never expected for that to even be a possibility. I taxied out onto taxiway 2 and then saw Aircraft Y under tow on taxiway 2. He was far away and there was no threat of a collision but there was a conflict now on 2. Ground advised us we were supposed to hold short of 2, sounded annoyed, and then told the Aircraft Y tow crew to pull into the run-up area which they did and told us to continue which we did with no further complications. Receiving taxi instructions during a landing roll out while a pilot is still "flying" the jet and concentrating is definitely a threat I will address moving forward in my briefings.

Narrative: 2

Daytime/VMC arrival into ZZZ. Normal landing/rollout, aircraft decelerating brakes MAX, Tower issued clearance to exit via Taxiway 1, hold short Taxiway 2, contact Ground. Clearance heard/understood/read back accurately by First Officer, misheard/misunderstood by Captain as "exit Taxiway 1, Taxiway 2, contact Ground." First Officer unaware of misunderstanding. Clearing runway, VHF 1 switched to Ground. Ground transmission blocked by simultaneous transmission of third aircraft, essentially unreadable to First Officer. Captain still exiting left on 1, continued left turn onto 2. First Officer assumed transmission heard/understood sufficiently by Captain to continue taxi. Turning onto 2, CA noted Aircraft Y under tow opposite direction on Taxiway 2, stopped aircraft well short of conflict. Reprimanded by ground for failing to hold short Taxiway 2. Tow crew directed to turn into holding pad, allow Aircraft Y to pass. Conflict resolved, ground directed taxi to parking via 2. Breakdown in CRM/communication/First Officer verification. Contributing factors included: ATC taxi instructions issued during high workload period (short field landing, brakes MAX, transfer of controls). Minimal length of Taxiway 2 resulted in a) limited area to clear runway and still hold short taxiway A, and b) insufficient time to query ground regarding blocked transmission and/or verify with Captain understood taxi instructions.

Synopsis

Air carrier flight crew reported a taxiway incursion and ground conflict resulted from receiving ATC taxi instructions during a high workload landing roll and not being able to clarify with Ground Control.

Time / Day

Date : 202107

Local Time Of Day : 0601-1200

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 : Commercial Fixed Wing

Crew Size.Number Of Crew : 3

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Cargo / Freight / Delivery

Flight Phase : Cruise

Airspace.Class A : ZZZ

Person : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Not Flying

Function.Flight Crew : First Officer

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

ASRS Report Number.Accession Number : 1821911

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Dispatch

Person : 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

Function.Flight Crew : Relief Pilot

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1821918

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Dispatch

Person : 3

Location Of Person : Hangar / Base
Location Of Person.Aircraft : X
Location In Aircraft.Other
Reporter Organization : Air Carrier
Function.Dispatch : Dispatcher
Qualification.Dispatch : Dispatcher
ASRS Report Number.Accession Number : 1821651
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Dispatch
Communication Breakdown.Party2 : Flight Crew

Person : 4

Location Of Person : Hangar / Base
Location Of Person.Aircraft : X
Location In Aircraft.Other
Reporter Organization : Air Carrier
Function.Dispatch : Dispatcher
Qualification.Dispatch : Dispatcher
ASRS Report Number.Accession Number : 1821930
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Dispatch
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Deviation / Discrepancy - Procedural : Weight And Balance
Anomaly.Deviation / Discrepancy - Procedural : Hazardous Material Violation
Anomaly.Deviation / Discrepancy - Procedural : FAR
Detector.Person : Dispatch
When Detected : In-flight
When Detected : Routine Inspection
Result.Flight Crew : Overcame Equipment Problem
Result.Aircraft : Equipment Problem Dissipated

Assessments

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

Narrative: 1

During Cruise we received an ACARS message from the company [Dispatch] that they had left 1768kg (initial message said 1768lbs but was later corrected) of Dry Ice off the DG manifest. We began to send follow up messages back and forth to confirm the location and total quantity of the dry ice. It was determined that the total quantity was 1884kg vs the DG manifest value of 166kg. Basically, 2 cans worth of Dry Ice had not be accounted for on the DG manifest. The crew deployed the Drager CO2 monitoring system immediately and was also directed to do this from the company. We also ran the QRH for this event. Upon further review, it was determined by crew and Dispatch that the dry ice quantity on board not only exceeded normal FOM limits, but was over the supplemental limits in the FOM. I began a conference call with the Dispatcher, DO, and Flight Operations. Based on

all the information, they recommended we deploy the CO2 monitoring system and keep a close eye out for any elevated CO2 levels, but that we should be able to continue safely to our destination which was another 8 or so hours away. We knew if the levels were elevated we could follow the QRH and use oxygen to breathe safely and divert if needed. We also knew that we were flying right over ZZZ1 in about an hour which we could just divert to immediately to remedy the problem. This would give us time to get ready for the divert and allow us to burn enough fuel to get below maximum landing weight. So basically our options were 1) continue or 2) divert. We woke up the Captain to provide him all of the data so he could make the decision. With all the data and the opinions of the crew, he decided we should continue. The decision was supported by the crew and Dispatch. The rest of the flight was uneventful. Obviously, undocumented hazardous materials is a big deal and could have serious safety concerns. Luckily everything worked out here. Once the issue was identified, Dispatch was a little slow to get us all the info and to provide input. I believe this was because the Dispatchers had a shift change. I think this led to information slowly being provided to all parties. The cause was someone [erred] in the chain of [custody] during loading, documenting, and manifesting must have made an error which led to this dry ice not being manifested.

Narrative: 2

Approximately 20 minutes into flight, we received a message via ACARS from Dispatch that 1768lbs of dry ice went on the aircraft unmanifested and to please use supplemental dry ice procedures. At that time the RFO was in the jump seat and he retrieved, turned on and distributed a Drager monitor to each crew member. Once established in cruise, CA proceeded to the CRM as planned/briefed and RFO took the left seat. Subsequently we received message that the unmanifested dry ice was 1768kg, not lbs. We confirmed with that the 1768kg was on the main deck along with the 116kg that was manifested, for a total of 1884kg of dry ice on the main deck. The main deck limit is 1814kg. DO stated that he and dispatch agreed, that with all systems on the aircraft functioning properly and with FOM 10.37 DRY ICE SUPPLEMENTAL PROCEDURES in place, we were OK to continue to destination, however, if Captain desired to divert that would be appropriate as well given the over-limit situation. At that time, we had just passed the east coast of [State]. Diverting to a [company name] base at that time would have required dumping fuel in order to land under MAXLGW. FO and RFO discussed and determined that we would arrive overhead ZZZ1 on current flight planned route at MAXLGW and that if a divert decision was made, ZZZ1 was the most appropriate divert base. One hour prior to arriving overhead ZZZ1, FO awakened the CA in the CRM and informed him of the situation and [Dispatch's] deferral to him on a divert decision. CA agreed that continuing on was appropriate. FO/RFO informed [Dispatch] via ACARS of decision to continue to [our destination] using dry ice supplemental procedures. Rest of flight was uneventful. A [contributing] cause was it had something to do with this being a chartered/non standard flight.

Narrative: 3

After departure [Dispatch] was notified that there was 1763 kg of dry ice not shown on the DG or wgt/bal manifest. This brought the total amount of dry ice on the main deck to 1,879 kg. (116 kg was already accounted for in the wgt/bal). The maximum allowed under Supplemental Procedures is 1,814 kgs. The crew was notified via ACARS and we also discussed it with them on SATCOM conference call with Duty Office and Flight Operations. Dispatch, Crew, and Duty Officer agreed it was safe to continue using Dry Ice Supp. procedures and Drager CO2 monitors deployed in flight deck and CRM. The cause was the dry ice qty was never entered into the weight and balance.

Narrative: 4

Flight departed ZZZ2 over the Dry Ice allowable amount. No notification from ramp of the total weight of dry ice on board. Crew was not notified of the need to follow supplemental dry ice procedures. The cause was [Dispatch] was not notified of Dry Ice onboard. Ramp should double check dry ice is accounted for and a supplemental request is sent before final w/b is sent to crew.

Synopsis

Air Carrier flight crew reported Dispatch notification during cruise of incorrect amount of dry ice weight information provided to flight crew at departure.

Time / Day

Date : 202106

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Aircraft

Reference : X

ATC / Advisory.TRACON : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : B737-800

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Flight Phase : Initial Approach

Airspace.Class B : ZZZ

Person : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Captain

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Multiengine

ASRS Report Number.Accession Number : 1817229

Human Factors : Other / Unknown

Person : 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 : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

ASRS Report Number.Accession Number : 1817244

Human Factors : Other / Unknown

Human Factors : Human-Machine Interface

Events

Anomaly.Deviation - Track / Heading : All Types

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Anomaly.Deviation / Discrepancy - Procedural : Clearance
Detector.Person : Flight Crew
Detector.Person : Air Traffic Control
When Detected : In-flight
Result.Flight Crew : Requested ATC Assistance / Clarification
Result.Flight Crew : Overcame Equipment Problem
Result.Air Traffic Control : Provided Assistance

Assessments

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

Narrative: 1

We were flying ZZZ1 to ZZZ, a XA00 report in ZZZ1. It was the First Officer's (FO) initial trip back from a 10-month furlough. We were on the ZZZZZ RNAV arrival from the northeast. I was the PF. ZZZ was landing north. ZZZ airport had an overcast layer obscuring the airport. At the appropriate time, I briefed the ILS XXR approach. We set up the FMS and tuned/identified the NAV radios for XXR, the normal approach for this arrival. When we checked in with ZZZ Approach, we were advised to expect the ILS XXL. I briefed the approach and we tuned/identified the NAV radios. We were being vectored to intercept the localizer. It looked like we overshot the localizer on the NAV display, so I turned to intercept. ATC advised us, "It looks like you are lining up for the wrong runway," and turned us off of the approach. There were no conflicts with any other aircraft. They then told us to expect the ILS XXR. We flew that approach successfully to a landing. While we were setting up for the XXR approach, we discovered we never set up the FMS for the ILS to XXL. [I believe the cause was] early sign-in. Overcast skies obscuring airport. [It was also the] FO's first trip after furlough. [I suggest] verification that both the NAV radios are tuned and identified and the FMS is set for the proper runway/approach.

Narrative: 2

Planned and briefed approach for ILS Runway XXR and was given ILS Runway XXL. The CA (Captain) set up and briefed new approach. I verified the frequencies and inbound course but neither of us set the new approach into the FMS. Was getting vectors to the ILS XXL [and] we had the correct ID for the ILS. When the CA looked at the ND and saw himself flying through the course for what was ILS XXR, the wrong approach, he corrected the heading to go back to intercept the course on the ND. The Controller said you are turning to line up for wrong approach and told us to go around. I have not flown since [last year]. I also do not have much experience in the aircraft. Was first flight since furlough. [I plan on] getting more flying in and becoming more comfortable in the aircraft, getting back into the rhythm of the flights.

Synopsis

B737-800 flight crew reported a clearance deviation due to automation mismanagement and CRM issues.

Time / Day

Date : 202106

Place

Altitude.MSL.Single Value : 13500

Environment

Flight Conditions : VMC

Aircraft : 1

Reference : X

ATC / Advisory.Center : ZLA

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : GPS

Nav In Use : FMS Or FMC

Flight Phase : Descent

Flight Phase : Initial Approach

Route In Use.STAR : ZZZZZ

Airspace.Class E : ZLA

Aircraft : 2

Reference : Y

Aircraft Operator.Other

Make Model Name : Sail Plane

Crew Size.Number Of Crew : 1

Operating Under FAR Part.Other

Mission.Other

Flight Phase : Cruise

Airspace.Class E : ZLA

Person : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Flying

Function.Flight Crew : First Officer

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

Experience.Flight Crew.Total : 837

Experience.Flight Crew.Last 90 Days : 89

Experience.Flight Crew.Type : 837

ASRS Report Number.Accession Number : 1816084

Human Factors : Time Pressure

Human Factors : Distraction
Human Factors : Situational Awareness

Person : 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 : Multiengine
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Instrument
Experience.Flight Crew.Total : 315
Experience.Flight Crew.Last 90 Days : 77
Experience.Flight Crew.Type : 315
ASRS Report Number.Accession Number : 1816226
Human Factors : Situational Awareness
Human Factors : Distraction
Human Factors : Time Pressure

Events

Anomaly.Conflict : NMAC
Detector.Automation : Aircraft TA
Detector.Person : Flight Crew
Miss Distance.Horizontal : 500
Miss Distance.Vertical : 100
When Detected : In-flight
Result.General : None Reported / Taken

Assessments

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

Narrative: 1

Descending in to SNA on DSNEE 4 arrival between CARZZ and KADYN somewhere between 13,000-15,000 ft. we had a near miss with a glider. I was flying, never saw it. We got a primary target only, no mode C, 30 seconds or less from when the CA actually saw the glider, he guesses maybe 100 ft. vertically and 500 ft. laterally. The glider was right on the arrival path. It startled him, and even though I never saw it his reaction startled me. Great CRM, professionalism, training for us to get our focus back and not get distracted and become an unstable approach statistic in to the challenging SNA, especially after having hot brakes climbing out of ZZZ1 and having to lower the gear, it felt like a true multiple threat simulator session! Great scenario for an IOE.

Narrative: 2

Operating flight from ZZZ1 to SNA. Cleared to descend via the DSNEE 4 Arrival. Between CARZZ and KADYN Intersections at approximately 13,500 ft., we received a "Traffic, Traffic" TA with only a primary yellow circle popping up as a target with no altitude or trend information. The TA occurred about 20 seconds prior to us and the target converged. Center called "traffic at 12 o'clock, altitude and type unknown". The weather was VFR, but

it was hazy. We scanned the immediate area above and below and did not see it. Then I looked to my left and I saw a white colored glider passing less than 500 ft. laterally and within 100 ft. vertically. I did not pick it up until it was at our 8 o'clock position and as we were descending on the arrival. We must have NEARLY HIT HIM! He was heading southeast bound. This occurrence made the hair stand up on my neck and it really shook me up. Just as I reported the near mid-air, ATC gave us a frequency change to Approach. I was so taken-aback by what had just happened, I had to ask Center to repeat the frequency. Just as I was trying to re-establish contact with Approach, I heard Approach calling us on Guard, which I thought was strange as we had only been off of Approach for less than 30 seconds. There seemed to be either a late hand-off from Center and they were looking for us, or they saw the near miss and were trying to call us. I mentioned that we had just missed a glider and we were trying to regain our composure but we had switched over in a fairly timely manner. After a busy, but uneventful approach and landing to 20R at SNA, during the taxi-in to Gate XX, SNA Ground alerted us that Approach was requesting that we call them once we parked. I called and spoke to a Supervisor. His first question was am I going to file a report. I stated that I would. He took my name and number in the event that this occurrence needed further investigation. That glider was sailing on the main ridge-line just prior to entering the area. HE HAD NO MODE C transponder at an altitude that should have required him to have it. The glider was sailing on the direct arrival path of the STAR, and we are lucky that we hadn't arrived at our point of convergence 10 seconds sooner. When I saw him he was about 100 ft. higher than us at 8 o'clock as we were descending.

Synopsis

Flight crew reported a NMAC with a glider while they were on a STAR inbound to SNA.

Time / Day

Date : 202106

Local Time Of Day : 1201-1800

Place

Locale Reference.ATC Facility : ZZZZ.ARTCC

State Reference : FO

Altitude.AGL.Single Value : 10

Aircraft

Reference : X

ATC / Advisory.Center : ZZZZ

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 3

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Nav In Use : GPS

Flight Phase : Landing

Route In Use : Direct

Person

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 : Flight Instructor

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

ASRS Report Number.Accession Number : 1814363

Human Factors : Communication Breakdown

Human Factors : Situational Awareness

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Anomaly.Inflight Event / Encounter : Unstabilized Approach

Detector.Person : Flight Crew

Were Passengers Involved In Event : N

When Detected : In-flight

Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors

Primary Problem : Human Factors

Narrative: 1

The following narrative describes an event that took place while operating a passenger flight - the second segment of a two-segment day. For this particular flight, the Captain (CA) was the Pilot Monitoring (PM), the other First Officer (FO) was the Pilot Flying (PF), and I was positioned in the First Observer's seat as the additional crew member, aiding in pilot monitoring duties. The flight itself was uneventful and could be described as a straightforward intra-European flight. We continuously checked the weather on our way to ETAR in order to remain cognizant of the weather conditions expected for landing. Well before the top-of-descent, we pulled the final weather report, requested aero-data performance, loaded the expected ILS approach, and once all crewmembers were present on the flight deck and ready to discuss the descent/approach/landing, the PF conducted the approach briefing. All checklists were completed on schedule and as we approached ETAR, we confirmed with approach controllers that we would expect the ILS to Runway XX. As we came within approximately 20 or so miles from the field, we were given radar vectors to final. At the time, ETAR was experiencing a large number of air traffic, both inbound to the field, outbound from the field, as well as training aircraft in the traffic pattern. On the downwind leg, the PM programed the course fix intercept and executed the change with the PF's verbal concurrence. The winds at ETAR were light, visibility was great, skies had a higher scattered layer, and overall it was a nice VFR day. Due to the heat rising from the surface, we did have some convective and mechanical turbulence as we approached the runway, but nothing too far out of the ordinary for a summer afternoon. The aircraft was configured on schedule (if not slightly early to be conservative) and was stable (on speed, on path, configured for landing) well before 1,000 feet. After the "Stable" calls were made and we continued the approach, the PF disconnected automation (as briefed earlier) and continued the approach. The approach itself never destabilized as we approached the runway, however once in the flare, I noticed we were floating quite a bit. I had preloaded in my mind that floating beyond the touchdown zone would be a "go-around" call. As we began approaching the end of the touchdown zone (and below 10 feet RA), the PM made a comment that the end of the touchdown zone was approaching. As soon as the final touchdown zone marker disappeared under the nose and before I could make the call myself, the PM called "Go-around!" Almost as soon as this statement was made, the main tires touched down, the PF stated "too late" and the reversers were pulled. By the time the aircraft had touched down, the flight deck had just momentarily passed the end of the touchdown zone. The aircraft decelerated normally and we cleared Runway XX on taxiway Bravo. During taxi to the terminal building, the PF stated that we would discuss the landing at the gate, to which the crew agreed. Once we were safely at the gate with the engines secured, all checklists accomplished, and the deplaning process was well underway, we had an open discussion about what had happen and why a go around should have been conducted, especially since the call was made. The debriefing was well received by the PF, who expressed that he understood why his decision to continue the landing was not correct given the circumstances. The PF mentioned that from his perspective during the landing, he believed he had still been in the touchdown zone, whereas from my perspective, we were 100-200 feet beyond it. The PF also mentioned that he saw a low altitude bailed landing as being more hazardous than continuing the landing, however we reminded him that this is why bounced and bailed landing recovery are part of the Extended Envelope Training received on a bi-yearly basis. After a thorough discussion and debrief, the PF stated that he agreed that we should have conducted a go-around and remained open to any suggestions/recommendations/critiques as we conducted the debrief as a crew. We discussed the no-fault go-around policy that exists and I mentioned that the response to a go-around call made by any crew member should not, and can not be "too late," as this breaks down CRM, places the crew in an uncomfortable situation, and establishes a scenario similar to disregarding a statement of

"I'm not comfortable with this" where one crew member's decision to continue becomes dictating (even with deteriorating safety margins) when other crew members had already expressed concern. We discussed that, although ETAR's Runway XX was long and we had ample room to decelerate after touchdown, the decision to disregard a go-around call on a shorter runway could have drastically different results. With every critique or debriefing item mentioned, the PF was incredibly receptive, understood the points being made, and was internalizing the information being discussed. I also recommended that we as a crew file reports to take advantage of a program designed for reporting slips, lapses, and errors, as well as allow each crew-member to reflect on the event in order to further analyze what could have been done differently. This event outlines a deviation from stabilized approach criteria, simply due to the landing touchdown beyond the touchdown zone. Although the correct go-around call was made, the PF continued the landing due to the immediate touchdown occurring almost immediately after the go around call was made by the PM. Expectation bias and continuation biases are incredibly powerful by influencing decision making well into the landing maneuver. Experience of landing on runways and stopping with thousands of feet remaining can cause a false sense of security when procedural drift occurs. With this event, it was incredibly beneficial to not only take time to debrief as a crew, but to see the value in each crew-member submitting an ASAP report to simply share individual perspectives from the landing. Due to the debrief, we were able to discuss company policies, procedures, as well as determine what could have been the best course of action in order to mitigate similar threats in the future. The value of a debrief can allow for crew-members to internalize constructive criticism, rather than brush off an event as an outlier. During an event such as this, I believe a tremendous amount of learning was accomplished simply by following up and discussing the events as a crew. I recommend that the normalization of debriefings after a flight, especially after flights with an event, should be standardized among the pilots. Not only are debriefings a form of mentoring tools but setting aside ego and discussing areas of possible procedural non-compliance, performance deficits, CRM breakdowns, or unmitigated threats could reinforce learning among crew-members. This ties in directly with professionalism as aviators. Although I do not believe there was an intentional violation of regulations or disregard for safety, addressing this event as a crew served to promote learning, enhance safety, and build up colleagues rather than put them down. Emphasizing the normalization of go-arounds due to unstable approaches has also been viewed as a beneficial adaptation within the Atlas culture. However, although we are seeing a statistical decrease in unstable approaches resulting in a landing, I believe this is still a work in progress as we evidently have not reached the milestone of 100% go-arounds from unstable approaches. Emphasis can also be placed in recognizing that stable approaches can still destabilize in the last 10 feet during landing; whether drifting from center-line, landing beyond the touchdown zone, or excessive pitch during the flare. This is of course in addition to ability for any operating crew member to call for a go around at any point during the approach. The go around procedure should be accomplished as soon as the call is made, and the discussion of "why" should be reserved for when the aircraft is in level flight with checklists completed or once the aircraft is safely on the ground, parked at the gate, and checklists completed.

Synopsis

Air Carrier First Officer reported an unstable approach and non compliance with SOP's. The aircraft touched down and the "GO Around" call happened almost simultaneously, creating a CRM discussion at the arrival gate.

Time / Day

Date : 202105

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Relative Position.Distance.Nautical Miles : 40

Altitude.MSL.Single Value : 5000

Environment

Flight Conditions : VMC

Weather Elements / Visibility.Visibility : 10

Light : Daylight

Ceiling.Single Value : 3000

Aircraft

Reference : X

ATC / Advisory.TRACON : ZZZ

Make Model Name : ATR 42

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Flight Plan : IFR

Mission : Cargo / Freight / Delivery

Flight Phase : Climb

Route In Use : Vectors

Route In Use.SID : ZZZZZZ2

Airspace.Class B : ZZZ

Component

Aircraft Component : Engine

Problem : Failed

Person

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Function.Flight Crew : Pilot Flying

Function.Flight Crew : First Officer

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Flight Instructor

Qualification.Flight Crew : Instrument

Experience.Flight Crew.Total : 3200

Experience.Flight Crew.Last 90 Days : 20

Experience.Flight Crew.Type : 110

ASRS Report Number.Accession Number : 1811182

Human Factors : Communication Breakdown

Human Factors : Troubleshooting

Human Factors : Workload

Human Factors : Distraction
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation / Discrepancy - Procedural : FAR
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Overcame Equipment Problem
Result.Flight Crew : Requested ATC Assistance / Clarification
Result.Flight Crew : Returned To Departure Airport
Result.Air Traffic Control : Issued New Clearance

Assessments

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

Narrative: 1

During departure climb the airplane experienced a failure of the right engine. The prevailing environment in the cockpit promoted a breakdown in CRM (Crew Resource Management) prior, during and after the incident which led to a failure of complying with established procedures. Also, the Pilot in Command failed to declare an emergency after the engine was shut down. Although the airplane was under control the whole time and an eventual landing without incident was conducted, under different circumstances the breakdown in CRM could have led to a worst outcome.

Synopsis

First Officer reported engine failure on departure caused a return to the airport and a safe landing but the Captain did not comply with established procedures.

Time / Day

Date : 202105

Local Time Of Day : 1201-1800

Place

Locale Reference.ATC Facility : ZZZ.Tower

State Reference : US

Altitude.MSL.Single Value : 2100

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Tower : ZZZ

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 / Delivery

Flight Phase : Initial Approach

Airspace.Class D : ZZZ

Person

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

ASRS Report Number.Accession Number : 1805744

Human Factors : Time Pressure

Human Factors : Situational Awareness

Human Factors : Communication Breakdown

Human Factors : Confusion

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Deviation / Discrepancy - Procedural : Clearance

Anomaly.Inflight Event / Encounter : CFTT / CFIT

Detector.Person : Flight Crew

Detector.Person : Air Traffic Control

When Detected : In-flight

Result.Flight Crew : Became Reoriented

Result.Flight Crew : Requested ATC Assistance / Clarification
Result.Air Traffic Control : Issued Advisory / Alert
Result.Air Traffic Control : Issued New Clearance

Assessments

Contributing Factors / Situations : Airspace Structure
Contributing Factors / Situations : Chart Or Publication
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

[We were] cleared for the visual approach. Pilot in Command hand flew the visual approach. Switched to Tower and was cleared to land. During the descent to land Pilot in Command got too low. Second in Command informed Pilot in Command to climb as aircraft was too low and almost hit terrain Pilot in Command said he was good, Second in Command advised Pilot in Command to immediately climb. Pilot in Command was reluctant to climb. Tower informed us that we were too low for that sector of the approach and to Immediately climb. Pilot in Command climbed back up to 3,100 feet from 2,000 feet, then landed normally. Pilot in Command lost situational awareness during a visual approach. Pilot in Command initially did not react and did not listen to advice from Second in Command that the aircraft was too low on the Approach. It was not until the ATC Tower Controller told crew to immediately climb to 3,100 feet, did the Pilot in Command react and then climb back up to 3,100 feet. Suggest that the company discusses and better trains flight crews in performing visual approaches at day and night and to somehow incorporate improved Crew Resource Management Training so that if a Second in Command tells the Pilot in Command to climb or descend Immediately, he or she will listen and react immediately, and then ask questions later when the risk factor has been mitigated.

Synopsis

First Officer Pilot Monitoring reported the Pilot Flying flew too low on a Visual Approach and did not respond to his instructions to climb to avoid terrain until ATC also instructed them to climb.

Time / Day

Date : 202105

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.MSL.Single Value : 7000

Environment

Flight Conditions : VMC

Weather Elements / Visibility.Visibility : 10

Light : Daylight

Ceiling.Single Value : 2000

Aircraft

Reference : X

ATC / Advisory.TRACON : ZZZ

Aircraft Operator : Corporate

Make Model Name : Light Transport

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Flight Plan : IFR

Mission : Passenger

Flight Phase : Initial Climb

Route In Use.SID : ZZZZZZ2

Airspace.Class B : ZZZ

Person

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Corporate

Function.Flight Crew : Pilot Not Flying

Function.Flight Crew : Captain

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Instrument

Experience.Flight Crew.Total : 6000

Experience.Flight Crew.Type : 2000

ASRS Report Number.Accession Number : 1805214

Human Factors : Distraction

Human Factors : Workload

Events

Anomaly.Deviation - Altitude : Overshoot

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Anomaly.Deviation / Discrepancy - Procedural : Clearance

Detector.Person : Flight Crew

Miss Distance.Horizontal : 1000

Miss Distance.Vertical : 1000
When Detected : In-flight
Result.Flight Crew : Returned To Clearance

Assessments

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

Narrative: 1

Conducted a part 91 flight ZZZ1 to ZZZ2. I initiated a crew brief of the SID while still on the ramp...I had the chart display mainly zoomed in on the text description box to make the text bigger. I focused on the final altitude of 17,000 to the right of the text box that pertained to all runways. I had showed the PF the altitude and said "I will set 17,000 in the altitude select if you agree". He responded "affirm". I began to read the text version of the SID to myself and it read "Climb on a heading of 216 to intercept course 185 to ZZZZ, then on track 108 to cross ZZZZ1..." I announced we will arm LNAV for departure as the FMS matched this. At that point I did not finish reading and zoomed in and looked at the SID graphically but focused on the runway departure and how it fed into the initial FIX ZZZZ. I noticed all runways fed into ZZZZ. I knew that fix would be important on readback, (as it is at ZZZ3 for example), to ensure safety on parallel runway operations. Very short taxi out from FBO. Took off runway XXR, normal operations. Positive rate, gear up, "400 feet, flaps up select VS." Thus, we were in VS speed as is often the case for climbout. Tower sends us to departure. I call twice, no joy. Switch back to Tower and ask to confirm frequency. Call back through 6,000 and departure responds climb and maintain 7,000. We received this clearance at approximately 6,800 feet. We executed this clearance immediately however given out pitch attitude and climb rate we overshoot 7,000 feet and reached an altitude of 7,400-7,500 based on my best recollection. No TCAS alerts were issued. We maintained 7,000, were given another climb clearance and then before the ATC Controller switched us over, we were told of the possible deviation. What I have learned from this incident is to read the entire textual description in the SID and to take in the whole SID graphically as opposed to taking into account just the post departure/runway routing. I also learned poor habits can be formed from other airports, particularly our home base airport. We receive a SID on our clearance every time. We then get a heading on takeoff clearance from home base ZZZ2 ATC voiding the initial part of the clearance 99 percent of the time. Another factor is the scarcity of climb via SIDs that do not mainly incorporate "at or above." This incident taught me not to assume or have a bias to SID instructions. Another factor in this error was rust due to the COVID shutdown. Our awareness and CRM need improvement which will come with more recent operations I believe.

Synopsis

Corporate aircraft Captain reported overshooting assigned altitude during departure due to a late ATC Clearance. Captain also cited lack of flying as a contributing factor.

Time / Day

Date : 202104

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Relative Position.Angle.Radial : 289

Relative Position.Distance.Nautical Miles : 5

Altitude.MSL.Single Value : 1800

Environment

Flight Conditions : IMC

Weather Elements / Visibility : Rain

Weather Elements / Visibility : Turbulence

Weather Elements / Visibility.Visibility : 2

Light : Daylight

Ceiling.Single Value : 1500

Aircraft

Reference : X

ATC / Advisory.TRACON : ZZZ

Aircraft Operator : Personal

Make Model Name : Skyhawk 172/Cutlass 172

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 91

Flight Plan : IFR

Mission : Training

Nav In Use : GPS

Flight Phase : Initial Approach

Route In Use : Vectors

Airspace.Class E : ZZZ

Person : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : FBO

Function.Flight Crew : Instructor

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Flight Instructor

Qualification.Flight Crew : Commercial

Experience.Flight Crew.Total : 1380

Experience.Flight Crew.Last 90 Days : 124

Experience.Flight Crew.Type : 435

ASRS Report Number.Accession Number : 1804019

Human Factors : Distraction

Human Factors : Fatigue

Human Factors : Situational Awareness
Human Factors : Training / Qualification
Human Factors : Workload
Human Factors : Confusion

Person : 2

Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Personal
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Commercial
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Student
Qualification.Flight Crew : Instrument
Experience.Flight Crew.Total : 277.1
Experience.Flight Crew.Last 90 Days : 17.3
Experience.Flight Crew.Type : 100
ASRS Report Number.Accession Number : 1804065
Human Factors : Distraction
Human Factors : Situational Awareness
Human Factors : Time Pressure
Human Factors : Training / Qualification
Human Factors : Workload
Human Factors : Confusion

Events

Anomaly.Deviation - Altitude : Overshoot
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : Clearance
Anomaly.Inflight Event / Encounter : Weather / Turbulence
Anomaly.Inflight Event / Encounter : CFTT / CFIT
Detector.Automation : Air Traffic Control
Detector.Person : Air Traffic Control
When Detected : In-flight
Result.Flight Crew : FLC complied w / Automation / Advisory
Result.Flight Crew : Became Reoriented
Result.Air Traffic Control : Provided Assistance
Result.Air Traffic Control : Issued New Clearance
Result.Air Traffic Control : Issued Advisory / Alert

Assessments

Contributing Factors / Situations : Airspace Structure
Contributing Factors / Situations : Chart Or Publication
Contributing Factors / Situations : Environment - Non Weather Related
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Contributing Factors / Situations : Weather
Primary Problem : Human Factors

Narrative: 1

I was acting as a flight instructor on board Aircraft X, a Cessna 172S on a local IFR flight practicing approaches. My student is a Certified Flight Instructor (CFI) candidate who was

gaining instrument currency and proficiency. We began with an ILS approach at ZZZ1 with my student flying the aircraft and me handling ATC communications to reduce his workload in the hard IMC conditions. We crossed a cold front while receiving vectors for the ILS approach where we encountered light to moderate turbulence and precipitation. We completed the ILS approach without incident and proceeded to the VOR for the VOR-A approach into ZZZ, planning to complete a Low Approach Only. We experienced severe turbulence which forced the autopilot (GFC700) to disconnect and I took the controls of the aircraft and requested deviations to the north as necessary to track clear of the progressing cold front. Once we got into smoother air, I gave my student the flight controls and we proceeded direct ZZZ2 [VOR] for a procedure turn. Our plan was to complete the VOR-A approach and then receive radar vectors for the RNAV 01 at ZZZ. My student had proclaimed that he wanted to avoid going back through the cold front while getting vectored for the RNAV 01 approach and suggested we circle to land at ZZZ and cancel the IFR flight plan. When my student suggested this, we had passed the Final Approach Fix inbound and began a descent to the Minimum Descent Altitude and were switched over to advisory frequency. I switched frequencies back to Approach to tell them our intentions to try and circle to land since they were expecting us to go missed on the practice approach. When I told ATC of our intentions, they replied in the affirmative and added "Aircraft X, low altitude alert, check altitude immediately, altitude indicates 1,800." I replied the altitude checks and requested an altimeter setting. ATC replied with an altimeter setting of 29.58 and we had a setting of 29.67 set in. I figured this was why they gave us the low altitude alert but then quickly realized that the Minimum Descent Altitude for the segment of the approach we were on was 2,020 feet and we were at 1,720 feet with the new altimeter setting. I informed my student to return to 2,020 feet and we continued on the approach without issue and proceeded with the missed approach with vectors to the RNAV01 at ZZZ. During the missed approach, I was surprised at myself that I did not catch that the student had descended below the Minimum Descent Altitude and I assessed why that had happened during a period of smooth flight and during the post flight discussion with my student. During the lead up to the approach, the encounter with the severe turbulence had shaken both me and my student. We also had a back seat passenger who was an instrument student who had never been in IMC before. I was concerned with the safety of my student and the back seat student and began thinking about the circle to land approach and how we would request vectors for the RNAV Approach if we were unable to circle to land in order to stay away from the front line. I had determined from the weather when we departed ZZZ that circling for the runway at ZZZ would have been nearly impossible with the current ceilings. I told my student this and informed him we would need to execute the RNAV Approach in order to make it back into the airport. The workload at the moment was very high and the effects of the turbulence certainly could have impaired multitasking skills for both my student and I. When we began the descent on the approach, we left 3,000 feet for 2,020 feet which is the Minimum Descent Altitude until a fix which then the Minimum Descent Altitude decreases to 1,760 feet. My student did not reset the altitude select when we ran our Final Approach Fix check and the altitude select remained at 3,000 feet. Additionally, when I recognized we were below the published Minimum Descent Altitude, I should have instructed my student to execute the missed approach as 91.175(E)(1)(i) states, rather than just climbing back up to the Minimum Descent Altitude. This flight was also my third flight in hard IMC this day, and this VOR approach was my 8th approach in IMC in a span of 6 hours. I am an experienced Flight Instructor with over 45 hours in actual instrument conditions and over 150 approach logged, but never before had I completed so many IMC flights in such a time span with the challenging conditions of the frontal passage. My self-assessment prior to this flight determined I was able to complete the flight successfully with good quality of instruction to the student, but the extraordinary conditions we experienced during the flight quickly eroded that ability for me, in addition to the highly

divided workload situation we found ourselves in while inbound on the VOR Approach which led to the descent below Minimum Descent Altitude and failure to execute the missed approach immediately after. I think also a more comprehensive briefing of the approach would have aided in my student's short term memory of the initial difference of Minimum Descent Altitude. Even though I briefed the Minimum Descent Altitudes, I do not think they were retained due to the stress and workload of the situation. If this event were to occur again, I would better instruct my student to execute the missed approach rather than working to reclaim the missed Minimum Descent Altitude.

Narrative: 2

The aircraft had 3 people on board for a local approaches flight in IMC conditions in Aircraft. This flight took place while a stationary front was passing through the area. This caused for almost constant moderate turbulence at times during the flight close to the frontal passage. The flight started with an ILS approach into ZZZ1. After the ILS approach we were vectored to go to the ZZZ2 VOR. Along the way, we had to deviate twice for turbulence. This, as well as IMC conditions, was causing a good amount of sensory overload for myself and the flight instructor with me. At times during the flight the autopilot was being used, but at one point, the amount of turbulence actually caused the autopilot to disengage. Because of this, at the time of the deviation, I was hand flying the aircraft while the other pilot was loading the VOR Approach. When we proceeded inbound on the approach, there is a step down to a minimum of 2,020 feet until an 8 DME fix. Then the minimum goes lower to 1,760 feet. With the sensory overload that both I and the other pilot were experiencing during the IMC flight, we ended up descending below the altitude minimum below the fix. ATC had not updated our altimeter setting in a decent amount of time. We were called by ATC letting us know for a low altitude and to immediately recover. They gave us an updated altimeter and our altitude after the correction showed it being right at the approach total minimum. Instead of executing an immediate missed approach we climbed back up to 2020 feet then re-descended to the 1,760 minimums. By doing this we unfortunately broke 14 CFR 91.175 (c) 1, 3 and (e) 1. The proper action would have been to either, not conduct the flight in the first place or, to immediately execute the missed approach once realizing the descent below the step down. We also could have stopped the flight after the ILS approach into ZZZ1. The rest of the flight utilized great CRM, but during this approach, a better action to even ask as the approach started would have been to double check the approach and its minimums including each step down.

Synopsis

Instructor and student reported descending below Minimum Descent Altitude, which they attributed to an incorrect altimeter setting, and turbulence.

Time / Day

Date : 202104

Local Time Of Day : 0001-0600

Place

Locale Reference.ATC Facility : ZZZZ.Tower

State Reference : FO

Altitude.MSL.Single Value : 3000

Environment

Flight Conditions : Marginal

Aircraft

Reference : X

ATC / Advisory.Center : ZZZZ

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Cargo / Freight / Delivery

Nav In Use : GPS

Nav In Use : FMS Or FMC

Nav In Use.Localizer/Glideslope/ILS : XXL/ILS

Flight Phase : Initial Approach

Route In Use : Direct

Person : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

ASRS Report Number.Accession Number : 1802319

Human Factors : Communication Breakdown

Human Factors : Fatigue

Human Factors : Physiological - Other

Human Factors : Situational Awareness

Human Factors : Time Pressure

Human Factors : Workload

Human Factors : Confusion

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Person : 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)
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Instrument
ASRS Report Number.Accession Number : 1802085
Human Factors : Workload
Human Factors : Troubleshooting
Human Factors : Time Pressure
Human Factors : Physiological - Other
Human Factors : Other / Unknown
Human Factors : Fatigue
Human Factors : Communication Breakdown
Human Factors : Situational Awareness
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Deviation - Altitude : Excursion From Assigned Altitude
Anomaly.Deviation - Track / Heading : All Types
Anomaly.Deviation / Discrepancy - Procedural : Clearance
Anomaly.Ground Event / Encounter : Ground Equipment Issue
Detector.Person : Flight Crew
Detector.Person : Air Traffic Control
Were Passengers Involved In Event : N
When Detected : In-flight
Result.Flight Crew : Became Reoriented
Result.Air Traffic Control : Issued Advisory / Alert

Assessments

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

Narrative: 1

Intercepting the unstable Localizer on a 225 vector, approximately 16 nm final, the aircraft started to join the Localizer. The Localizer shifted to the right and the aircraft began a hard right turn to intercept passing of approximately 240 degrees. I instructed the FO to stop the turn and come back to the left toward final approach heading. He did not reply to my direction and did not act. As the aircraft passed approximately 255 degrees, I took command of the aircraft, disconnected the auto-pilot and started a turn back to the Localizer. I was concerned about the numerous aircraft on final for Runway XX. In my turn back to the Localizer I overshot the Localizer and deviated from the assigned 900 meter altitude by approximately 100 meters. I intercepted the Localizer, got back on altitude, and flew an uneventful ILS and normal landing. This all happened unexpectedly. The hard right-hand turn to intercept is unprecedented in my XX years of flying [this type aircraft]. Unstable Localizer and Autopilot aggressive turn to intercept. Fatigue affected my flying after taking the aircraft The current schedules to service this country during Covid leave no extra margin of safety when things like this go wrong. Multi-leg days, with long turns

between flights, after crossing X time zones leave little margin of safety. Also, the very long trip extensions for crew members leads to fatigue.

Narrative: 2

I was the PF for the 2nd leg of the night which was a night recovery. At altitude I had briefed the STAR and approach, and once the descent started, we received numerous altitude, heading, and airspeed clearances as the controller was trying to work what appeared to be a fairly large recovery into ZZZZ [Airport]. ATIS reported that simultaneous ILS approaches were being flown to [Runway] XXL as well as [Runway] YY. Approaching ZZZZ, we were being vectored for the ILS Y, Runway XXL and at about 20 miles were cleared "heading 215, maintain 180 knots to 8 miles, maintain 900 meters until intercepting the Localizer, report established." We were already configured at flaps 15 with the ILS tuned and the approach checklist complete. The assigned heading provided a comfortable 15 degree cut, but with winds of about 120 at 25 knots at our altitude (overshooting crosswind), and parallel approaches being conducted, with the autopilot still engaged, I was diligently watching the automation. I pressed the APP/LAND tile and initially the aircraft maintained heading, but after a few seconds, it started making some gentle (level) turns left and right. Initially these turns were mild and we even chuckled at what a poor job the AP was doing to maintain heading to intercept. Suddenly, the magnitude of one of the turns to the right increased markedly and the aircraft was in a level turn to the right of approximately 25 degrees angle of bank with the heading coming through approximately 230 degrees. As I spent just a few seconds (no more than 4 or 5 I would say) trying to determine what the autopilot was doing, the CA called out, "turn left, turn LEFT, I have the airplane" and executed a maneuver that I would describe as similar to a PRM breakout maneuver. He disconnected the AP, added power, and reversed our turn, climbing and accelerating in the process. The maneuver was aggressive enough that I thought it possible the CA had SA to something that I was missing since I had already started to reach for the heading selector in order to get the plane to level its wings and come back to the left (note: things were happening very quickly now and I did not verbalize this FMC input since I would have just been trying to talk over the CA telling me to turn left even though the airplane did start to shallow its turn to the right once I pulled the selector). I verbalized "you have the controls" and monitored his inputs. As former fighter pilots, the CA and I both have fairly wide comfort zones and although the maneuver was fairly aggressive, I was still comfortable with the aircraft's attitude and remained quiet as I monitored the aircraft's flight path. I did not want to add to the confusion of the moment by asking questions or saying anything unnecessary since the CA was very purposeful in his maneuver. Now things became quite busy because in addition to receiving a "bank angle" audible warning due to our steep turn to the left, the approach Controller began talking to us rapidly. He made several transmissions and told us repeatedly that he had us on a heading that was not going to intercept the Localizer and that we were above our assigned altitude and asked what we were doing. I replied that we were still below the glidepath at approximately 930 meters, and maneuvering to intercept the Localizer. After a few more moments the CA stabilized the aircraft's attitude, I selected FMS speeds (since we had accelerated to approximately 210 knots and needed to slow back to 180 knots), and he began a turn back to the right to intercept the Localizer. The CA re-armed the approach (but never re-engaged the AP), slowed to the assigned speed, returned to the assigned altitude, and leveled the wings on an appropriate intercept heading. The FD provided what appeared to be valid guidance to shoot the rest of the approach. The aircraft was configured and stable before glide-slope intercept and the remainder of the approach proceeded normally with me remaining in my role as PM. We went from conducting a routine controlled approach, to one where I think we had widely differing perceptions of what was actually occurring in the space of literally about 4 or 5 seconds. This rapid breakdown of CRM resulted in actions that were perhaps more

aggressive than they needed to be, and a deviation from the ATC clearance. I would actually say there were two separate events. The first being the aircraft's unexpected and overly aggressive turn to the right to capture the Localizer for ILS Runway XXL, and the second being our response to it. The first I would potentially attribute to a software issue, a problem with the ILS tune, or some sort of RF interference. As far as the second I would suggest the following; 1) Even though I did not feel fatigued during the approach, it was at the end of a long day and it's possible I underestimated my level of fatigue. That said, I did have some coffee prior to Beginning of Daylight (BOD) for this reason and, I felt like the CA and I were both alert and engaged and don't feel like my response to the aircraft was unacceptably slow or inappropriate. 2) The CA believed that the intercept angle was excessive (he referenced 45 degrees during our debrief) and that based on his prior experiences, there was no way the airplane was going to be able to capture the Localizer. Since I had not experienced the automation act in the manner it did during our approach, I was perhaps more comfortable than I should have been with the AP's ability to capture the Localizer, even with the admittedly substantial intercept angle that we had before the CA took the controls. 3) The CA stated during the debrief that he thought we had already flown through the Localizer, and that he was therefore worried about a lack of separation from the traffic that was flying the ILS to Runway XX, to our right. I did not perceive that we had flown through the Localizer for the following reasons: a) We were in a phase of flight where we both (certainly I was) monitoring the raw Localizer data in anticipation of Localizer capture, and neither of us ever called "Localizer alive". I felt like I was hawking this for the reasons listed above (overshooting crosswind and proximity to other landing traffic). b) The AP commanded a turn to the right, which in my mind it would have only done if it were trying to intercept the Localizer from the left. c) When ATC contacted us, it was to say that we were not on an intercept heading. He did not indicate that we had flown through the Localizer or were encroaching on the protected airspace between the approach corridors for the active runways. He never issued a vector to East which is likely what he would have done had he perceived there to be a risk of loss of separation. d) When we finally got the situation under control, the aircraft intercepted the Localizer from the left. Again, this entire narrative took place in what I suspect was less than a minute. Between the uncommanded turn to the right and the CA taking the controls, maybe 5 seconds passed. That said, I could have acted sooner and certainly should have verbalized when I reached for the heading selector to stabilize the heading, since that may have precluded the CA from taking the controls and executing the "escape" maneuver. I think in the CA's mind, we were probably already past the point where that was going to mitigate our situation since he perceived that we had already crossed the Localizer, but it might have helped. I wish the CA would have verbalized why he was maneuvering as aggressively as he was. I thought that perhaps he saw an impending collision that I did not have SA of, and so I stayed quiet for longer than I should have before I started to rebuild the picture and work to develop a CRM. Ultimately, he was well within his authority to act in the manner he did and fully adhered to the company's three step intervention process. This was a tough one for me to analyze and I welcome any feedback you might have.

Synopsis

Air carrier flight crew reported an altitude and track heading deviation during approach to an international airport. The crew stated this sequence of flights, since the COVID-19 pandemic started, are very long and fatiguing which may have been a factor in the event.

Time / Day

Date : 202104

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : AVL.Airport

State Reference : NC

Altitude.MSL.Single Value : 5100

Environment

Flight Conditions : VMC

Light : Night

Aircraft

Reference : X

ATC / Advisory.TRACON : AVL

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : GPS

Flight Phase : Initial Approach

Route In Use : Vectors

Airspace.Class C : AVL

Person

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 : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1802287

Human Factors : Situational Awareness

Events

Anomaly.ATC Issue : All Types

Anomaly.Deviation / Discrepancy - 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 : Took Evasive Action

Result.Flight Crew : Returned To Clearance

Result.Flight Crew : Requested ATC Assistance / Clarification

Result.Air Traffic Control : Provided Assistance

Assessments

Contributing Factors / Situations : Human Factors

Primary Problem : Human Factors

Narrative: 1

During the approach briefing for RNAV GPS 35 at AVL, I had pointed out to the Captain that due to obstacles and terrain characteristics in the vicinity of AVL, ATC would keep us high until very close to the station. As anticipated, Atlanta Center kept us at a high altitude (I do not remember exactly, but well above 15,000) until about 12-15 miles from the station. Upon being handed to Asheville Approach, and considering the terrain, night time, and the need for sufficient airspace to descend to a reasonable altitude in order to execute an effective and stable approach, I requested radar vectors for the RNAV GPS 35 (glideslope for the ILS was out of service). Approach instructed us to descend to 6,000 and to a heading that would put the aircraft on a downwind to Runway 35. Subsequently, the Approach Controller gave us a heading that put the aircraft on a left base leg to Runway 35, and instructed us to descend from 6,000 to 5,100. During this descent, the GPWS issued an aural TERRAIN caution. We immediately initiated a climb, advised ATC of the situation, and stopped the climb at 6,000, at which point the GPWS silenced. In addition, we advised we had the field in sight, and were cleared for a visual approach to Runway 35. The minimum sector altitude corresponding to the left base leg to Runway 35 stated 6,200 ft. We should have queried ATC of the validity of the instruction to descend from 6,000 to 5,100. From a CRM standpoint, The Jeppessen AVL Airport Reference Page alludes to the fact that a high rate of descent in the vicinity of the airport may cause a GPWS activation due to mountainous terrain in the vicinity (We did not exceed 1500 fpm), hence an emphasis on this matter during the approach briefing, in conjunction to minimizing the rate of descent to, perhaps, no more than 700 fpm, more than likely would have avoided the situation.

Synopsis

Air carrier First Officer reported a CFIT event during approach under Approach Control which was followed by an uneventful visual landing.

Time / Day

Date : 202103

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Environment

Flight Conditions : VMC

Light : Dawn

Aircraft

Reference : X

ATC / Advisory.Center : ZZZ

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 : Descent

Airspace.Class A : ZZZ

Component

Aircraft Component : Turbine Engine

Aircraft Reference : X

Problem : Malfunctioning

Person

Location Of Person.Aircraft : X

Location In Aircraft : General Seating Area

Reporter Organization : Air Carrier

Function.Flight Attendant : Flight Attendant In Charge

Function.Flight Attendant : Flight Attendant (On Duty)

Qualification.Flight Attendant : Current

ASRS Report Number.Accession Number : 1797204

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Attendant

Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Aircraft Equipment Problem : Critical

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Detector.Person : Flight Crew

Detector.Person : Flight Attendant

Were Passengers Involved In Event : N

When Detected : In-flight

Result.General : Maintenance Action
Result.Flight Crew : Overcame Equipment Problem

Assessments

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

Narrative: 1

During cruise, 3 hours in the flight, I heard a loud noise that sounded like a stall/chug. I was near L1 door. I asked the A FA (Flight Attendant), he heard it but he didn't. Later on, I went to the back of the plane. Aft galley & told the C FA what I felt and she told me she felt something "unusual" on the floor of the aft galley, probably about the same time I was in the fwd galley. We decided to call the pilots (called them twice) but they didn't pick up. We would try again a few minutes later, figured they were busy with the sound but just then, they called for a lavatory break. We ended up forgetting to notify them. During decent, wheels down, the C FA & I felt the aft of the aircraft chug a few times and make the strange popping sounds. We both looked at each other and decided to talk about it upon landing. When we landed, we both agreed it was "abnormal" so we called the pilots when we were disarmed and at the gate. After calling the pilots and explaining to them, the Captain told us to go to the flight deck and close the flight deck door. He ended up explaining to us that they did feel the abnormal chugs and thought it was a bird strike and didn't know until we were on the ground that the engine had failed (showed us on the monitor a red icon on the engine) but didn't really explain other wise. Myself and the rest of the crew didn't feel that great about the debrief. The A & C were able to go but the D and I had to continue on to ZZZ. That night, going to bed, I realized how serious the situation was and made me feel uneasy. On date, after landing in ZZZ1, a different Captain was talking about the incident because earlier in the day, there was an emergency landing by another airline and the [type aircraft]. Anyhow, when he realized I was on the ETOPS flight, he mentioned that we were lucky to be alive. He did an amazing job explaining that our situation was a "compressor failure" and many things can cause that but the biggest concern was that after leaving ZZZ2, the engine was sending pings to maintenance notifying of the engine overheating...the pilots decided to continue on to ZZZ3. Knowing that bit of information, and then to experience the compressor failure and no good CRM, I am frustrated, annoyed and somewhat uneasy flying to ZZZ2 now after hearing unfamiliar sounds about three hours into flight (the C FA heard these sounds as well), I called the pilots at about 3 hours into flight but didn't get a hold of them. I then forgot until the next set of sounds were heard at gear down. Upon parking at the gate, I called the pilots and I was instructed to talk to them with the door shut when I go to the front. After all guests were off the plane, I explained to the pilots again what sounds we heard and the Captain told me (then the rest of the crew) that the sounds heard were those in line of what is heard of a 'bird strike'. He then mention something to the fact that the engine went off line (he said this because I pointed out that the engine symbol on the instrument panel had a red square on it) about two times and we all were then confused and he said we shouldn't worry about it. Better CRM and think about the whole ready, safe, go action plan. There should have been a way better debrief by the pilots. After an event like this, I shouldn't be the one pushing for answers when I felt uneasy.

Synopsis

Flight Attendant reported misgivings over Crew Coordination and Communication over compressor stalls during this and other flights, including ETOPS.

Time / Day

Date : 202103

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Aircraft

Reference : X

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 : Parked

Flight Phase : Cruise

Component

Aircraft Component : Air Cycle Machine

Aircraft Reference : X

Problem : Malfunctioning

Person

Location Of Person.Aircraft : X

Location In Aircraft : General Seating Area

Reporter Organization : Air Carrier

Function.Flight Attendant : Flight Attendant (On Duty)

Qualification.Flight Attendant : Current

ASRS Report Number.Accession Number : 1796734

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Attendant

Communication Breakdown.Party2 : Flight Attendant

Events

Anomaly.Aircraft Equipment Problem : Less Severe

Anomaly.Flight Deck / Cabin / Aircraft Event : Smoke / Fire / Fumes / Odor

Anomaly.Flight Deck / Cabin / Aircraft Event : Illness / Injury

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Anomaly.Inflight Event / Encounter : Weather / Turbulence

Detector.Person : Flight Attendant

Were Passengers Involved In Event : Y

When Detected : Routine Inspection

When Detected : Pre-flight

When Detected : In-flight

Result.General : Maintenance Action

Result.Aircraft : Equipment Problem Dissipated

Assessments

Contributing Factors / Situations : Aircraft

Contributing Factors / Situations : Human Factors

Primary Problem : Aircraft

Narrative: 1

During boarding there were 2 JS riders, plus nonrevs with seats, plus working crew in the aft galley which I attempted to work around to complete duties. There was some impediment. During MX (Maintenance) delay a NONREV from Cabin C came to aft galley and argued with me about why it was not OK for her to charge her cell phone with the vacuum outlet in the galley. I advised her of the safety policy regarding that. After demo I was in aft galley when I smelled strong oil and oil exhaust smell that extended a few rows into the cabin past Row 31, including lav. It seemed to dissipate after several minutes with forward movement of plane which is common so did not report then. During cruise a pax (passenger) from Row 33 came aft to complain of nausea and headache asking for water and pain med and denied having symptoms prior to flight and complained of fumes bothering him. I smelled oil in the aft galley area intermittently throughout flight, and was experiencing some mild symptoms myself but still did not write report on paper prior to calling CA (Captain) to keep him informed. All 3 MC crew were in galley when pax complained. FA (Flight Attendant) 4 provided water and med to pax. FA3 and FA4 both went forward for pilot breaks and cabin surveillance AFTER I called the FD about this issue so I assumed FA1 would be informed by someone else including the CA, but he was not. My mistake which I apologized to him for. During cruise we were experiencing turbulence in the aft so I waited several minutes before calling the FD to notify we were experiencing turbulence in the aft and to request SB (seat belt) sign on if they felt it was appropriate. During cruise I went forward to provide CDW about aft lav to FA1 but he was in the lav for an extended period of time and I had MC duties to attend to so I slipped the form under the FD door and called the FD to tell them same. At gate arrival a stronger smell of oil entered the aft galley area and cabin and lav so I called the FD, for a 4th time, with out calling FA1 first, to confirm AFT doors showed unarmed, asking to vent aft galley and report the very strong fumes of oil. He asked me to fill out the info on paper and to see him to debrief together and asked who all was involved. I tried to do an ALLCALL from the aft but was unsuccessful in reaching the entire crew with one call so tried to do individual calls. I was only able to reach FA3 and FA1 who began to yell at me about my poor CRM and said he only found out when the FD door opened and the CA said something about it. Both the CA and FA1 said I did not follow CRM procedures and said only the FA1 is to call the FD on cabin issues. I was unaware that was the case even for safety situations, including turbulence in the aft, that I was primarily aware of and apologized. FA1 accused me of intentionally creating conflict and of having a pattern of same. Each of the last 3 times I have flown with him he asks me what I want to be when I grow- up in front of passengers, another time we flew together he yelled at me for making a PA about the seatbelt sign prior to XA:00 as FA2 because he thought the IFM said XB:00 not XC:00 and people were sleeping, and only the FA1 makes announcements. I suppose this factored into why I was directly calling the FD and not using the loud interphone to call FA1 as well. And why I did not opt to make the turbulence without seat belt sign on announcement instead. I can't speak to why no one else told him about fumes and pax complaint. There was an opportunity during the crew briefing to establish cabin to FD flow that I think was missed. With multiple employee pre-boards and a full flight we were all highly tasked during the pre-boarding and boarding processes I have experienced both FD wanting only to speak with FA1 and stating such and also being invited to call with any safety concerns regardless of position in cabin. In my main concern and focus for safety of flight I unintentionally possibly violated CRM flow on this flight.

Synopsis

Air Carrier Flight Attendant reported physiological symptoms from intermittent cabin fumes which were also reported by passengers.

Time / Day

Date : 202103

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Ground : ZZZ

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 : Taxi

Person : 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)

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Multiengine

Experience.Flight Crew.Last 90 Days : 56

Experience.Flight Crew.Type : 5614

ASRS Report Number.Accession Number : 1795884

Human Factors : Communication Breakdown

Human Factors : Other / Unknown

Human Factors : Situational Awareness

Human Factors : Time Pressure

Human Factors : Distraction

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Person : 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 : Instrument
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Air Transport Pilot (ATP)
Experience.Flight Crew.Last 90 Days : 210
Experience.Flight Crew.Type : 10000
ASRS Report Number.Accession Number : 1795887
Human Factors : Time Pressure
Human Factors : Situational Awareness
Human Factors : Other / Unknown
Human Factors : Communication Breakdown
Human Factors : Distraction
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Flight Deck / Cabin / Aircraft Event : Passenger Misconduct
Anomaly.Deviation / Discrepancy - 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 : Chart Or Publication
Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

During single-engine taxi out, the A FA called the cockpit, informing us of passengers' non-compliance with the facemask policy. The decision was made to return to the gate. As we taxied back toward the Ramp, I coordinated with the Captain, advising that I felt it was appropriate to perform an After Landing flow prior to returning to the gate. Captain agreed, and I accomplished the flow. While holding for a gate, and on the apron with the parking brake set, the A FA called back to the cockpit, advising that the passengers were now willing to comply and that the three FAs were comfortable with continuing the flight. At this point we re-accomplished a Before Taxi flow (as appropriate for our single engine taxi configuration), then ran a Before Taxi Checklist. We then coordinated with ATC to proceed with a taxi clearance for departure. The Number 1 engine was started and the rest of the taxi and takeoff proceeded uneventfully. Once airborne, I noticed that we had departed with the autobrake selector in the OFF position. As I thought about the sequence of events leading to that I thought of two things: placing that switch to RTO takes place in the Captain's Before Start flow. I also recalled that when I performed the After Start flow (following the Passenger incident), I placed the Window Heat switches to ON, another item that is normally accomplished in the Captain's Before Start flow. Clearly, in our unique situation, a Before Taxi flow, followed by a Before Taxi Checklist was insufficient to reposition all switches to their appropriate positions prior to taxi and takeoff. Of note, neither of us felt rushed, and we both felt that we used good CRM to methodically think through our situation before continuing, yet in the end, something was missing. I've referenced the manuals, looking for a procedure that would have trapped our errors, but am still left wondering. Since we started the original taxi single engine and never shutdown that engine, the procedure in Flight Ops Manual never entered our minds, yet

that guidance probably would've caught the error. Non-standard Ops lead to inadvertent takeoff with auto brakes selected off.

Narrative: 2

On taxi out, the A FA called to tell me that there was a family being non-compliant regarding the face mask policy. I made the decision to taxi back to the gate. I asked the FO to complete the After Landing Checklist. While we were waiting for a gate, the FA called to tell us, "Never mind, the issue is resolved." At that point, we completed the Before Taxi Checklist and taxied to the runway. After takeoff, the FO pointed out that RTO switch was not re-selected to "armed." Our unique situation made it impossible for autobrake re-selection to occur. In this situation, our normal checklist does not catch the error. I should have triple checked everything because our routine taxi out was interrupted. RTO reengage missed during a taxi back to the gate and subsequent cancellation of that.

Synopsis

Air carrier flight crew reported missing re-setting the auto-brake system before takeoff and cited dealing with a passenger not complying with face mask policy as a contributing factor.

Time / Day

Date : 202103

Local Time Of Day : 0601-1200

Place

Locale Reference.ATC Facility : ZLA.ARTCC

State Reference : CA

Altitude.MSL.Single Value : 21000

Environment

Light : Daylight

Aircraft : 1

Reference : X

ATC / Advisory.Center : ZLA

Aircraft Operator : Air Taxi

Make Model Name : EMB ERJ 135 ER/LR

Operating Under FAR Part : Part 135

Flight Plan : IFR

Mission : Passenger

Flight Phase : Descent

Airspace.Class A : ZLA

Aircraft : 2

Reference : Y

ATC / Advisory.Center : ZLA

Make Model Name : Any Unknown or Unlisted Aircraft Manufacturer

Airspace.Class A : ZLA

Person : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Taxi

Function.Flight Crew : Pilot Not Flying

Function.Flight Crew : Captain

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Multiengine

ASRS Report Number.Accession Number : 1792528

Human Factors : Situational Awareness

Person : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Taxi

Function.Flight Crew : Pilot Flying

Function.Flight Crew : First Officer

Qualification.Flight Crew : Commercial

Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Multiengine
ASRS Report Number.Accession Number : 1792529
Human Factors : Situational Awareness

Events

Anomaly.Conflict : Airborne Conflict
Anomaly.Inflight Event / Encounter : CFTT / CFIT
Detector.Automation : Aircraft Terrain Warning
Detector.Automation : Aircraft RA
When Detected : In-flight
Result.Flight Crew : Took Evasive Action

Assessments

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

Narrative: 1

Flying from ZZZ-BUR we were in cruise assigned by ATC to start a descent from FL220 to FL180. Upon passing through FL215 ATC asked us to stop our descent at FL210, we complied and stopped at 210. Upon reaching 210 we received a TCAS TA. The FO and myself immediately looked at the TCAS screen and started to visually look for the traffic. He was getting closer to our six mile ring and he was still climbing, we saw him on our TCAS inside of our six mile ring and now at our same altitude. It was at this time the we received an RA. The FO immediately disconnected the autopilot and started to comply with the RA. At this time ATC told us to climb to FL230 I told him we were complying with an RA event and we could be unable to climb to 230. The RA initially gave us a command to descend at 3200 FPM and then the rate of descent was increased by the RA to 4500 FPM which was complied with. We leveled the aircraft off after the RA was complete at FL190. We asked ATC if he had any further instructions for us, he said to level at 190 and he would be back momentarily. He proceeded to give the other aircraft that caused the RA a phone number to contact center. The pilot sounded like he was possibly in distress in a potentially hypoxic situation from the tone and behavior of his radio calls and struggle to follow any ATC instructions at the time. We continued to descend into Burbank and now on SoCal Approach were given a heading of 150 and 5k feet which took us right over a mountain that gave us a terrain warning momentarily as we leveled at 5k feet. We cross this terrain at 5,000 often on a vector from ATC we happened to cross right over the very peak of this terrain and with the descent rate down we suspect that the rate of closure was too much for the GPWS. Upon landing in Burbank on the ILS Z 8 we received on more TCAS TA/RA as we crossed over ZZZ1 traffic in the pattern below caused our TCAS to give us a "Monitor vertical speed" we complied and landed at Burbank without further incident. All events that took place were as a result of other aircraft and ATC vectors. We as a crew exercised all appropriate training to comply with all events.

Narrative: 2

While operating ZZZ-BUR level at FL 220, LA center on 132.5, issued a descend and maintain from FL220 to FL190. Passing through FL21.5 ATC amended clearance with a limit of FL210. We leveled off at 210 without any deviation but noticed an aircraft rapidly approaching our guarded zone on TCAS. Momentarily after we noticed this, a traffic advisory was made by the TCAS system and followed by and immediate command for "monitor vertical speed". The vertical speed initially commanded was 3700 fpm. The target aircraft did not level off at their assigned altitude. After the autopilot was immediately

disengaged and the descent was initiated to the commanded rate, the TCAS prompted "increase vertical speed" commanding roughly a 4500 FPM decent rate. LA center was notified and after the aural clear of conflict was heard and agreed on the aircraft was level at FL190 and ATC issued a new clearance. With no further issues the flight continued through Joshua approach and then onto SoCal approach. With SoCal approach upon completion of the JANNY5 arrival into BUR SoCal assigned a vector of hdg 190 and descend to 5,000 ft. Level at 5,000 feet we crossed over a mountain peak that was at 3,734 feet. This caused a terrain warning and a subsequent " terrain terrain pull up". The aircraft climbed roughly 100 ft since the conditions were VFR and clear. After the terrain clearance was accomplished, SoCal assigned a heading of 110 and 3000 till established and cleared for the ILS-z Runway 8 into BUR. Upon passing over ZZZ1 we received another traffic advisory and that was followed with a RA. The RA did not state any vertical speed as the target aircraft had already passed behind us. The flight landed at BUR on Runway 8 with no adverse issues or events after that point. Continue to follow SOPs and be a vigilante and proactive flight crew and practice good CRM techniques.

Synopsis

Air carrier flight crew reported that during arrival into BUR airport they had experienced an RA and later had a terrain warning caused by passing over a mountain peak at a high rate of descent.

Time / Day

Date : 202102

Local Time Of Day : 0601-1200

Place

Locale Reference.ATC Facility : ASE.TRACON

State Reference : CO

Relative Position.Distance.Nautical Miles : 14

Altitude.MSL.Single Value : 13000

Environment

Flight Conditions : VMC

Aircraft

Reference : X

ATC / Advisory.TRACON : ASE

Aircraft Operator : Air Taxi

Make Model Name : Learjet 60

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 135

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Nav In Use.Localizer/Glideslope/ILS : LOC DME-E

Flight Phase : Initial Approach

Airspace.Class D : ASE

Person

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Taxi

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Flight Instructor

Experience.Flight Crew.Total : 7900

Experience.Flight Crew.Last 90 Days : 60

Experience.Flight Crew.Type : 2960

ASRS Report Number.Accession Number : 1790605

Human Factors : Confusion

Human Factors : Situational Awareness

Human Factors : Training / Qualification

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : ATC

Events

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Anomaly.Deviation / Discrepancy - Procedural : FAR

Anomaly.Inflight Event / Encounter : CFTT / CFIT

Detector.Automation : Air Traffic Control

When Detected : In-flight

Result.Flight Crew : Executed Go Around / Missed Approach

Result.Air Traffic Control : Issued Advisory / Alert

Assessments

Contributing Factors / Situations : Human Factors

Primary Problem : Human Factors

Narrative: 1

We were flying from ZZZ to ASE and I was the pilot flying. As we approached Aspen, which at that time was reporting VFR, we were given vectors to intercept LOC DME E into ASE. I looked over and noticed the LOC approach was not properly set up. I warned the monitoring pilot of this but at that point we made visual contact with the airport. We accepted clearance to maintain 13,000 ft until established and clearance to execute LOC DME E approach. Having visual contact with the airport we started our descent. A layer of clouds moved in below us as we made the final turn inbound. At the entire time we had full visual contact with all the terrain around. We lost sight of the airport due to the cloud layer, at the same time ATC issued an altitude alert. I emphasize that we were in full visual contact with all the terrain and that visibility at our flight level was unrestricted. The pilot monitoring advised that we had terrain but lost a visual with the airport and said that we would be going missed and starting a climb. We got another altitude alert from ATC. We advised we are in a climb and asked for vectors to give time to decide what to do. We proceeded to ZZZ1 airport afterwards. We were NOT in IMC conditions at any phase of the flight and we maintained visual clearance from all the terrain. The mistake was communication breakdown with ATC and in part CRM in regards to the intentions to execute a visual approach. At no time aircraft was in IMC conditions and we were maintaining clearance with terrain at all times. The aircraft was never put in any unsafe condition. I learned from this how CRM and communication has to be mastered the entire time.

Synopsis

Learjet First Officer reported receiving a low altitude alert from ATC after descending early on a cleared instrument approach.

Time / Day

Date : 202102

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : A321

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Parked

Person : 1

Location Of Person.Aircraft : X

Location In Aircraft : General Seating Area

Cabin Activity : Boarding

Reporter Organization : Air Carrier

Function.Flight Attendant : Flight Attendant (On Duty)

Qualification.Flight Attendant : Current

ASRS Report Number.Accession Number : 1789180

Human Factors : Time Pressure

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Attendant

Communication Breakdown.Party2 : Flight Crew

Person : 2

Location Of Person.Aircraft : X

Location In Aircraft : General Seating Area

Cabin Activity : Boarding

Reporter Organization : Air Carrier

Function.Flight Attendant : Flight Attendant (On Duty)

Qualification.Flight Attendant : Current

ASRS Report Number.Accession Number : 1789785

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Attendant

Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Aircraft Equipment Problem : Less Severe

Anomaly.Flight Deck / Cabin / Aircraft Event : Smoke / Fire / Fumes / Odor

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Detector.Person : Flight Attendant

When Detected : Aircraft In Service At Gate
Result.General : Maintenance Action
Result.Flight Crew : Overcame Equipment Problem
Result.Aircraft : Equipment Problem Dissipated

Assessments

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

Narrative: 1

The Number 2 and 4 Flight Attendants (FA) called to report strong odor in aft galley. I continued boarding while the Number 1 FA went in to speak with the Captain. She returned and said we were to continue boarding. I could hear the aft FAs calling Captain while we stood in entry area. The Number 1 would go in to cockpit to get updates from the calls. A deadheading pilot then came from the back of plane and went to the cockpit to speak with the Captain. There was some question about it being a urine smell and perhaps the cleaning of the lavs. We had neared the end and I walked through closing bins, etc. As I got to row 25 I smelled a very strong and pungent dirty sock smell. I went to aft galley and told them it was a dirty sock smell and where I began smelling it. I asked them to relay that info up front. The Number 2 and 4 wanted the Captain to come and smell because they disagreed with that assertion. I had returned to the front of aircraft and the Number 1 and Captain went to the back. When he returned he seemed perturbed that the Number 1 was not immediately behind him and wanted to close up. I said I would close the remaining overhead bins. The Number 1 returned and we departed. First, I believe we should have stopped boarding and deplaned the passengers and crew until the cause/type/potency of odor could be established. Following the operating procedures for deplaning at the gate would have allowed a quicker review of the situation and the concerns for safety until a definitive answer could be established while removing passengers and crew from a potentially harmful exposure.

Narrative: 2

We commenced the boarding and Flight Attendant #2 and I walked to aft galley and both smelled a noxious odor. I called the Flight Attendant 1, three times and she in turn told the Captain. He said "it is probably a leaky trash bag or rotten food." Flight Attendant 2 called the Captain directly and he again blew us off. We had a deadheading pilot also go to cockpit to relay information and when he got back, he said the "theory is that it is a leaky trash bag". We had been on the aircraft for 4 hours prior to this event as we brought the aircraft in from ZZZ. The fumes were coming out of air vents in galley and aft lavs and was going into c zone. 33 minutes after we first notified Captain, at the end of boarding, he came to the back and said "I don't smell anything, we are going to ZZZ1". With that, he turned and walked back to the front. Yes, the fumes had just dissipated by that point, 33 minutes later. There was no interaction, NONE. He obviously did not care about the noxious fumes in the aft section of aircraft. For 33 minutes, he continued to disregard every attempt to tell him what was happening in the back. He's a Check Airman, really? He's supposed to be the best of the best. I felt like my safety was jeopardized and I would never feel safe flying with him again. What if I reported smoke, would he say it is stale cigarette smell on someone's shirt? The one important bit of information he might need might come from the most junior Flight Attendant or even a new hire. In this case he had 4 very senior Flight Attendants and disregarded all of us when we made 5 attempts to get his help in telling him about the noxious odors. Captain obviously needs some intense CRM

training. Maybe giving a check ride to another pilot and trying to manage fume events are just too much for him. It obviously was.

Synopsis

A321 flight attendants reported a communication breakdown with the Captain regarding cabin odor during boarding.

Time / Day

Date : 202102

Place

Locale Reference.ATC Facility : ZZZ.ARTCC

State Reference : US

Altitude.MSL.Single Value : 40000

Environment

Weather Elements / Visibility : Turbulence

Aircraft

Reference : X

ATC / Advisory.Center : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : B787 Dreamliner Undifferentiated or Other Model

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Cruise

Airspace.Class A : ZZZ

Person

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)

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Multiengine

Experience.Flight Crew.Total : 11102.03

Experience.Flight Crew.Last 90 Days : 141.83

Experience.Flight Crew.Type : 1016.48

ASRS Report Number.Accession Number : 1786404

Events

Anomaly.Deviation - Altitude : Excursion From Assigned Altitude

Anomaly.Deviation - Speed : All Types

Anomaly.Deviation / Discrepancy - Procedural : Clearance

Anomaly.Inflight Event / Encounter : Weather / Turbulence

Anomaly.Inflight Event / Encounter : Loss Of Aircraft Control

Detector.Automation : Aircraft Other Automation

Detector.Person : Flight Crew

When Detected : In-flight

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

Result.Flight Crew : Regained Aircraft Control

Assessments

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Weather

Primary Problem : Weather

Narrative: 1

During cruise at FL400 mountain wave was encountered. The airspeed exceeded Vmo/Mmo with accompany EICAS alert, Master Caution Alert and audible alert. I was the pilot flying and the FO was Pilot monitoring. The FO extended the speed breaks to full extend and reduced the throttles immediately to idle. The aircraft descended 500 feet. The airspeed reduced below Vmo/Mmo, the warnings stopped. The FO retracted the speed breaks and the autothrottles increased to maintain VNAV programed speed. This all occurred within 10-20 seconds. I was attempting to determine what was happening as the FO accomplished the above items. ATC was notified of the mountain wave and altitude excursion. We briefed the mountain wave and actions which were taken. I reviewed the Flight Manual regarding high altitude overspeed situations. It was determined that the actions taken deviated from FM directed guidance. We reviewed CRM items on what went right, what went wrong and what we would do in the future. It was a great discussion. It became apparent to me that the 4 hour departure delay and all the associated tasks had taken a toll on my ability to process information in a timely manner. I was slow to react to the overspeed. As a result, the FO used CRM skill of leadership to deploy the speed break and reduce the throttles. We had a conversation about the FO acting too quickly and me not acting quickly enough. Maintenance Control was contact to determine what items needed to be included in the report regarding the overspeed. An electronic logbook write up was submitted.

Synopsis

Air carrier Captain reported that an airspeed exceedance and altitude excursion occurred when the aircraft encountered a mountain wave.

Time / Day

Date : 202101

Environment

Flight Conditions : VMC

Weather Elements / Visibility : Thunderstorm

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 3

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Cruise

Person

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Not Flying

Function.Flight Crew : First Officer

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Total : 9517.27

Experience.Flight Crew.Last 90 Days : 187.27

Experience.Flight Crew.Type : 3798.45

ASRS Report Number.Accession Number : 1784953

Human Factors : Communication Breakdown

Human Factors : Physiological - Other

Human Factors : Situational Awareness

Human Factors : Confusion

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Attendant

Events

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Detector.Person : Flight Crew

Were Passengers Involved In Event : N

When Detected : In-flight

Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Environment - Non Weather Related

Contributing Factors / Situations : Human Factors

Primary Problem : Human Factors

Narrative: 1

The Lead Flight Attendant had apparently talked to the Captain or First Officer about masks. They said something to me about it after my break along the lines that she was upset and combative. I was surprised, as I wore my mask (a KN95 on the ground and a solid multi-layer cloth one in the air) all times outside of the flight deck and in the flight deck if a Flight Attendant was present. Additionally, the other First Officer did as well. The Captain wears glasses that fog easily with a mask on. He wore a mask on the ground, he did not airborne because it would greatly interfere with his duties both because he wouldn't be able to see and could not communicate. This was our 4th leg together and we had no issues with masks among ourselves or other flight attendants. Additionally, both the Captain and other First Officer already had COVID which they had gotten from people they knew at home, not in the workplace. Before our next rest room break I got out a new unused N95 mask for the Flight Attendant that would be in the flight deck while I was in the bathroom. When I called back and ask for the break she ordered me that the pilot remaining in the flight deck should wear the crew oxygen mask. I said that was not something that we did anymore-the practice stopped months ago because of COVID. I offered her the N95 for extra protection because the Captain can't wear a mask and do his job. She refused it. Instead continuing to wear what appeared to be a single layer stretchy black cloth mask. Additionally the flight attendant blocking the cart was wearing a KN95 but the Lead FA did not send her into the flight deck. I found the flight attendant to not be willing to exercise self-help and any wearing of an N95 and apparent multiple complaints to be a distraction from my flight duties. This was not good for crew CRM. While the single pilot on the flight deck, I was distracted from monitoring the airplane by her distress and complaints.

Synopsis

Air Carrier First Officer reported poor CRM with the Lead FA regarding the company face mask policy on the Flight Deck.

Time / Day

Date : 202101

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase.Other

Person

Location Of Person.Aircraft : X

Location In Aircraft : Galley

Cabin Activity : Service

Cabin Activity : Safety Related Duties

Reporter Organization : Air Carrier

Function.Flight Attendant : Flight Attendant (On Duty)

Qualification.Flight Attendant : Current

ASRS Report Number.Accession Number : 1781107

Human Factors : Communication Breakdown

Human Factors : Physiological - Other

Human Factors : Other / Unknown

Human Factors : Situational Awareness

Communication Breakdown.Party1 : Flight Attendant

Communication Breakdown.Party2 : Flight Crew

Events

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

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Detector.Person : Flight Attendant

When Detected : Pre-flight

Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Company Policy

Contributing Factors / Situations : Environment - Non Weather Related

Contributing Factors / Situations : Human Factors

Primary Problem : Environment - Non Weather Related

Narrative: 1

I took the insert of the food catered for the pilots up to the flight deck prior to passenger boarding. The Captain asked me to set it on the jump-seat behind him. During boarding, the Captain came out and told us that the First Officer does not wear a mask in the flight deck and asked if either Flight Attendant A or myself would be willing to come up to the flight deck if the Captain needed a lavatory break in flight. We both said that we would not be comfortable with coming up there if the First Officer was not wearing a mask. Upon landing, I realized that the insert of flight deck food remained in the flight deck until after landing. Better CRM between flight deck and flight attendants if this situation comes up. I honestly don't think that anyone even thought about it. Flight Attendant A and I just knew that we were not going to put ourselves into the flight deck if the First Officer wasn't wearing a mask, which we would have had to in order to grab the insert. But it absolutely was not intentionally left on the flight deck for takeoff and landing on our part.

Synopsis

Flight Attendant reported the FA crew were unwilling to enter the flight deck because the First Officer would not wear a face mask.

Time / Day

Date : 202012

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZZ.Airport

State Reference : FO

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft : 1

Reference : X

Aircraft Operator : Corporate

Make Model Name : Learjet 40

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 135

Flight Plan : IFR

Mission : Passenger

Flight Phase : Takeoff / Launch

Aircraft : 2

Reference : Y

Aircraft Operator : Corporate

Make Model Name : Medium Transport

Crew Size.Number Of Crew : 2

Flight Plan : IFR

Flight Phase : Taxi

Person

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1780384

Human Factors : Communication Breakdown

Human Factors : Situational Awareness

Human Factors : Time Pressure

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.ATC Issue : All Types
Anomaly.Conflict : Ground Conflict, Critical
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Ground Incursion : Runway
Detector.Person : Flight Crew
When Detected.Other
Result.Flight Crew : Overcame Equipment Problem
Result.Flight Crew : Returned To Clearance
Result.Flight Crew : Took Evasive Action

Assessments

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

Narrative: 1

While operating a part 135 trip from ZZZZ to ZZZ1 we experienced a runway incursion while departing on runway 14. The possible incursion happened at intersection Lima and runway 14 which is approximately 9000 ft. from the start of the runway. I am also confident that the other aircraft was a Medium Transport. At the time, the ground and tower controllers were operating on separate frequencies by two different people. Once holding short, we advised tower that we were ready for departure to which he responded for us to line up and wait as he had landing traffic a few miles out on runway 10. A few moments later, he cleared us for an immediate departure to which we thought he was trying to get us out before the traffic inbound for 10 landed. From our position on the runway, we could not see that landing traffic and could only go off what he told us earlier. As pilot monitoring, I completed the before takeoff checks and the pilot flying released the brakes and started to advance the throttles. As we rolled down the runway, I made the call of "airspeed alive both sides," and at that moment I could see in my peripherals that an aircraft far down the runway was approaching a hold short at intersection Lima. I called out to the PF (Pilot Flying) that there was an aircraft nearing the runway at a rather quick speed on the right side and keep an eye on him if possible. As we passed 80 kts and were quickly approaching V1 the aircraft began crossing the runway I called for an abort. It is hard to recall how long I waited for a response from the PF, but it had to have been about a half a second to a second and at that point I looked down again and we were passed V1. I called "V1, rotate" and we took off and started the climbout. When we passed the aircraft that crossed, we were a hundred feet or so in the air and they were turning on to taxiway hotel. We climbed out as usual and once above 10,000 ft. the PF engaged the autopilot, and we began talking about the situation. My first question was if he heard me call the abort, to which he replied that he did. He then told me as he was processing everything, he made the decision that a high-speed abort would have been more dangerous as we were just about to rotate, and the incursion aircraft was still almost a mile down the runway from us. We had switched to Center at that point already and I took the second radio to call back Approach and let them know what happened. I informed the controller that we had a possible runway incursion, and that the Medium Transport was just finishing crossing the runway as we had taken off. They said the supervisor was following up with the situation, had no further questions and appreciated the report. When thinking back to the situation we were guessing that the tower controller wanted to get us out before the landing traffic on runway 10 while at the same time the ground controller wanted to get the Medium Transport across the runway before we took off. Due to runway crossing clearances being given on the ground frequency, we have no idea that was happening while we were given our takeoff clearance while on tower. Finally, we talked about the importance of when a decision is made, to verbalize it so that we remain an effective crew.

When one pilot makes a decision without informing the other of that decision, especially at high speeds during takeoff, it is imperative that everyone is on the same page. We continued our way to ZZZ1 with no additional issues. The whole situation is complex and looking back it is hard to think of things we could have done differently. Due to operating procedures at the airport, we had no way of expecting that aircraft to cross in front of us down the runway as we executed our expedited departure. It is most important to maintain proper crew coordination and CRM through communication to remain a safe and efficient flight crew.

Synopsis

LR-40 Captain reported a critical Ground conflict during takeoff roll with a runway incursion aircraft at far end of departure runway.

Time / Day

Date : 202011

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.MSL.Single Value : 10000

Environment

Flight Conditions : VMC

Aircraft

Reference : X

ATC / Advisory.TRACON : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Nav In Use : GPS

Flight Phase : Climb

Route In Use.SID : ZZZZZ2

Person

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Not Flying

Function.Flight Crew : First Officer

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Total : 10135

Experience.Flight Crew.Last 90 Days : 62

Experience.Flight Crew.Type : 72

ASRS Report Number.Accession Number : 1772774

Human Factors : Situational Awareness

Human Factors : Training / Qualification

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Deviation - Altitude : Crossing Restriction Not Met

Anomaly.Deviation - Altitude : Overshoot

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Anomaly.Deviation / Discrepancy - Procedural : Clearance

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

Assessments

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

Narrative: 1

Climbing out of ZZZ on the ZZZZZ2 RNAV Departure. The departure lists the fix ZZZZZ as cross at or below. As monitoring pilot I was waiting for the hand off from Tower to Departure. Tower was busy handling other aircraft, and sometimes they hang on to you a little longer than normal. My mind was fixed on listening for the hand off, and wondering why we didn't get it. Not to mention I am brand new to the aircraft and have not flown much in the last several months. I finally decided to switch to Departure on my own and about that time I noticed the autothrottles retarding. I realized what had happened, the flying pilot had overlooked the level off and we crossed the fix 600-700 feet high. I contacted Departure and we continued the flight without further incident.

Synopsis

Air Carrier First Officer reported an altitude deviation during departure and cited poor CRM and lack of flying as contributing factors.

Time / Day

Date : 202010

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Relative Position.Angle.Radial : 180

Relative Position.Distance.Nautical Miles : 1

Altitude.AGL.Single Value : 1000

Environment

Weather Elements / Visibility : Fog

Weather Elements / Visibility : Icing

Weather Elements / Visibility.Visibility : 6

Light : Daylight

Ceiling.Single Value : 400

Aircraft

Reference : X

ATC / Advisory.Center : ZZZ

Aircraft Operator : Corporate

Make Model Name : Small Aircraft

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Flight Plan : IFR

Mission : Passenger

Flight Phase : Initial Climb

Airspace.Class E : ZZZ

Airspace.Class G : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Corporate

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Flight Instructor

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

Experience.Flight Crew.Total : 7000

Experience.Flight Crew.Last 90 Days : 100

Experience.Flight Crew.Type : 1500

ASRS Report Number.Accession Number : 1770347

Human Factors : Other / Unknown

Human Factors : Time Pressure

Human Factors : Physiological - Other

Human Factors : Situational Awareness

Events

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : FAR
Anomaly.Inflight Event / Encounter : Weather / Turbulence
Anomaly.Inflight Event / Encounter : VFR In IMC
Detector.Person : Flight Crew
When Detected : Pre-flight
When Detected : Taxi
When Detected : In-flight
Result.General : None Reported / Taken

Assessments

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

Narrative: 1

I arrived at the airport before dawn with my copilot, an equally qualified ATP, for a planned departure around sunrise from an uncontrolled field overlaid by Class G airspace. The flight involved carrying a group of passengers on a transcontinental itinerary, with two short stops. Knowing the morning surface temps were likely to be at or near freezing, with potential for frost, we had arranged for the aircraft to be hangared for the night and to be pulled out around the time we intended to arrive. We had anticipated clear skies, based on the available forecasts.

On arrival at the airport we discovered the upper surfaces of the wings were covered in frozen droplets. The line crew explained that a rain shower had blown through before they put the aircraft in the hangar the previous evening, and that the wings were still wet when they towed it out in the am. Unfortunately, they had pulled it out a little earlier than arranged, which had given the water time to freeze. The temp reported by the AWOS at that time was -XC. Another unanticipated factor was a low broken cloud layer instead of clear skies. I asked the line crew to put the plane back in the hangar and called the passengers and informed them there would be a delay.

Once the drops had melted we dried the surfaces with towels, then called the passengers to come to the airport. With passengers onboard I started the engine, began the taxi, and had the copilot call the clearance. Clearance informed us there would be several minutes delay due to traffic departing a nearby field. The delay turned into 20 minutes and as we sat at the hold line a fog settled in, restricting surface visibility to around 1/4 mile. The OAT read minus 1. Given the restricted visibility and potential surface icing conditions we decided it was unwise to depart, even though we suspected the fog layer was only a few hundred feet thick. I went aft and explained the situation to the passengers, then taxied back to the ramp. By this time we were already almost two hours' delayed.

The fog persisted another 90 minutes or so, during which time the passengers grew increasingly anxious about the prospect of having to postpone the trip to the following day. We had learned that morning of an impending inter-state COVID quarantine rule change with potentially very negative consequences for us in the event of further delay. All this put us under considerable pressure to depart.

The fog eventually lifted into low clouds, and we noticed an area of blue sky appear off the

departure end of the runway. Surrounding fields were reporting clear skies. The AWOS at our departure field was reporting 400 feet overcast and 6 miles visibility. Under normal circumstances I would have elected to depart IFR. However, faced with the already considerable delay and irritated passengers I made a quick decision to depart VFR, anticipating that we could maintain class G cloud clearance requirements in the initial climb and would be beyond the area of low clouds over the field by the time we were entered Class E airspace. I was highly familiar with the terrain in the area, having landed at the field several times in the preceding week and noted no local traffic on TCAS or the CTAF.

In the initial climb, however, I discovered I had misjudged the cloud coverage off the departure end, and was felt the safest route was to climb into IMC instead of stay below the deck. We ended up IMC as we entered Class E airspace, only clearing the tops around 1,000 AGL, in violation of FAR 91.155.

After departure I asked my copilot to pick up our IFR clearance with the Local Controller. He then informed me that he had actually activated a hold for release clearance with clearance before departure while I had been outside the airplane informing the passengers that we were ready to board. While a hold for release clearance does not prohibit a VFR departure, the AIM does state that the hold for release should be canceled before a VFR departure.

In hindsight it is clear to me I should have handled the situation differently. I should have resisted the pressure to get wheels up quickly, and remained on the ground until either an IFR departure clearance could be obtained from clearance, or the weather had lifted to the point I could be absolutely certain a VMC departure and climbout could be made. My rushed decision making and hasty conduct of the takeoff resulted in poor judgment and a lapse in good CRM.

Synopsis

Corporate Captain reported poor judgment resulted in flying VFR into IMC. Captain reported outside pressures to depart contributed to the event.

Time / Day

Date : 202010

Place

Locale Reference.Airport : ZZZ1.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Parked

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

Experience.Flight Crew.Total : 3136

Experience.Flight Crew.Last 90 Days : 36

Experience.Flight Crew.Type : 3136

ASRS Report Number.Accession Number : 1768450

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 : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

Experience.Flight Crew.Total : 3361

Experience.Flight Crew.Last 90 Days : 53

Experience.Flight Crew.Type : 3361
ASRS Report Number.Accession Number : 1768472

Events

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : Weight And Balance
Detector.Automation : Aircraft Other Automation
Result.General : None Reported / Taken

Assessments

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

Narrative: 1

After the parking checklist was completed we found a ACARS printout informing us of an overweight landing. The printout listed the Max Structural Landing weight of 146,300, the actual landing weight section was blank. Using our ZFW and arrival gate fuel we were approximately 200 pounds overweight on landing. This overweight landing was due to two shortened routings we received by ATC saving time and fuel. We completed a post flight debriefing which included a review of the OFP (Off-line Flight Planning) - FMS INIT LOAD section. The flight was dispatched to land only 568 pounds below max structural landing weight. We failed to identify this threat before departure or enroute which led to the subsequent error.

Our expectation bias of recent low passenger loads and light aircraft combined with a lack of recency of experience was a threat we didn't identify properly. Plus in past experiences if a potential landing weight concern exists, Dispatchers have highlighted this threat as a note in the OFP.

Narrative: 2

After arrival to the gate we received an overweight landing message. After reviewing our ZFW and fuel load we determined that we landed approximately 200 lbs over max landing weight. After discussion between the CA and I we agreed a lack of CRM was the ultimate cause of the deviation. My thought process was as follows:

Our flight from ZZZ to ZZZ1 was planned to land almost 1,000 lbs below MLW. As part of my pre-flight planning I always note the spread between both takeoff and landing weight verses the maximum values. A 1,000 lbs gap on landing did not stand out to me as something I would need to worry about. During our flight to ZZZ1 we received a number of shortcuts that shortened our route, and early in the flight we were certainly heavy on the fuel. However, as we neared the top of descent our fuel number vs the HOWGOZIT had dropped and was just several hundred pounds heavy.

When requesting the landing data our FMC wt was about 3,000 lbs over MLW, and while it mentally recognized this, I did not verbalize it to make sure the CA was also aware (again in my mind I was not thinking landing weight was going to be an issue). I also did not mention our weight as a potential threat during my arrival briefing.

Synopsis

Air carrier flight crew reported an overweight landing.

Time / Day

Date : 202010

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Tower : ZZZ

Make Model Name : Gulfstream G280

Crew Size.Number Of Crew : 2

Flight Plan : IFR

Flight Phase : Final Approach

Flight Phase : Initial Approach

Route In Use : Direct

Airspace.Class D : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

ASRS Report Number.Accession Number : 1766003

Human Factors : Time Pressure

Human Factors : Situational Awareness

Human Factors : Communication Breakdown

Human Factors : Distraction

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : ATC

Events

Anomaly.ATC Issue : All Types

Anomaly.Conflict : NMAC

Anomaly.Deviation - Altitude : Excursion From Assigned Altitude

Anomaly.Deviation / Discrepancy - Procedural : Clearance

Detector.Automation : Aircraft RA

Detector.Person : Flight Crew

Miss Distance.Horizontal : 500

Miss Distance.Vertical : 400

When Detected : In-flight
Result.Flight Crew : Took Evasive Action

Assessments

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

Narrative: 1

TCAS RA while flying inbound on ILS XXR ZZZ. Exceptionally busy local ZZZ Tower Controller with multiple VFR in pattern and adjacent Class D airspace including helicopter operations. Listening to [the] Controller manage multiple, busy aircraft in [the] pattern including one helicopter, [I] slowed [the] aircraft to 180 kt., downwind pattern entry. Numerous call outs additionally for traffic just outside control zone led to heavy workload for crew entering pattern. Called out airport in sight and given visual clearance on 8-mile left base XXR. Joined localizer inbound. [A] low level helicopter in pattern was consuming [the] majority of [the] Tower Controller instructions either due to training occurring in [the] helicopter, or [an] inability to comply with Tower instructions and widening their pattern out for [the] landing jet - us. Continuing inbound at the marker, I elected to stay one dot above glide slope due to [the] continuing inability of [the] helicopter to comply with Tower instructions to turn away from final approach course for us. Inside the marker one dot high, [I] received [a] TCAS RA from [the] helicopter turning base early towards us. PNF (Pilot not Flying) had helicopter in sight [the] entire time. Immediately started to arrest descent when TCAS RA abated. Continued [the] approach, reestablishing glide slope intercept without unusual maneuvering required, to an uneventful landing.

ZZZ during VMC weather is always an exceptionally busy airport with mix of high and low speed traffic in addition to multiple flight schools based there. Slowing the aircraft significantly assisted us and likely ATC Tower with sequencing for landing XXR and smaller aircraft, XXL. Estimate [there was] one dozen aircraft in pattern, with more nearby. Additionally, staying high on glide slope using situational awareness VFR likely provided further altitude separation for this eventual encounter. Non-complying VFR pattern helicopter to Tower instructions for whatever reason, highlights perils at this airport and necessitates good crew situational awareness and CRM. I did not follow up with ZZZ Tower with non-complying instruction helicopter, deeming [the] encounter a good learning lesson for all of us.

Synopsis

G280 Captain reported deviating from the ATC clearance due to receiving an RA.

Time / Day

Date : 202010

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : RKSI.Airport

State Reference : FO

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Operating Under FAR Part : Part 121

Flight Plan : IFR

Nav In Use : FMS Or FMC

Flight Phase : Initial Approach

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Relief Pilot

Function.Flight Crew : First Officer

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Multiengine

ASRS Report Number.Accession Number : 1765743

Human Factors : Confusion

Events

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Detector.Person : Flight Crew

When Detected : In-flight

Assessments

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Manuals

Contributing Factors / Situations : Procedure

Primary Problem : Manuals

Narrative: 1

On descent into ICN, we were changing the FMS/CDU from a previously planned and entered south-runway, STAR, and approach, which was in the FMS database and EFB (Electronic Flight Bag) Jepp, to a different north-runway, STAR, and approach. At that time, we noticed most of the FMS/CDU north runway STAR names and identifiers were different than our EFB Jepp Data. Then, we verified EFB Jepp data dates. They were the new, updated today (expires yesterday). However, we identified the FMC database, that

starts yesterday, was not selected.

We verified and confirmed remaining FMC route waypoints for accuracy. They were the same as EFB Jepp waypoints. We decided to continue up to the verified route end waypoint, (before STAR begins). CRM alternatives and precautions were evaluated. Weather was CAVOK. Upon contact with ICN-Radar, we advised that our STAR/Approach database was inaccurate and requested radar vectors for an arrival to a visual approach, before STAR entry waypoint. We received radar vectors, prior to the last route end waypoint. We continued with normal radar vectors and descents to a visual approach and landing. [Causal factor was] FMC out of date.

Synopsis

Air carrier Flight Crew reported Flight Management Computer Database was out of date.

Time / Day

Date : 202010

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 50

Environment

Flight Conditions : VMC

Aircraft

Reference : X

ATC / Advisory.Tower : ZZZ

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 : Landing

Airspace.Class B : ZZZ

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

Experience.Flight Crew.Total : 15927

Experience.Flight Crew.Last 90 Days : 0

Experience.Flight Crew.Type : 5783

ASRS Report Number.Accession Number : 1764793

Human Factors : Training / Qualification

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 : Captain

Function.Flight Crew : Check Pilot

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
Experience.Flight Crew.Total : 1656
Experience.Flight Crew.Last 90 Days : 33
Experience.Flight Crew.Type : 1656
ASRS Report Number.Accession Number : 1764820
Human Factors : Distraction
Human Factors : Situational Awareness

Events

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

Assessments

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

Narrative: 1

On ILS [Runway] XXL configured for an autoland upon hearing GPWS warning a go-around was initiated by me and successfully vectored back around for another approach to [Runway] XXR that was successful. In the debrief we both recognized the aircraft was not fully configured for landing thus the warning. Mitigating factors length of duty day, complacency due to the fact the approach was going well, maybe stress due to the current events i.e., COVID-19, and company uncertainty in today's world. Threats also included new Captain IOE and check airman flying in right seat. We all have been flying less.

Narrative: 2

I was flying as the LCA and pilot monitoring. While conducting new Captain IOE on Aircraft X, we were setting up for an autoland on Runway XXL in ZZZ. The arrival and approach were briefed to include known and anticipated threats. We were vectored around for the approach and cleared for the ILS XXL. The approach mode was armed and the second autopilot engaged. Just prior to intercepting the glideslope, the gear was lowered and flaps 5 was selected. We were in VMC conditions with the runway in sight. The touchdown zone altitude was set as we continued the approach. The 1,000 feet call and 500 feet call were made by me acting as pilot monitoring. The response to 'set missed approach altitude cleared to land' and 'flare armed stable' were made respectively by the IOE student. After 500 feet we received GPWS alerts for 'Terrain' and as we approached the runway threshold, a 'Pull Up' warning was [received]. After observing that we were in normal landing position, I made the ill advised call to continue. As the autopilot began to enter the flare we realized we were still at flaps 5 and not configured to land. I immediately called for a Go-Around and the Go-Around procedure was executed. We advised ATC and were vectored around for a second approach for [Runway] XXR. We executed the approach and landed without further incident. Upon arriving at the gate, we debriefed our errors as well as the breakdown in CRM/TEM monitor crosscheck and SOP. We also debriefed our failure to adhere to the GPWS warning. We concluded that the combination of limited currency, outside current distractions (COVID, displacements,) and a long duty day may have created a moment where we completely lost focus. The decision to go-around saved our poor performance from becoming an accident.

Synopsis

Air carrier flight crew reported executing a go-around due to a ground proximity warning.

Time / Day

Date : 202009

Local Time Of Day : 0601-1200

Place

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC

Weather Elements / Visibility.Visibility : 10

Light : Daylight

Aircraft

Reference : X

Aircraft Operator : Corporate

Make Model Name : Helicopter

Operating Under FAR Part : Part 91

Flight Plan : VFR

Mission : Ferry / Re-Positioning

Flight Phase : Takeoff / Launch

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Corporate

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Single Pilot

Qualification.Flight Crew : Commercial

Qualification.Flight Crew : Rotorcraft

Experience.Flight Crew.Total : 8450

Experience.Flight Crew.Last 90 Days : 15

Experience.Flight Crew.Type : 5600

ASRS Report Number.Accession Number : 1763155

Human Factors : Situational Awareness

Human Factors : Time Pressure

Human Factors : Distraction

Events

Anomaly.Deviation / Discrepancy - Procedural : FAR

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Detector.Person : Flight Crew

When Detected : Pre-flight

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

Our helicopter's annual expired the last day of Month. The closest maintenance facility was closed for flights due to the COVID pandemic. On [date] we requested a special flight permit (SFP) to the FAA for a ferry flight to be conducted 5 days later. This was the first time I have done this type of application. The FAA takes time to process these applications and I became anxious, thinking the owner would not like [it] if we continued to delay the helicopter's maintenance. So, I made the decision to continue the flight 5 days later, although the SFP was pending. I let a non-existent external pressure influence my decision to conduct the ferry flight. The helicopter was in perfect condition, but I realized that it was a mistake and should have waited for the FAA SFP response to conduct the flight. I believe more training on CRM and aeronautical decision making and FAR knowledge will help me deter these types of situations in the future.

Synopsis

Pilot reported being under pressure and flew a ferry flight without proper documentation.

Time / Day

Date : 202009

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 500

Aircraft

Reference : X

ATC / Advisory.Tower : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Nav In Use : GPS

Flight Phase : Final Approach

Route In Use : Direct

Airspace.Class B : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1761850

Human Factors : Communication Breakdown

Human Factors : Training / Qualification

Human Factors : Other / Unknown

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Anomaly.Inflight Event / Encounter : Unstabilized Approach

Detector.Person : Flight Crew

When Detected.Other

Result.Flight Crew : Became Reoriented

Assessments

Contributing Factors / Situations : Human Factors

Primary Problem : Human Factors

Narrative: 1

I continued to land after still stabilizing an unstable visual approach below 500 feet AGL.
Causes - Complacency, poor descent planning, minimal currency (I haven't been flying much recently).

Lesson - Use multiple descent planning tools and techniques to improve vertical situational awareness and solidity feedback from other pilot on an approach.

Synopsis

Air Carrier Captain reported an unstable approach due to poor CRM and lack of flying.

Time / Day

Date : 202009

Local Time Of Day : 0601-1200

Place

Locale Reference.ATC Facility : ZZZ.TRACON

State Reference : US

Altitude.MSL.Single Value : 6000

Environment

Flight Conditions : IMC

Aircraft

Reference : X

ATC / Advisory.TRACON : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Nav In Use : GPS

Flight Phase : Final Approach

Route In Use : Direct

Airspace.Class B : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Total : 25000

Experience.Flight Crew.Last 90 Days : 25

Experience.Flight Crew.Type : 2880

ASRS Report Number.Accession Number : 1761773

Human Factors : Communication Breakdown

Human Factors : Situational Awareness

Human Factors : Training / Qualification

Human Factors : Fatigue

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Deviation - Track / Heading : All Types

Anomaly.Deviation / Discrepancy - Procedural : Clearance

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

Assessments

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

Narrative: 1

I made a delayed turn from base to final approach while conducting the ILS XXR into ZZZ. The reason for the delayed turn was a momentary lapse in CRM skills. I was the flying pilot, my copilot was the monitoring pilot. We were on a base leg when the Controller gave us a turn towards the final approach. I remember dialing in the correct heading, but forgot to press heading select. About ten seconds or so elapsed before the Controller asked if we were turning. I realized my error and immediately pressed heading select. The Controller gave us a new heading and an approach clearance. We turned onto final with a slight overshoot and above the glide slope. We configured for landing and used vertical speed mode to intercept the glide slope from above. We were on speed and altitude well before the 1,500 foot gate. Other than the late turn and the high glide slope intercept, there was no other incident or error.

The fact is the I/we made an error by not following through with Verbalize Verify and Monitor. I know that we both verbalized the heading change, I recall we both Verified setting the heading, we both, however, forgot to monitor the FMAs for the change. I think that we realized the something wasn't right a split second before the controller queried us.

There were many threats preceding this error. This is an all-night flight with an early morning low visibility arrival. The airspace is quite congested and there were many aircraft with similar sounding call signs. We had a runway change while on the arrival and the Controller kept us little higher and gave us a turn a little earlier than we had expected. I had a scheduling change in the middle of this pairing which reduced my rest time a day before this leg. Do to the current global pandemic and the reduced airline schedules, neither of us had flown very much in the past six months. I know I felt a bit rusty and tired.

To mitigate this I gave what I thought was a good approach brief before top of descent, and we briefed the changed approach during the arrival. We still failed to monitor the FMA change at a crucial moment. It was an error I hope I/we don't repeat.

Synopsis

Air Carrier Captain reported a track deviation during approach and cited fatigue and low flight time during the pandemic as contributing factors.

Time / Day

Date : 202008

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : NFW.Airport

State Reference : TX

Relative Position.Distance.Nautical Miles : 1

Altitude.MSL.Single Value : 2300

Environment

Flight Conditions : VMC

Weather Elements / Visibility.Visibility : 10

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Tower : FWS

Aircraft Operator : FBO

Make Model Name : Small Aircraft, High Wing, 1 Eng, Fixed Gear

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Flight Plan : None

Flight Phase : Initial Approach

Route In Use : Direct

Airspace.Class D : NFW

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : FBO

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Flight Instructor

Qualification.Flight Crew : Commercial

Qualification.Flight Crew : Instrument

Experience.Flight Crew.Total : 1100

Experience.Flight Crew.Last 90 Days : 300

Experience.Flight Crew.Type : 900

ASRS Report Number.Accession Number : 1758896

Human Factors : Communication Breakdown

Human Factors : Distraction

Human Factors : Situational Awareness

Human Factors : Training / Qualification

Human Factors : Confusion

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Communication Breakdown.Party2 : ATC

Events

Anomaly.Airspace Violation : All Types

Anomaly.Deviation / Discrepancy - Procedural : FAR

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Exited Penetrated Airspace

Assessments

Contributing Factors / Situations : Chart Or Publication

Contributing Factors / Situations : Human Factors

Primary Problem : Chart Or Publication

Narrative: 1

Prior to this flight, I was designated as the pilot in command (PIC) and I would be "under the hood" flying in simulated instrument conditions. We departed from ZZZ1 airport under Visual Flight Rules (VFR) and proceeded towards FWS where we planned to perform the necessary practice approaches. The winds were calm and FWS reported a north flow on their ATIS, landing Runway 35L. I contacted Spinks Tower and requested the practice ILS Runway 35L approach and was cleared as requested and told to "Maintain VFR and report the outer marker inbound." When I reported the outer marker inbound Spinks Tower asked how the approach would terminate; I requested a touch-and-go followed by a turn out to the south to set up for the practice RNAV (GPS) Runway 35L approach, which was cleared as requested and I was instructed to "Report the Final Approach Fix (FAF) inbound."

After self-vectoring myself towards the Initial Approach Fix (IAF), I turned left to intercept the approach course and proceeded inbound towards the Intermediate Fix (IF) and then turned inbound on the final approach course. After reporting the Final Approach Fix (FAF) inbound to Spinks Tower I was again asked how the approach would terminate. I informed the Tower that I would like to execute the published Missed Approach Procedure (MAP) and was subsequently "Cleared for the option Runway 35L" and told "Left turn out approved." The approach was flown to minimums and with no "runway in sight" call-out from my safety pilot, I promptly executed a go-around and proceeded to follow the published Missed Approach Procedure (MAP). The missed approach holding fix for this particular approach is located 22 NM west of the airport and after executing a climbing left turn towards the holding fix, and upon leaving FWS airspace, I was told "Frequency change approved" by the Tower. Upon completion of the hold, my safety pilot, and I decided to request another practice approach at FWS, except this time we intended to fly the RNAV (GPS) Runway 17R, which would be opposite the direction of traffic, so that I could perform a circling approach. After leaving the holding fix I contacted Spinks Tower again and made my request for the practice RNAV (GPS) Runway 17R approach and stated my intentions to perform a circling approach. The Tower acknowledged my request and subsequently cleared me for the practice RNAV (GPS) Runway 17R approach, while still 22 NM southwest of the airport, and I was told to "maintain VFR" and to "report the Final Approach Fix (FAF) inbound." At this point I should have reviewed the VFR sectional chart on my iPad and briefed any airspace conflicts or obstructions along the route since I was unfamiliar with the 17R approach course but I was quickly becoming task saturated with setting up for the approach and teaching the circling maneuver; all while flying the airplane. After being cleared for the practice RNAV (GPS) Runway 17R approach I proceeded direct to the Initial Approach Fix (IAF) which is 15 NM northwest of the airport and located in NFW's Class D airspace when flown at the altitude depicted on the FAA

approach plate (AL-6917). Between briefing and setting up for the approach, maintaining precise heading and altitude control, and simultaneously teaching the approach to my safety pilot while being "under the hood," I was unknowingly proceeding directly towards NFW's Class D airspace. This atypical loss of situational awareness led me to unintentionally enter into Class D airspace without establishing two-way radio communication as I proceeded to intercept the Initial Approach Fix (IAF) on the practice approach. This unintentional entry into Class D airspace went unnoticed by both myself and my safety pilot, until we were 4 NM inside the airspace. Once I was made aware of my mistake, I immediately discontinued the practice approach and executed a right, 180 degree turn to exit the airspace. I informed Spinks Tower that I was changing direction because I was inside of NFW's Class D airspace and Spinks Tower replied and said that I was told to "Maintain VFR" but due to task saturation I lost situational awareness and failed to comply with this instruction. I requested a frequency change from Spinks Tower so that I could establish two-way radio communication with NFW Tower to avoid any traffic conflicts or loss of separation. I then contacted NFW Tower and stated my position and intentions. At this point, I was almost outside of NFW's Class D airspace when NFW Tower approved me for a transition with no further instructions. After regaining my situational awareness, I informed NFW Tower that I would like to cancel my transition and instead depart their airspace entirely. NFW Tower acknowledged my intentions and responded with "frequency change approved." No further communications were received from NFW Tower indicating a traffic conflict or loss of separation but this atypical loss of situational awareness is inexcusable. In light of this event, it has come to my attention that the approach plate published by Jeppesen for this same Instrument Approach Procedure (IAP), FWS RNAV (GPS) Runway 17R, depicts NFW's Class D airspace along the initial approach segment whereas the FAA approach plate (AL-6917) does not. In my opinion, if the FAA approach plate for this Instrument Approach Procedure (IAP) were to depict NFW's Class D airspace along the initial approach segment, as it does on the Jeppesen version, then similar mistakes could be avoided and situational awareness would be greatly improved in this busy terminal area. Contributing factors in this event were my failure as the pilot in command to maintain situational awareness while conducting a practice Instrument Approach Procedure (IAP) under Visual Flight Rules (VFR) conditions as well as a breakdown in communication between myself and my safety pilot, [who] made no mention of our impending situation, demonstrating a lack of Crew Resource Management (CRM).

Synopsis

Pilot reported flying approaches into FWS airport entered NFW Class D airspace without clearance and cited FAA charting issues as a contributing factor.

Time / Day

Date : 202008

Local Time Of Day : 0601-1200

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Cruise

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : General Seating Area

Cabin Activity : Safety Related Duties

Cabin Activity : Boarding

Reporter Organization : Air Carrier

Function.Flight Attendant : Flight Attendant (On Duty)

Qualification.Flight Attendant : Current

ASRS Report Number.Accession Number : 1758346

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Attendant

Communication Breakdown.Party2 : Flight Attendant

Events

Anomaly.Flight Deck / Cabin / Aircraft Event : Passenger Misconduct

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Detector.Person : Flight Attendant

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

Primary Problem : Human Factors

Narrative: 1

I was the B FA on Aircraft X. We had a passenger that did not want to wear his mask. Said he had a medical condition. I told him since it was not said or documented in our records [the mask] had to be over his nose if he was not drinking or eating. Passenger was seated in XX1. FA A told me she was talking to him before takeoff. I had to remind him on service. FA D came and said he was not in compliance. We explained to her. Breakdown was in CRM on my part. Allow medical notes from doctors.

Synopsis

Flight Attendant reported a passenger was non compliant with face mask policy during flight. Reporter stated the passenger said he had a medical condition, but it was not noted in the crew's records.

Time / Day

Date : 202008

Place

Altitude.MSL.Single Value : 39000

Environment

Flight Conditions : VMC

Aircraft

Reference : X

ATC / Advisory.Center : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : B757 Undifferentiated or Other Model

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Flight Phase : Cruise

Airspace.Class A : ZZZ

Component

Aircraft Component : Air Conditioning and Pressurization Pack

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 : Instrument

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

Experience.Flight Crew.Total : 8382

Experience.Flight Crew.Last 90 Days : 11

Experience.Flight Crew.Type : 3976

ASRS Report Number.Accession Number : 1757150

Human Factors : Communication Breakdown

Human Factors : Confusion

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Person : 2

Reference : 2
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : First Officer
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Multiengine
Experience.Flight Crew.Total : 6908
Experience.Flight Crew.Last 90 Days : 38
Experience.Flight Crew.Type : 3098
ASRS Report Number.Accession Number : 1757155
Human Factors : Troubleshooting
Human Factors : Situational Awareness
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Ground Event / Encounter : Other / Unknown
Detector.Person : Flight Crew
When Detected : In-flight
Result.General : None Reported / Taken

Assessments

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

Narrative: 1

FO (First Officer) and I left the hotel to have breakfast together at the airport as the food available at the hotel is limited. After breakfast we proceeded to the departure gate.

The aircraft was extremely hot when we first boarded and there was no airflow. While I briefed Purser and the cabin crew, FO went to the cockpit to try to cool down the airplane. He noticed the compartment temperatures were 94 degrees and the APU (Auxiliary Power Unit) was not running. He started the APU and turned the packs on. When he returned from the walk around, he mentioned that the PC air was hooked up but not turned on.

I relayed the situation to station operations, and they said that they had contacted maintenance some time ago to start the APU. When boarding began the aircraft was still very warm, the compartment temperatures read 84 degrees. Later in the boarding process the Customer Service Agent mentioned that they had called 3 times about the air conditioning issue as well.

The departure, climb, and early cruise were normal. At FL390 and after approximately an hour into the flight we setup for a restroom break. When I left the flight deck, I noticed how warm it still was in the cabin. After returning to the cockpit I checked the cabin temperature indication and saw that they remained high at 82 to 84 degrees and that the temperature selectors were near full cold. I also noticed the cabin altitude seemed

unusually high. While FO was in restroom, I moved the temperature selectors to full warm to clear any ice that might have built up in the packs. After a minute or two there was no change, so I began the first steps of the Cabin Temperature Hot Procedure (2.20.24). Step 8 in the procedure calls for turning off the left pack. I was reluctant to do that as the air flow seemed low already and I was concerned about pressurization. FO had returned to the cockpit by this time, and I began to suspect the possibility that the recirculation fans may not be operating correctly. I then asked FO to try cycling the recirculation fans. While I meant in my mind the right recirculation fan only, I did say fans (plural). FO promptly complied with my request and turned both recirculation fans off and then on. With a sinking feeling in my chest, I immediately heard the overboard exhaust valve open in the belly of the plane. I then checked the cabin pressurization panel and saw it starting to climb.

I immediately called it to FO's attention and asked him to contact ATC (Air Traffic Control) for a lower altitude. I wanted to make sure that everyone in the cabin was near an oxygen mask, so I turned on the seat belt sign and called Purser and told him to get the crew to their jumpseats. I then made a PA "Flight Attendants, take your jumpseat." While we were in the descent, the cabin altitude warning sounded. We completed the immediate action items, started the CABIN ALTITUDE QRC, and advised ATC. Very quickly in the descent the cabin altitude began to descend. The cabin altitude warning went out, and we completed the QRC (Quick Reference Checklist) as control of the cabin had been regained. We leveled off at FL230 as the cabin altitude was well below 10,000 ft. During the descent, the cabin temperature returned to normal at approximately 74 degrees.

As there is no SATCOM, we contacted dispatch via ACARS "CALL ME". We spoke to them on AIRINC VHF, but the frequency had gaps and we had difficulty discussing the issue with the Dispatcher and [Maintenance Control]. I'm not certain for the cause of this. I was having no difficulty with ATC communication, but there were numerous breaks where we could not talk to dispatch. We asked dispatch to calculate our fuel burn for a flight to ZZZ.

I briefed the Flight Attendants on the situation. I made a PA to the customers explaining that we were having difficulties with the air conditioning system, and I apologized for the abrupt descent. I assured them that there was no need for concern and that we were considering an alternate route to ZZZ. I told them that I would keep them informed.

With normal pressurization and temperature restored we climbed up to FL290, stopping at FL250 and FL270 to confirm that normal pressurization and air conditioning would continue. Both the FMC (Flight Management Computer) and Dispatch showed us landing at ZZZ with acceptable reserves at FL290. Dispatch advised us that there were no delays into ZZZ. The only weather concern was a storm cell over ZZZ1 that we had in sight and was easily detoured around.

After consulting with Dispatch and FO I cancelled the priority request. ATC then recleared us to ZZZ VOR and then ZZZ1 VOR for the STAR arrival. I updated the passengers and gave them our new ETA. Subsequent arrival and landing normal.

After arrival at ZZZ, I completed ELB (Electronic Flight Bag) entries. Dispatch advised us earlier that a Mechanic would meet the flight to discuss the write up. We called Maintenance as no one met the flight. They told us they would call someone for us. We waited for another approximately :15 but no one arrived. We had to leave as our next flight was departing from the other concourse.

Before the Cabin Crew left, I asked them if there was any concern by the passengers and how things went from their eyes. They all complimented FO and I and said that not a single passenger had expressed any concern at all. They appreciated the communication and thanked us for our consideration and professionalism.

On our way to the next flight I contacted the FODM and debriefed her on the event. As we were on the concourse, I asked her to email me some sort of confirmation and her name, but as of this writing that has not arrived.

On our flight to ZZZ1 FO and I reflected on what went well and what could have gone better.

Obviously starting the APU or turning on the PC air to cool the airplane prior to our arrival would have helped things. The poor airflow in the aircraft was likely a factor as well. In my experience it takes an awfully long time to cool off an airplane that has been allowed to get that hot on the ground. But, normally once airborne with cooler exterior temperatures and the packs running on the engine bleeds the aircraft will cool before the top of climb.

However, the most important error was when I asked FO to cycle both recirculation fans. Equally important was not leaving the left recirculation fan off when I knew the overboard exhaust valve had opened. Doing so would have put the left pack in high flow and it is possible that the cabin would not have climbed like it did. This lacking in systems knowledge on my part has been corrected with a vengeance over the last 24 hours. Repair of this error took the next hour of the flight. My communication and monitor/cross check was lacking regarding the issue of "fan" v "fans." This is a lesson I have learned extremely well from this and will use it to teach with in the future. The precision of the spoken word is often casual, but at times and situations like this it is critical that time be taken to convey a precise message.

The B756 Flight Manual had the information and resources I needed to address the situation. However, my concerns over pressurization caused me to question turning off a pack in this situation. In retrospect, it would have been better to try turning off a pack that can be turned back on rather than open a hole in the bottom of the plane that can't be closed (even though that was not my intention).

I think the planning and decision making went well. FO and I weighed the pros and cons of cancelling the priority handling and the option of diverting enroute. In each case he provided good input that helped me make the decision. As mentioned before, we did have some challenges in communicating with Dispatch to get Dispatcher's input. As I was never able to have a conversation with [Maintenance Control] I did not have the benefit of their input in the decisions. I was able to speak to [name removed] long enough to get concurrence on cancelling the priority request but most all the communications we had were through ACARS.

Our workload management went well overall. FO and I were able to separate our duties, but then come together and recreate a shared mental model of the situation.

Purser, and the rest of the cabin crew also did a great job in handling the situation. The fact that none of the passengers expressed any concerns after the flight is a testament to their composure and professionalism. Please forward my thanks to them all.

FO did an excellent job during this and all the flights we flew. He is very capable and experienced, and managed the flying and ATC coordination perfectly while I was tending to the other duties. He is a fantastic resource on the flight deck. I truly look forward to flying with him again.

Narrative: 2

As a senior line holder FO (First Officer) and since my arrival to the fleet, I can say that in the last X+ years I fly the 767-300 about 70%, the 767-400 20% and the 757-200 10% on international route exclusively. I probably have flown the 757-300 no more than 6 times during my entire time on this fleet, of which the bulk has been this month. Which is to say I am far more familiar with the system and operations of the 767 of the four types we are qualified to fly. Aviate, Navigate and Communicate are all the same regardless of AC type, but there is something to be said for exposure to the daily operation and exposure to a specific type, in my opinion.

On date my Captain was replaced by a standards Captain in need of some currency, I only mention this because within XX+ years of flying, any pilot will admit that flying with a standards Captain can be a learning experience on my many levels, to say the least. I for one, always take advantage of this situation, to seek clarification and learn. Having said that, I am also fully aware of the CRM (Crew Resource Management) dynamics and stress that may come with these opportunities. My attitude is that I always try to fly SOP (Standard Operating Procedure) and learn or question when the need arises. I have been an FO longer than I have been Captain in my career but consider myself an aviator more concern with the safety of flight than ego and hence regardless of what position I am flying, I fly with the mentality that we are both here to support each other and get from point A to B safely.

Captain has been around a long time, and I found him to be very approachable and willing and wanting to pass on knowledge, which is welcomed.

Our 1st day was a 11h duty day, for a total schedule break of 13.5 hours. From my previous trip I already knew that there would be no inflight meal provided on our last sector and worse the airport food court as well as the Hotel room service would be closed by the time we arrived.

Furthermore the next day 1st flight also does not provide a meal, which will requires that you plan ahead and arrive to the airport to get your breakfast.

The above situation combined with a short layover, travel to the airport, Covid related procedure to start the duty day and if you really want to be at the aircraft 45 minute (as per Company report criteria - not enough time in my opinion) prior to departure, creates a situation where a crew not familiar with this trips particularities, could end up been hungry throughout the night and/or half of the next day, (until you get to ZZZ where you have 1.5h break in between flights with an AC change) and all that comes with not eating well in a 24h period. With a 13.5h break you are either going to have to decide on getting less than optimum sleep or nourishment, in my opinion.

I made Captain aware of this potential situation and we decided that getting to the airport early enough to eat and get to the aircraft 1h prior would be the best course. And that's exactly what we did and is where the event of the flight starts.

We arrived to the gate, and I was immediately approached by the lead gate agent, who

informed me that the cabin crew could not start their duties as the cabin was extremely hot.

The Gate agent told me he only had X0 passengers and that boarding was scheduled to start. I strongly recommended that he should ask us before boarding verify that the cabin would be at an acceptable temperature to board. While the Captain was briefing the Flight Attendant out near the gate, I went to the cockpit where I found the following;

1- The three cabin zone thermostats indicated 95F throughout the aircraft.

2- Every AIR VENT inside the cockpit was closed.

3- Not one sun shade or visors were installed or used in the cockpit. 4- The 757-300 was on Ground power and APU off, both recirculating fan off and window heat ON and I want to say the AC battery was off. However, I cannot say with certainty, regarding battery switch.

As regards to the Four points above, I was surprised to find an aircraft that had landed in ZZZ1 the day prior (where August temperatures average 85-95F and 75% humidity).

I for one always open all air vents and use any possible shade to minimize the baking affect in the flight deck. And I cannot imagine what would motivate any flight crew to close all the vents etc.

I started the APU, opened all vents in the cockpit and setup the AC to cool at maximum. As I left the cockpit to do my walk around and I suggested to our flight attendants that they close all window shades and open all airflow vents to help accelerate cooling.

While doing my walk around I found that the Ground AC (Air Conditioning) air hose was connected to the AC but the system was not turned on. Another uncomfortable sight for me to discover, as why would the AC hose be connected but system not turned on with the APU off.

Upon my return to the cockpit I noticed that only a few vent had being opened in the business class but all shades still opened. I asked the galley Flight attendant about it and was given a shrug of the shoulders.

I mentioned to the Captain all that I found (4 points above plus no ground AC air) and he directed me to call ops.

Ops stated that they had called the mechanics various times about getting the AC cool in some manners before our arrival. Clearly this did not happen.

By the time all passengers started boarding (seemed to me that somewhere along the way my suggestion fell on deaf ears) and were finished boarding 15 minutes before scheduled departure. The AC was indicating still 89F, and Purser said that passengers were complaining about the heat.

By the time we got to the Runway I noted and pointed out to the captain that the temperature was still showing 85-86F.

I was the flying pilot and we departed. I made it a point to mention to the captain that I would climb FL280 so as to facilitate getting to altitude and colder conditions faster, and get above the various buildups that where already starting. Furthermore because of our

light weight I requested we climb to FL390.

The 757-300 like the 767 has a cockpit temperature setting, without a temperature readout, but to me the cockpit felt comfortable enough. It was not until the TOC (Top Of Climb) or some minutes past that, I noticed and pointed out that the cabin temperature still showed 83-84F.

However, it wasn't until about an hour into the flight, entering ZZZ1 Center that we stepped out for a bathroom break and Captain noticed that the cabin was indeed still extremely warm, especially the galley. I concur with Captain's assessment after I stepped out of the flight deck as well.

By time I came back to the flight deck, Captain mentioned to me that he had reviewed and started with the procedure regarding a hot cabin or something to that effect. But that neither manual or max cooling etc were having any affect. Around this time into ZZZ1 Center and at FL390, Captain said he was going to try to see what could be done to help with this minimum cooling of the cabin, situation.

He thought that perhaps the packs had frozen over, a fair and common occurrence, I agreed but did mentioned that in my past experience usually you will get some signs of this situation ie ice pellets, but that I had not seen or felt any since the gate, especially with all the humid air.

As he researched more, I offered to take the radio as well PF (Pilot Flying) duties. At some point he asked me to turn off the recirculation FANs, which I repeated "turning off both Recir Fan R n L" and executed the command.

Here is where my lack of experience with the 757-300 system, combined with flying with a standards Captain, becomes more interesting as I think had I been flying with a normal line pilot, I would have requested that we use and follow the checklist. And perhaps prevented us from turning off the L Recir Fan.

In this scenario I was now following his guidance and thinking that because of his position perhaps he knew of a fix or something relating to this situation learned in his day to day exposure as a standards Captain.

Soon after recycling both FAN, we noticed then cabin started to climb at 300fpm from Cabin Altitude of 8,000 ft. As the cabin altitude passed 9,000 ft. I suggested we get our mask ready and the Captain asked for a lower FL.

We received FL340 and I descended expeditiously. Still the cabin continued to climb and prior to getting the Cabin Altitude Warning, I had my mask on and established communications, Soon after we initiated a rapid descent to FL230 and advised ATC.

The expedited descent was executed and while the Captain established radio communication, I flew the AC to FL230 and requested vectors. Once I thought Captain was regrouping with me, I requested expedited descent check list.

Clearly we had moved one from a temperature control situation to a pressurization situation. However because we saw it coming I was able to make the maneuver more gentle without excessive nose dive and we reached FL230 in what seemed like a fairly quick time period never exceeding 300k nor did the cabin pressure exceed 11,000 ft.

Flying at FL230 and FL290 and while I spoke to ATC, I requested vectors toward the west to avoid weather and was able to access that if need be we, could still make it to ZZZ1 with plenty of fuel.

Captain had some difficulty reaching or maintaining communication with Dispatch and Maintenance, I did tried to back him up but was more focus on Flying the aircraft and maintain ATC communication.

Which in it self was not a smooth process, as the frequencies provided by Center were not working well, so I requested we stay with 121.5 for a while.

Hearing that Captain was unable to maintain constant communications with company, I sent an ACARS messaged to dispatch with ETA and estimated Landing fuel in ZZZ, if we chose to proceed to ZZZ flying at FL290.

When the Captain and I came back together we both agreed that the AC was maintaining Cabin Altitude of 8,000 ft steady at FL230. And to make communication easier, we decided to remove our oxygen mask.

We both agreed that we could make it to ZZZ at FL230 and agreed that we could try slowly climbing in increments back to no higher than FL290.

I was still working the ATC radio and PF (Pilot Flying). While the Captain coordinated via ACARs with dispatch and requested a an updated OFP etc to ZZZ.

With concurrence and keeping Captain aware of all altitude changes, I was able to climb to FL290 and cabin altitude was holding steady.

When the Captain and I, regrouped he asked me to cancel the priority handling which I questioned him about it. My reasoning being that given the situation, why not maintain the priority handling. And that I suspected they would put us back on the filed route and that would cost us more time and fuel. He requested we cancel and he would explain it to me on the ground.

As far as I could follow, he spoke to the passengers and we kept everyone informed.

I told ATC that we wanted to cancel the priority status, that cabin pressurization control was regained. At which point ATC controller stated that managers standing behind him needed to confirm that we desired to cancel the priority status and if we were still on oxygen mask.

I stated that we were no longer on oxygen and cabin pressure was holding. ATC seemed ok and they accepted our cancellation and rerouted us back on filed plan.

The next sector gave us short cuts almost direct ZZZ. And we landed I believe with over 8k of fuel and 25 minutes early.

As far as cancelling the priority handling I can see the Captain's point, specifically "why fly an hour, if the ac is in priority status with so many other landing airport enroute."

That's a point that can be argued on either side. But my SA (Situational Awareness) was good and I believed we had enough fuel to arrive safely in ZZZ even if where placed back on our route filed. Which we did still ahead of schedule and with plenty of fuel.

Captain and I finished all checklist QRH (Quick Reference Handbook) and prep for the STAR (Standard Terminal Arrival Route) and landing.
I landed uneventfully and we arrived to gate.

We debriefed what went well and what we could improved on before leaving the aircraft.
A Status message, "Out Flow Door opened" written and informed to maintenance.

I went to get lunch while Captain spoke to the Chief Pilot. When we regrouped I was told we would continue to ZZZ1.

Synopsis

B757 flight crew reported accidental depressurization in cruise when troubleshooting a pack malfunction.

Time / Day

Date : 202007

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Aircraft : 1

Reference : X

ATC / Advisory.UNICOM : ZZZ

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 : Taxi

Aircraft : 2

Reference : Y

Make Model Name : Small Aircraft

Operating Under FAR Part : Part 91

Flight Phase : Takeoff / Launch

Airspace.Class G : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Instrument

ASRS Report Number.Accession Number : 1754416

Human Factors : Communication Breakdown

Human Factors : Confusion

Human Factors : Situational Awareness

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Conflict : Ground Conflict, Less Severe

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

When Detected : Taxi

Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Environment - Non Weather Related

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Staffing

Primary Problem : Staffing

Narrative: 1

While taking Runway X for departure in ZZZ, we saw a single engine tail wheel GA aircraft climbing on the upwind leg and turning out to the north around midfield after taking off the opposite direction on Runway YY. We were unaware of this departing traffic until seeing them airborne at what I would guess 200 feet AGL. I stopped the aircraft around the runway numbers when I saw the airborne aircraft and we had not initiated our takeoff roll. They were most likely off the ground by the time we taxied onto the runway, but we could not see all the way to the opposite end due to runway slope. The GA aircraft made a CTAF radio call telling us he had self announced his intersection departure off Runway YY. We told them we were unaware they were taking off the opposite direction.

The airport was uncontrolled at this time of day due to reduced Control Tower hours of operation. We were monitoring CTAF frequency while holding short of the runway and simultaneously getting our IFR clearance from Center. I remember hearing a call on CTAF but couldn't clearly understand it. This was further hindered by listening to both radios at the same time. I don't recall hearing any previous CTAF calls such as this other aircraft self announcing their taxi. When the other aircraft called us after taking off, my First Officer mentioned he believed to have heard the aircraft announce departure off Runway XX. The aircraft stated he announced an intersection takeoff for Runway YY. Main contributing factors were an airport that has enough traffic volume to require a Control Tower not having their Tower open, nice VFR weather for GA flying, the GA pilot not being clear about their intentions over CTAF or speaking up when we announced our takeoff intentions for the opposite runway, calm winds allowing for takeoff from either direction, and not pausing as a crew before taking the runway to verify we understood the unclear CTAF call and would be clear of conflicting traffic.

I would assume the Control Tower is running a reduced schedule due to less air traffic than normal given the current coronavirus climate. It would be better if they were open at this time in the morning when Part 121 flights are scheduled. Self announcing on CTAF is everyone's responsibility at an uncontrolled airport. The GA aircraft could've been clearer about their intentions and made more calls. As a crew, we did our part by announcing our intentions, and that should have caught the attention of the opposite direction traffic. The only remaining factor that could've prevented this potential runway incursion would be for us to use good CRM by each focusing our listening attention on individual comm radios during situations requiring monitoring of both, and ensuring to verify that any unclear radio calls are not coming from any potentially conflicting traffic.

Synopsis

Captain reported a GA aircraft departed in opposite direction while they were on the runway ready for takeoff. The Tower was closed at the time of the event.

Time / Day

Date : 202007

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Weather Elements / Visibility : Rain

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : Heavy Transport

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Flight Phase : Takeoff / Launch

Flight Phase : Taxi

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Flying

Function.Flight Crew : First Officer

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Total : 13270

Experience.Flight Crew.Last 90 Days : 16

Experience.Flight Crew.Type : 1396

ASRS Report Number.Accession Number : 1751568

Human Factors : Communication Breakdown

Human Factors : Situational Awareness

Human Factors : Confusion

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : ATC

Events

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Detector.Person : Flight Crew

When Detected : In-flight

Result.General : None Reported / Taken

Assessments

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

Narrative: 1

Operating Flight ABC ZZZ to ZZZ1. Neither the Captain nor FO were very familiar with ZZZ and with steady rain, and as the FO, I was focused on providing taxi instructions to the Captain from the south ramp until cleared to cross XXC. While crossing XXC, the Tower initially cleared us to turn right on Taxiway X to YY. After turning onto X, I commenced the before takeoff checklist which was interrupted by a Tower transmission for us to turn right onto X, which we had already done. This created momentary confusion for the crew but I completed the checklist, briefing YYR full length. Just as I completed the before takeoff checklist, Tower cleared us onto the runway and cleared us for takeoff. A proper runway verification was not done, the expectation was for full length and as the flying pilot I did not have the situational awareness, nor did the entire crew, that the aircraft was at an intersection while accepting a clearance onto the runway for departure. We commenced a normal takeoff with the FO as the flying pilot and at V1 it appeared that we had used up more than the normal amount of runway, at rotate speed I commenced a normal rotation with roughly 2,000 feet of runway remaining. After initial climbout, the crew discussed the fact that the takeoff roll had used up too much runway. Upon further investigation we realized we had taken off from intersection YY/YYR with takeoff numbers for full length on Runway YYR. We had briefed full length YYR during the preflight taxi briefing and had selected full length YYR (wet runway) when requesting takeoff numbers.

The crew as a whole did not perceive the threat that we could be given an intersection takeoff nor did we catch the error that we had numbers for full length while accepting an intersection departure. This error was not repaired and the crew put themselves and the aircraft into an undesirable and improper state. Monitoring/crosschecking along with situational awareness were the major CRM skills that were lacking. As a crew we discussed this at length during the flight and the remainder of the flight proceeded normally.

As a crew we could have aided in averting this situation by using our CRM skills by discussing or realizing that we may be assigned an intersection departure in ZZZ, the flying pilots were both from ZZZ2 where intersection takeoffs are not relevant. The fact that very few of us on this type aircraft are flying normal schedules in the current environment and that we may be operating under abnormal personal stress or out of airports we normally don't operate out of requires that we double our efforts to ensure we employ the very best of our CRM skills to ensure we all have the situational awareness to ensure continued safe operations.

Synopsis

Air carrier First Officer reported they had numbers for a full runway takeoff, but were given and executed an intersection takeoff.

Time / Day

Date : 202007

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Environment

Flight Conditions : IMC

Weather Elements / Visibility : Windshear

Aircraft

Reference : X

ATC / Advisory.Tower : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : Light 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 : Takeoff / Launch

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 : First Officer

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

ASRS Report Number.Accession Number : 1750466

Human Factors : Other / Unknown

Human Factors : Confusion

Human Factors : Situational Awareness

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Multiengine
ASRS Report Number.Accession Number : 1750468
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 / Discrepancy - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : Weather / Turbulence
Detector.Automation : Aircraft Other Automation
Detector.Person : Flight Crew
When Detected.Other
Result.General : None Reported / Taken

Assessments

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

Narrative: 1

Takeoff conditions were IMC and windy. It was my leg to fly. Before takeoff we briefly briefed the possibility of wind shear after takeoff. Once we did the takeoff, we actually encountered a caution wind shear. The reason for this [report] is my insufficient wind shear SOP. I did not move the thrust lever to max nor said the callout. Because I did not move the levers to max thrust the wind shear guidance did not activate. However, because I seemed to have tunnel vision, thought it did activate and ensured positive aircraft control at all times. The Captain also missed the call outs, however I do not blame the Captain for it as she was probably focused on seeing if I would ever push the thrust lever to max and ensure I had positive aircraft control.

The Captain and I had a thorough briefing once we landed about the issues and how we could have done better. We briefed that next time we should ensure we go over the procedure mentally and do some chair flying to better prepare as to avoid the heat of the moment mistakes in not the most comfortable turbulence and situation. Additionally, I learned how my body reacted and will ensure next time I do the SOP properly.

At the moment of wind shear, I knew what I had to do; callout wind shear max thrust and push it to max thrust. However, in the heat of the moment I may have suffered confirmation bias when I heard the ATTCS (Automatic Takeoff Thrust Control System) move thrust automatically to max thrust and made me hesitate. So when I noticed my hesitation I just forgot about SOP and focused on maintaining aircraft control by ensuring airspeed wings level with the rolling tendencies the turbulence was doing.

Narrative: 2

After departure from Runway XXR and into the beginning of our takeoff climb we received a "caution windshear". The aircraft was configured for a no flex takeoff prior to departure and the Captain briefed windshear guidance procedures in the event windshear was

encountered. However, once the caution occurred the windshear escape procedure was not executed properly. The Pilot Flying (First Officer) pitched to 20 degrees and maintained heading, however did not call out or move the throttles to the max thrust position or press the toga button. PF did proceed to call out of windshear and recover. The Pilot Monitoring (Captain) recognized windshear and the aircraft maintaining an increasing Ra position. While verifying the thrust position, the PM became aware thrust lever position hadn't moved up and toga button not pressed. The PF started to turn towards the assigned heading around 1,000 feet and around when the caution cleared. The PM attempted to communicate max thrust but became distracted by the turn, ATC instructions and got tongue tied. The aircraft proceeded with the flight with no other occurrences.

PM and PF discussed the occurrence, identifying what went wrong and how to prevent future errors. The PF explained how he heard the engines spool up thus creating misperception and how he focused on the departure. The PM believes the missed call out created missed triggers and lead to getting behind. We believe better communication and speaking louder is an effective solution to prevent tunnel vision and enhance situational awareness. The weather posed threats and a changing environment that requires risk management and quality CRM. We understand these events happen within seconds and that maintaining vigilance will eliminate errors and mitigate threats. Reviewing procedures and call outs as a crew and individually will help eliminate future errors and maintain safe operations.

Synopsis

Air carrier flight crew reported receiving a windshear warning on takeoff and failing to perform the Wind Shear Maneuver.

Time / Day

Date : 202006

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Relative Position.Angle.Radial : 159

Relative Position.Distance.Nautical Miles : 20

Altitude.MSL.Single Value : 8100

Environment

Flight Conditions : VMC

Weather Elements / Visibility.Visibility : 10

Light : Daylight

Ceiling.Single Value : 999

RVR.Single Value : 9999

Aircraft

Reference : X

ATC / Advisory.TRACON : ZZZ

Aircraft Operator : Military

Make Model Name : Military Trainer

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Flight Plan : IFR

Mission : Training

Flight Phase : Initial Approach

Route In Use.Other

Airspace.Class E : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Military

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Captain

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Flight Instructor

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Air Traffic Control.Military : 10

Experience.Flight Crew.Total : 2278

Experience.Flight Crew.Last 90 Days : 313

Experience.Flight Crew.Type : 1841

ASRS Report Number.Accession Number : 1747275

Human Factors : Workload

Human Factors : Confusion

Human Factors : Situational Awareness
Human Factors : Distraction
Human Factors : Training / Qualification

Events

Anomaly.Deviation - Altitude : Excursion From Assigned Altitude
Anomaly.Deviation / Discrepancy - Procedural : Clearance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : CFTT / CFIT
Detector.Person : Flight Crew
Miss Distance.Vertical : 600
When Detected : In-flight
Result.Flight Crew : Executed Go Around / Missed Approach
Result.Flight Crew : Became Reoriented
Result.Air Traffic Control : Issued Advisory / Alert
Result.Air Traffic Control : Issued New Clearance

Assessments

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

Narrative: 1

Conducting a military training flight. Flew 2 ILS Approaches and executed published missed to hold at a fix at 10,300 feet and set up for a different approach. I initially requested a procedure turn, but then realized our position did not make sense and amended the request for a straight in approach. Aircraft was VMC. Once cleared for approach we left 10,300 feet for crossing altitude of 8,100 feet. Due to task saturation and change of request for approach clearance the pilots did not see the NoPT altitude of 8,700 feet until 16 DME and mistakenly descended to 8,100 feet 6 miles early. Upon notification by Approach of a low altitude alert, aircrew immediately waved off, re-established in holding and copied the phone number and coordinated clearance back to our point of origin. The aircrew verified our publications were up to date and re-established good CRM with the aircraft in a safe position.

Synopsis

A pilot practicing approaches reported executing a go-around after the flight crew descended below a crossing restriction and received a low altitude alert from ATC.

Time / Day

Date : 202006

Local Time Of Day : 1201-1800

Place

Locale Reference.ATC Facility : ZZZ.TRACON

State Reference : US

Altitude.MSL.Single Value : 5150

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft

Reference : X

ATC / Advisory. TRACON : ZZZ

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 B : ZZZ

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 : Check Pilot

Function.Flight Crew : Captain

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Flight Instructor

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Instrument

ASRS Report Number.Accession Number : 1746738

Human Factors : Situational Awareness

Human Factors : Training / Qualification

Human Factors : Distraction

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Multiengine
ASRS Report Number.Accession Number : 1747003
Human Factors : Training / Qualification
Human Factors : Confusion
Human Factors : Communication Breakdown
Human Factors : Situational Awareness
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Deviation - Altitude : Excursion From Assigned Altitude
Anomaly.Deviation - Speed : All Types
Anomaly.Deviation / Discrepancy - Procedural : Clearance
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Returned To Clearance
Result.Air Traffic Control : Issued New Clearance

Assessments

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

Narrative: 1

As a line check airman, I was teaching and providing operating experience to a First Officer (FO) transitioning back to the Aircraft X type, after flying another aircraft type. I was the pilot flying and the trainee FO was in the pilot monitoring role. During our arrival into ZZZ, we received a STAR change from the ZZZZZ arrival to the ZZZZZ1 arrival due to East flow in ZZZ. This clearance was initially given without a runway transition, so we followed company procedure and put in the ZZZZZ1 arrival with XR Transition per the approach notes. At this time, we both mentioned that XR was closed, but decided to follow company procedure with the intention of changing the runway later.

The FMS and Automation systems from the trainee's previous aircraft had an auto-throttle and VNAV system. The Aircraft X type does not have these systems, so the descent needs to be manually managed with the thrust levers and vertical speed. The difficulty was compounded because we were using a single FMS Aircraft X type which is physically located in the 4 o'clock position from the Captain, making it nearly impossible to monitor the flight instruments and FMS simultaneously. I was teaching some techniques to manage the altitude and speed adjustments during the RNAV star. When the PM checked in with approach control, we were assigned Runway Y as anticipated. We tuned in the localizer frequencies and briefed the changes for runway Y, but neglected to reprogram the FMS due to the high workload of managing the STAR restrictions.

During the downwind portion of the STAR, ZZZ Approach assigned us to descend to expedite descent to 5,000 MSL. I aggressively descended the aircraft, and when approaching 5,400 MSL ATC told us to climb and maintain 6,000 MSL. I climbed the aircraft back up using the autopilot, but was confused and distracted by this unusual

change of altitude.

ATC gave us a vector for the base to runway Y. I was verbally instructing the FO how to sequence the FMS for the approach and made a quick visual check to make sure it was done correctly (not realizing the waypoints were still programmed for runway XR). I also coached the FO to change the Navigation mode on the FO's Navigation display for greater situational awareness and in case the FMS is improperly programmed.

ATC gave us an intercept vector over the ZZZZZ2 intersection and cleared us to intercept the Localizer. I intended to initially track inbound on the FMS and switch to the ILS when within 18 NM. I had a mental red flag and thought "That's not right" when I heard ZZZZZ2 but saw ZZZZZ3 Intersection on my MFD. The localizer had already passed for the FO's Nav Display, but due to his lack of recent experience and FMS differences from the previous aircraft, he did not mention this to me. I realized we were overshooting and shutoff the autopilot, while turning back toward the south to re-intercept the Runway Y course. As I was doing this, ATC noticed our error and gave us a vector to re-intercept.

As I was intercepting and re-stabilizing the aircraft, I let the aircraft drift up and down about 150 feet. I was also initially slow to get the aircraft slowed to an ATC assigned 160 kts because they were querying us about what happened. I reengaged the autopilot, aggressively slowed the aircraft and we were re-established for a stabilized approach. We were very lucky that XR was closed this day, otherwise a serious traffic issue could have occurred.

Cause: Poorly positioned Single FMS on Aircraft X type, Loading Arrival and Runway Changes using RNAV STARs, ATC altitude change distraction, low and non-recent experience of FO in training environment, overall decreased currency and proficiency of all pilots due to COVID-19 effects on industry, high workload during RNAV STAR.

Neglected to reprogram FMS and verify waypoints for correct runway after ATC assignment, Untimely Teaching, FO not speaking up about localizer movement.

I will guard against untimely teaching and focus more on my primary responsibility of flying and monitoring the aircraft, especially close to the terminal area. When training pilots coming from another aircraft, I will start from an assumption that their situational awareness is nil and that they might not have the recency with procedures, Flight Guidance, and FMS to back me up. I will be extra careful to listen and put runway changes into my FMS soon after they are assigned by ATC.

Narrative: 2

Left seat pilot (PF) Right seat pilot (PM). There was a lack of communication between the check airman and trainee due to the check airman focusing primarily on training instead of flying the airplane. During the departure briefing, as a right seat pilot, I asked to load Runway Y instead of Runway XR although STARS was saying Runway XR. This was because Runway XR was closed according to ATIS. But the left seat pilot replied that we should load the FMS with the runway on STARS and he would correct it when we received our runway assignment. While cruising, left seat (PF) and right seat (PM) executed positive exchange of controls for the arrival briefing. Suddenly things changed by ATC; such as arrival and runway while trying to stay away from weather.

Meanwhile, left seat pilot asked for weather related deviation 15 degree to the right. I asked to make sure right or left because there were storm cells to the right. Left seat pilot affirmed and asked again to the right. I requested from ATC 15 degree to the right due to

weather. ATC was astounded and repeated the question "Are you asking for left or right?" I said right, ATC replied standby and 10 seconds after approved weather deviation to the left because of the weather to the right. We then established left deviation from current heading to avoid weather. After left seat pilot finished the arrival briefing, we executed a positive exchange of controls and right seat resumed PM duties. When the left seat then resumed PF duties, the high speed warning occurred 3 times. Both side frequencies and courses were set for Runway Y, but the FMS was still on Runway XR. ATC instructed us to descend and maintain 5,000 feet from 6,000 feet. While we were around 5,300 feet, ATC instructed us to climb and maintain 6,000 feet. PF did not change the altitude. I said again, ATC assigned 6,000 feet. He bugged 6,000 feet and verified but he did not start climbing. I reminded him again that we should climb to 6,000 feet and he finally started climbing. I then verified once more with ATC to ensure assigned 6,000 feet was correct. We got vectors to Runway Y ILS and as a PM, I switched to green needles to make sure all was OK.

While left seat was on FMS, I figured out we were going to deviate from Runway Y course and I pushed the TCS and started turning to the right. Simultaneously, left seat pilot kicked the auto pilot off and back to Runway Y course. ATC advised us of a 20 degree deviation while we were around 210 KIAS and asked to reduce speed to 170. I offered gear down, but left seat pilot did not respond. I offered gear down again and ATC then asked to reduce speed to 160 KIAS immediately. Finally, PF asked for gear down and flaps 22. I was almost going to ask to go around, but we corrected and were able to configure the airplane. We made it stable and landed without much hassle.

Cause: Lack of crew communication. Mutual errors. Lack of verification when FMS was set up due to changing STARS and runway and fast paced environment. Meanwhile, left seat pilot was talking about topics related to training purposes. As a result, the aircraft automation established us for Runway XR instead of Runway Y.

Always take your time. If behind the airplane, ask for help from ATC. If you cannot descend or climb immediately due to lack of crew communication, advise ATC unable. Make sure both pilots are on the same page regardless of their level of experience, seat or check airman status. We are human beings and we may make mistakes, therefore CRM plays a crucial role in the safety of flight instead of being single pilot. It is a gray area and a question between left seat and right seat pilots of what action would be better if STARS is saying a specific runway and that runway is closed. I learned from this event that the crew should be strict about the sterile cockpit rule regardless of it being a training event. Therefore, both crew members can then focus on flying the airplane in order to prevent staying behind the airplane. Finally, the most important thing I have learned from this event is regardless of the other pilot's position/status, do not assume they will do everything correct.

Synopsis

Air carrier flight crew reported experiencing an unstabilized approach and setting up to land on a closed runway with anticipation of changing to landing runway later.

Time / Day

Date : 202005

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Parked

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : General Seating Area

Cabin Activity : Boarding

Reporter Organization : Air Carrier

Function.Flight Attendant : Flight Attendant (On Duty)

Qualification.Flight Attendant : Current

ASRS Report Number.Accession Number : 1744573

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Attendant

Communication Breakdown.Party2 : Flight Attendant

Events

Anomaly.Deviation / Discrepancy - Procedural : FAR

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Detector.Person : Flight Attendant

When Detected : Pre-flight

Assessments

Contributing Factors / Situations : Company Policy

Contributing Factors / Situations : Environment - Non Weather Related

Contributing Factors / Situations : Human Factors

Primary Problem : Human Factors

Narrative: 1

Upon boarding my flight I was approached by a Flight Attendant refusing to wear a mask. I inquired why and was informed COVID is fake and masks violate constitutional rights. I was afraid of confrontation to push back further, so I just asked Flight Attendant to stay

away from me. It created an uncomfortable work situation where I had to decide between feeling safe, and wanting to maintain peace. For the rest of the trip not only was my health put at risk, but others were as well. From other cabin to each and every passenger on board, our health was more at risk then it needs to be due to non-compliance of a requirement.

To avoid a lack of CRM and a situation where FAs might become hostile towards each other, as well as for everyone's health and safety, masks must be mandated unless strictly for medical reasons.

Synopsis

Flight Attendant reported that another Flight Attendant refused to wear a mask during boarding and throughout the flight. Reporter expressed concern that the health of passengers and other cabin crew were put at risk.

Time / Day

Date : 202005

Local Time Of Day : 1801-2400

Place

Locale Reference.ATC Facility : ZZZ.TRACON

State Reference : US

Altitude.MSL.Single Value : 5000

Environment

Flight Conditions : VMC

Light : Night

Aircraft

Reference : X

ATC / Advisory.ATC Facility : ZZZ

Make Model Name : Any Unknown or Unlisted Aircraft Manufacturer

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Flight Plan : IFR

Flight Phase : Initial Climb

Route In Use.SID : ZZZ

Airspace.Class E : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Function.Flight Crew : Pilot Not Flying

Function.Flight Crew : First Officer

Qualification.Flight Crew : Air Transport Pilot (ATP)

Experience.Flight Crew.Total : 11300

Experience.Flight Crew.Last 90 Days : 5

Experience.Flight Crew.Type : 50

ASRS Report Number.Accession Number : 1743749

Human Factors : Training / Qualification

Events

Anomaly.Deviation - Altitude : Excursion From Assigned Altitude

Anomaly.Deviation / Discrepancy - Procedural : Clearance

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 : Human Factors

Primary Problem : Human Factors

Narrative: 1

Altitude deviation due to poor CRM while PIC was flying with auto pilot off. Contributing factor low recent flying due to COVID slow down. Deviation immediately reported to ATC and corrected.

Synopsis

Corporate pilot reported having an altitude deviation while hand-flying the aircraft and attributed it to lack of flying due to the COVID-19 slow down.

Time / Day

Date : 202005

Local Time Of Day : 0601-1200

Place

Locale Reference.ATC Facility : ZAN.ARTCC

State Reference : AK

Altitude.MSL.Single Value : 11000

Aircraft

Reference : X

ATC / Advisory.TRACON : A11

Aircraft Operator : Air Carrier

Make Model Name : B747-400

Crew Size.Number Of Crew : 3

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Cargo / Freight / Delivery

Nav In Use : FMS Or FMC

Flight Phase : Descent

Route In Use.STAR : NEEL6

Airspace.Class E : ZAN

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 : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

ASRS Report Number.Accession Number : 1743683

Human Factors : Time Pressure

Human Factors : Confusion

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 : First Officer

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Instrument

ASRS Report Number.Accession Number : 1743684

Human Factors : Confusion

Human Factors : Time Pressure

Person : 3

Reference : 3
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)
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Instrument
ASRS Report Number.Accession Number : 1743685
Human Factors : Confusion
Human Factors : Time Pressure

Events

Anomaly.ATC Issue : All Types
Anomaly.Deviation - Speed : All Types
Anomaly.Deviation / Discrepancy - Procedural : Clearance
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Requested ATC Assistance / Clarification
Result.Air Traffic Control : Issued New Clearance

Assessments

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

Narrative: 1

While descending on NEELL 6 RNAV Arrival into ILS 07R at ANC with Auto Pilot engaged, ATC asked us to maintain 310 kts. or greater transition airspeed for spacing. When aircraft just passing below 11,000 ft. it began to slow to 240 kts. Then, ATC asked us to keep up the speed. Then I asked ATC more than 3 times to confirm to descend below 10,000 ft. with more than 250 kts. high speed. 310 kts. ATC's response was "Affirmative!" Shortly afterward, ATC told us to maintain 280 kts. or greater until further advised.

Narrative: 2

While in cruise just before we started our descent, ATC instructed us to increase speed for separation into ANC. During the descent approaching 10,500 ft. ATC instructed us to maintain 280 kts. or better as long as practical. I don't remember the exact wording of the ATC clearance at this point, but it was obvious that ATC wanted a high speed descent because we were #1 for ANC. As we approached 10,000 ft. I realized that we were not slowing to 250 kts. I looked over to the 3rd middle observer and mentioned that our speed was too high.

The issue was not brought to the operating crew's attention. As we continued our high speed descent through 9,960 ft., I raised my voice to bring the speed to the crews attention. At this point the two operating crew-members recognized that I was advising them to slow down but claimed that ATC had given them high speed below 10,000 ft. I replied "ATC can't instruct you to do that". We continued a high speed descent. I did not press the issue because there were no immediate safety concerns. From the 4th observer

seat, I was at a disadvantage because I had no direct link to the intercoms and raising my voice could have caused a CRM issue that was worse than the initial issue. We eventually slowed to 250 kts. at 4,500 ft. Afterwards, the flight continued normally.

After we blocked in, we talked about the issue but the entire crew maintained the position that ATC had instructed them to exceed 250 kts., therefore it was allowed. The decision for a high speed decent seemed to be from a confusion between the regulations vs. the ATC clearance. Additional confusion seemed to arise from the regulations in foreign countries, and which countries allow us to exceed the limitation.

Narrative: 3

[Report narrative contained no additional information.]

Synopsis

B747 flight crew reported that ATC instructed them to maintain greater than 250 kts. airspeed below 10,000 ft.

Time / Day

Date : 202005

Local Time Of Day : 0001-0600

Place

Locale Reference.ATC Facility : ZZZ.Tower

State Reference : US

Altitude.AGL.Single Value : 1500

Environment

Flight Conditions : VMC

Aircraft

Reference : X

ATC / Advisory.Tower : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Flight Phase : Final Approach

Airspace.Class B : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

ASRS Report Number.Accession Number : 1742866

Human Factors : Situational Awareness

Human Factors : Distraction

Human Factors : Workload

Human Factors : Communication Breakdown

Human Factors : Confusion

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Anomaly.Inflight Event / Encounter : Unstabilized Approach

Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Regained Aircraft Control

Assessments

Contributing Factors / Situations : Environment - Non Weather Related

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Procedure

Primary Problem : Human Factors

Narrative: 1

Flying into ZZZ at 2,500 feet with VFR conditions ATC was vectoring us for the approach to XXL. It was XA:00pm and we were the only airplane in the sector due to the COVID flight reductions. We were on a downwind when we were asked if we had the airport in sight for a visual approach. I said that I did and the FO was comfortable with my decision. This is where all the mistakes started.

I failed to communicate my plan on how to fly this approach. I disconnected the autopilot. I proceeded to the FAF ZZZZZ and told the FO to select 1,500 feet the altitude for ZZZZZ and started to descend in FLCH. Since I haven't flown much since the flight reductions I'm embarrassed to admit my flying skills were very poor. I descended to 1,300 feet at ZZZZZ as I made the sharp turn to intercept. The FO was giving me good guidance but the long day, lack of currency and tunnel vision for the runway made me just not hear his excellent CRM prompting. Again, I'm embarrassed to say from ZZZZZ to below 1,000 feet I got below the glideslope twice. At 500 feet we were stable and landed.

I should have gone around, but like the many pilots before me that have written scenarios of unstable approaches, I didn't. Why not? Because it was VFR, because it was an easy approach, because I could do this. All the reasons that lead to unstable approaches. In all my years of flying, this is the worst decision and execution of my career. I am truly embarrassed to admit this. I am now one of those "How In the World Did They Do That" pilots. I only can hope you don't use this as your new teaching scenario.

So many lessons learned from this one. Visual approaches are one of the most difficult to perform. We don't do them on a regular basis. Fly it as a full ILS. Give yourself enough room outside the FAF to get set up. Don't rush it. Use the autopilot to get set up. Don't hand fly. Especially when it is late and you may be tired. Communicate all your intentions clearly to your flying partner. VVM. Hear and listen to your partner. They are 2 different things. Don't have a big ego and Go-Around. It's not a failure. I know all of these lessons, but failed to execute them. I'm sure the stress of current world events, our company's financial situation, the lack of flying and a lot of other outside influences are contributing factors to this but certainly no excuse.

Synopsis

Air carrier Captain reported experiencing an unstabilized approach in which they should have executed a go-around but decided to continue and stabilized at 500 feet. Captain reported rustiness from lack of flying contributed to the event.

Time / Day

Date : 202005

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Aircraft

Reference : X

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Parked

Component : 1

Aircraft Component : Aircraft Logbook(s)

Aircraft Reference : X

Problem : Improperly Operated

Component : 2

Aircraft Component : Minimum Equipment List (MEL)

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 : 1742825

Human Factors : Distraction

Events

Anomaly.Aircraft Equipment Problem : Less Severe

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Anomaly.Deviation / Discrepancy - Procedural : MEL / CDL

Detector.Person : Flight Crew

When Detected : Pre-flight

Result.General : None Reported / Taken

Assessments

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

Narrative: 1

We operated two flights with an incorrect MEL applied. Flights A and B were operated under the incorrect MEL. MEL XX-X-XX was applied to Aircraft. The correct MEL should have been XX-X-XY. Due to flight deck wipe down I did not review logbook and MEL closely enough nor did I make sure I communicated completely with FO for confirmation.

I need to remember to utilize CRM when it comes to MEL compliance.

Synopsis

Air carrier Captain reported operating flights with an incorrect MEL applied. The flight deck sanitizing process was cited as a reason for not closely reviewing the logbook and MEL.

Time / Day

Date : 202004

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ITO.Airport

State Reference : HI

Relative Position.Distance.Nautical Miles : 12

Altitude.MSL.Single Value : 2200

Environment

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Tower : ITO

Aircraft Operator : Air Carrier

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

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Initial Approach

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Pilot Not Flying

Function.Flight Crew : Captain

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Multiengine

Experience.Flight Crew.Last 90 Days : 150

ASRS Report Number.Accession Number : 1740453

Human Factors : Situational Awareness

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Flying

Experience.Flight Crew.Last 90 Days : 150

Experience.Flight Crew.Type : 2500

ASRS Report Number.Accession Number : 1740457

Human Factors : Situational Awareness

Events

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Anomaly.Deviation / Discrepancy - Procedural : Clearance
Anomaly.Inflight Event / Encounter : CFTT / CFIT
Detector.Automation : Aircraft Terrain Warning
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Took Evasive Action
Result.Flight Crew : Became Reoriented

Assessments

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

Narrative: 1

I have flown the visual to Runway 8 at ITO a few times. Was aware from experience and briefing materials that it is difficult to be wings level at 1000 ft. It was the FOs (First Officer) first time flying the arrival. I stressed this point on the briefing, which I believe to have helped set up the FO to over think the approach. We were initially high as ATC switched from Runway 26 to 8. The FO got back on profile aggressively and in fact got below the profile, but seemed to be in the mindset that he was still behind. We were leveled off at 2200 ft., our last cleared altitude by ATC. It was a good altitude provided we stayed along the coast. He [was] established on a heading which created a base leg that would allow for us to be wings level at 1000 ft., but also transitioned 2 NM inland.

I noticed this, but elected not to say anything as 1) My technique is not the only one. 2) When I saw that we were below profile and still 12 NM from the field, I challenged him when he asked for gear down. Recognizing that this second point is a sure way for CRM to break down. To complicate matters there was turbulence (the Release had an unusual note "low level turb on leeward side of terrain...use caution") and while we were below the scattered layer over the terrain a few stray clouds did impede our heading.

The terrain from the coast while appearing gentle rises rapidly. I became uncomfortable moments prior to the GPWS warning as the RADIO ALT populated reinforcing that we were too low. The aircraft rolled right (I thought due to turbulence, but upon discussion it was to stay clear of clouds) followed by a GPWS caution which was immediately cut short and a warning ensued. He delayed the escape maneuver rolled away from the terrain. As I called for the escape maneuver the GPWS conflict was resolved.

Narrative: 2

While on approach to Runway 8 at ITO we had the airfield visual and were subsequently cleared for the visual approach from the southwest. I made a right turn and continued descent to 2100 ft. MSL in order to get below the scattered deck of clouds approximately 4000 ft. MSL. The turn to the east was in order to create a bit more of a base turn in order to create a longer final, however, in doing so I was also flying towards the rising terrain.

Upon maneuvering to this base heading, I made a 30-degree banked turn to the southeast to further avoid a cloud. Upon doing so, turned more directly towards the rising terrain. Upon doing so the GPWS activated and alerted us about the terrain, after which I should have performed the terrain escape maneuver but I elected not to do that because we would have very quickly climbed into IMC conditions. So I just reversed the turn direction

immediately and the GPWS warning silenced. My base leg, which was approximately 1300 ft. radio altitude, continued the rest of the way to land uneventfully on Runway 8 at ITO.

Even though we had talked about the terrain being a factor and all of the GPWS alerts crews had been getting on their way into ITO, we could have planned better and planned for an even shorter base and final in order to make the terrain even less of an issue. If any deviations were needed to be made in order to stay visual, they should have been made away from the terrain not towards it.

Synopsis

Air Carrier flight crew reported receiving a GPWS terrain alert on a visual approach to ITO.

Time / Day

Date : 202004

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Ramp : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : EMB ERJ 145 ER/LR

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Parked

Airspace.Class C : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Instrument

ASRS Report Number.Accession Number : 1739626

Human Factors : Situational Awareness

Human Factors : Confusion

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Communication Breakdown.Party2 : Flight Attendant

Events

Anomaly.Flight Deck / Cabin / Aircraft Event : Illness / Injury

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy

Anomaly.Ground Event / Encounter : Loss Of Aircraft Control

Detector.Person : Flight Crew

When Detected : Taxi

Result.General : Physical Injury / Incapacitation
Result.Flight Crew : Regained Aircraft Control
Result.Flight Crew : Became Reoriented

Assessments

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

Narrative: 1

We were operating a morning first flight of day. The aircraft was put on a hardstand with no tug where with guidance from the ramp crew we would be able to start both engines and be directed to the movement area of the ramp. After completing the Engine Start Check, I looked over to the Ramper and with their permission, I released the parking brake. I however, did not reengage the parking brake. I then directed the First Officer to start both engines. The number 2 engine was started first. Following the start of the number 1 engine, the First Officer stepped on the brakes and simultaneously engaged the parking brake. This caused the airplane to stop abruptly.

I asked the First Officer why he did what he did, and he said that we were moving. I then said that it was my mistake for not having the parking brake engaged, but we were moving slowly and we were far from any equipment and people. I then asked the First Officer two questions Why did he not say to me that the aircraft was moving and I would have applied the brakes and why did he apply both the brakes and the parking brake at the same time ? He said that he was not sure the brakes alone would have stopped the airplane. We then proceeded with the rest of the normal checklists and taxied to the runway and departed. In flight, the Flight Attendant said she was injured from the whiplash and was bruised. She said she may see a doctor upon reaching our destination. At the end of the flight I exchanged my contact information with the Flight Attendant to keep me informed of her physical condition.

The whole sequence of events started with me not engaging the parking brake after releasing it for the out time. The threat of not recognizing that we do not have rammers to tell us to reset the brake after push was not addressed during our threat discussion and mitigation. My error was not seeing the airplane moving after the number one engine started and stopping the airplane before the First Officer. The undesired state was the fact that the aircraft moved when it should not have causing potential harm to the ramp crew and outside equipment. The other error I would say was CRM. The First Officer acted in the interest of safety and was the first to recognize the movement of the aircraft. He however over reacted. Based on the fact the airplane was moving slowly and we were far from rammers and equipment, I think he should have told me that we were moving and I would have stopped the airplane. If I did not react he then should have stepped on the brakes. This was the error on CRM our part. After talking to him I found out that he just finished IOE recently and this was his first trip after completing IOE. I think lack of experience in actual line operations caused him to act the way he did. I also should have checked with the Flight Attendant to see how she was doing after the airplane came to a stop.

What I learned was to be extra vigilant when you are taxiing out with no towbar from the gate. If we were close to people or equipment, this could have been bad. Addressing ramp operations with no tug driver telling you to "set the brake" is a threat that we should have

discussed and talked about. I also need to be more aware of aircraft (unintentional) movement in all situations and react appropriately.

Synopsis

ERJ145 Captain reported the parked aircraft began rolling on the ramp and the First Officer put the brakes on and the parking brake causing an abrupt stop injuring a Flight Attendant.

Time / Day

Date : 202003

Local Time Of Day : 0601-1200

Place

Locale Reference.ATC Facility : ZZZ.TRACON

State Reference : US

Altitude.MSL.Single Value : 13300

Environment

Flight Conditions : VMC

Aircraft

Reference : X

ATC / Advisory.Center : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Flight Plan : IFR

Flight Phase : Climb

Airspace.Class A : ZZZ

Component

Aircraft Reference : X

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 : 583.63

Experience.Flight Crew.Last 90 Days : 113.03

Experience.Flight Crew.Type : 583.63

ASRS Report Number.Accession Number : 1737621

Human Factors : Situational Awareness

Human Factors : Distraction

Human Factors : Confusion

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer
Function.Flight Crew : Pilot Not Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Multiengine
ASRS Report Number.Accession Number : 1737638
Human Factors : Confusion
Human Factors : Situational Awareness
Human Factors : Distraction

Events

Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Overcame Equipment Problem

Assessments

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

Narrative: 1

On climbout from ZZZ, at approximately 13,300 feet the Cabin Altitude Warning horn sounded and the Cabin Warning light illuminated. As the PF, I immediately disengaged the autothrottles, began to level off and informed the FO that "I had the radios." I then called ATC and told them I needed to level off and requested a slight descent back to 13,000 feet and that "I would get back with them." The descent to 13,000 was granted and I had the FO set 13,000 feet in the MCP (it had been set to 30,000 feet as this was our last clearance). FO immediately identified the issue that the packs were both in the OFF position. He turned them on. ATC asked if we needed assistance and I said no. We flew at 13,000 feet for approximately 2 or 3 minutes while the packs pressurized the cabin and the cabin began to descend. FO had previously silenced the warning horn. When the cabin descended below 10,000 feet the Cabin Warning light extinguished. I asked FO to call back to the cabin and ask if any O2 masks had deployed. None had. When the cabin was descended, I communicated with ATC that we were ready to accept a climb. ATC asked if I could tell them what the issue had been. I replied (paraphrasing) that, "We had a configuration issue with the cabin pressurization, and that we had fixed it and were good to go."

For this issue to occur there were basically four [causes] - 1. On my (CA) preflight, I failed to notice that the packs were off. 2. On taxi out during the Before Takeoff Checklist, I always look over and verify the pressurization switches. I did this here as well, but again, failed to notice the packs were off. 3. FO failed to notice the packs in the off position and position them correctly on the Before Takeoff Checklist. 4. PM (FO) failed to notice the packs were in the off position on the After Takeoff Checklist.

After we had corrected everything and were climbing out again, we discussed what happened briefly (we needed to compartmentalize as this was a short flight to ZZZ1 and we had "bigger fish to fry" than to get caught up about what happened). However, the FO mentioned something like "I must have looked up there like 5 times".

This was a case on both our parts of LOOKING but not SEEING. And THAT is a classic tell-

tale sign of fatigue. Yes, it was a short taxi to Runway XL in ZZZ but I felt (and FO agreed after) that we were not too rushed and were ready to go. The fatigue was a factor of: a) a longish day coming out of ZZZZ and then having to run through customs hall (came into Gate X), get on bus over to Terminal X, both get "random" going through KCM, [Known Crew Member] and then finally getting to our Gate (X, I think). We actually got to our gate with plenty of time, but all that I guessed contributed a bit to feeling "stressed." B) It is hard to say what impact all of the ongoing Coronavirus "stresses"; are doing. We did a great job all trip of compartmentalizing these issues (my FO is not even off probation, so definitely feeling stressed). There was no direct stress from all this COVID-19 stuff, but I believe there is a "cumulative" day-after-day buildup of stress (almost like water torture...drip, drip, drip). How much of it adds up and causes one to feel anxious or stressed is hard to say but I believe it does contribute to a feeling of feeling a little tired and exhausted no matter how much sleep we got the previous night.

On the upside, we both know that that will never happen to us again but it is disappointing how many "misses" there were that led to this. We also handled it well when it happened. I immediately arrested our climb and ensured there wasn't going to be a "rubber jungle." My FO dealt with the packs issue and kept his composure. We exercised good CRM and a division of duties and then both quickly got back to the flight which was short where many things are happening quickly.

Narrative: 2

On the second day of our pairing, during the second leg from ZZZ to ZZZ1, both the CA and FO completed normal preflight duties, to include all checklists from Pre-flight through Before Takeoff per SOP. We received a short taxi between the gate and runway, although we completed all checklists as normal prior to accepting takeoff clearance. CA was Pilot Flying, I was Pilot Monitoring. The Control Tower asked if we needed more time prior to takeoff due to a short taxi, but as we completed all checklists, we both agreed that we were ready for departure. Takeoff and initial climb out was uneventful. The PF was hand-flying, and called for configuration clean-up and After Takeoff checklists per SOP. As PM, I completed each per SOP. After checking into Departure ATC, and receiving climb clearance to Flight level 300, the Cabin Altitude warning light illuminated along with the aural horn at approximately 13,300 feet. The PF immediately verbalized and executed a level-off, said "I have the radios", as I scanned the pressurization panel to diagnose the malfunction. The PF immediately notified ATC that we were leveling-off, requested to descend and temporarily maintain 13,000 feet, and engaged Autopilot A while verbalizing it. ATC approved that request. Simultaneously, I recognized that both Engine Bleed Air Valve switches were in the "off" position. I verbalized that both were off, and immediately switched both Engine Bleed Air Valves to "on". I also verified that both Pack Switches were currently in the "on" position, with the Shut-off Valve in the "Auto" position. (Only the Bleed Air Valve Switches were in the wrong position for the phase of flight.) I then silenced the Cabin Altitude Warning Horn. The PF asked, "What is the cabin altitude and was the cabin pressurizing?"...I responded that the cabin indicated approx. 10,500 feet ...and after approximately one minute, that the cabin altitude gauge displayed a descent of approx. 1,000 FT/min. Once the cabin was below 10,000 feet PA, the Cabin Altitude Warning light extinguished, and the cabin continued to pressurize to the appropriate altitude. I reported all of this to the PF.

After confirming with the PF that our Bleed/Pack configuration was correct, the PF notified ATC that our configuration issue was fixed, and that we could continue our climb. The PF directed me to confirm with our FAs that the cabin oxygen masks did not deploy. I then used the Cabin call button and spoke to the FM, confirming that no masks deployed and the cabin was properly configured. I notified the PF that the cabin was "Ok, with no

masks." The Cabin Crew was unaware of the event. (Due to the short 1 hour flight, the CA debriefed the Cabin Crew of the event after we landed and de-planed). The CA and myself did a quick de-brief upon reaching cruise. Although we had completed all checklists per SOP, neither of us noticed that both Bleed Valve switches were off. As neither of us believed we moved the Bleed Air switches, we determined that they must have been in the "off" position since before we entered the aircraft, quite possibly from the prior crew completing a Termination Checklist. Although I read all the checklists, I missed that these switches were in the "off" position. The entire event occurred in only 2-3 minutes, from Cabin Altitude Warning to proper configuration and cabin pressurization. As a crew, we were in the 9th hour of our crew day, it was late in the evening, and we both felt that fatigue could have been a cause of our missing of the switch positions. Additionally, during routine operations, the Bleed Air switches are normally left in the "on" position, as the aircraft are normally turning into another pairing. I have not personally experienced many flights where I had to turn on the Engine Bleed Valves. A long crew day, and my greater focus on the pack switch positions during pre-flight, resulted, surprisingly, in my missing the position of the Bleeds.

Synopsis

Air carrier flight crew reported having an aircraft pressurization problem thinking it was an equipment problem but the Packs were not turned on.

Time / Day

Date : 202003

Place

Altitude.AGL.Single Value : 0

Environment

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Tower : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Parked

Cabin Lighting : High

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : General Seating Area

Cabin Activity : Deplaning

Reporter Organization : Air Carrier

Function.Flight Attendant : Flight Attendant (On Duty)

Function.Flight Attendant : Flight Attendant In Charge

Qualification.Flight Attendant : Current

ASRS Report Number.Accession Number : 1736305

Human Factors : Distraction

Human Factors : Other / Unknown

Human Factors : Situational Awareness

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Attendant

Communication Breakdown.Party2 : Flight Attendant

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : General Seating Area

Cabin Activity : Deplaning

Reporter Organization : Air Carrier

Function.Flight Attendant : Flight Attendant (On Duty)

Qualification.Flight Attendant : Current

ASRS Report Number.Accession Number : 1736314

Human Factors : Situational Awareness

Human Factors : Other / Unknown

Human Factors : Communication Breakdown
Human Factors : Distraction
Communication Breakdown.Party1 : Flight Attendant
Communication Breakdown.Party2 : Flight Attendant

Person : 3

Reference : 3
Location Of Person.Aircraft : X
Location In Aircraft : General Seating Area
Cabin Activity : Deplaning
Reporter Organization : Air Carrier
Function.Flight Attendant : Flight Attendant (On Duty)
Qualification.Flight Attendant : Current
ASRS Report Number.Accession Number : 1736320
Human Factors : Situational Awareness
Human Factors : Other / Unknown
Human Factors : Communication Breakdown
Human Factors : Distraction
Communication Breakdown.Party1 : Flight Attendant
Communication Breakdown.Party2 : Flight Attendant

Events

Anomaly.Flight Deck / Cabin / Aircraft Event : Illness / Injury
Anomaly.Deviation / Discrepancy - Procedural : FAR
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Flight Attendant
When Detected : Aircraft In Service At Gate
Result.General : None Reported / Taken

Assessments

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

Narrative: 1

After we arrived in ZZZ, we left XX passengers on the plane before the next crew was at the aircraft. We left for our next flight. We had a medical incident onboard during the flight. While our CRM was effective, there were many decisions to be made. While our country is currently in a national emergency, any serious medical event leads to uncertainty. All three flight attendants were in constant communication with the Captain. At first we were told no passengers could leave the aircraft when we landed. We had passengers who were aware of the situation and wanted to be involved. Of course our first priority was the safety of our passengers and crew, we also were aware of the effect any decision would have on the company. After discussion with Station Ops and Dispatch, the Captain was instructed to not hold the passengers, and that the aircraft would be cleaned upon arrival. We also spent the entire flight containing the incident so all passengers felt at ease about their safety. I felt we were successful. However, in this coronavirus environment, it was very stressful and we had to remain calm and in control. We were dealing with many different situations and important decisions during the flight.

Narrative: 2

After the deplaning of Flight XYZ from ZZZ to ZZZ1, the one of the crew members failed to stay with the XX through passengers. During this flight, we encountered many distractions including a passenger that vomited in the forward lav and we alerted the Captain due to the national concern over the scare of the coronavirus. The crew maintained excellent CRM skills when communicating with the flight deck. The flight deck notified medical service and Dispatch. I was also comforting a woman who was flying to see her gravely ill mother.

Narrative: 3

During the deplaning process on Aircraft X, the crew failed to stay with the aircraft with XX thru passengers on board. We had an incident on board where a passenger had vomited in the forward lav. We alerted the Captain because of the concern about the national emergency over the concerns of the spread of Coronavirus. He asked if we knew who it was that was sick, I was [not] sure. He said we may have to keep everyone on board until we know who it was. I informed the Captain that I didn't know who it was and as a precaution we took the forward lav out of service. We were very concerned about the Coronavirus and the possibility of contamination. The Captain called Station Ops and Dispatch to ask what action we should take. They advised us to have Ground Operations meet the aircraft to clean it. We also had an upset passenger on board who had just lost her mother.

Synopsis

Flight Attendants reported concerns about a sick passenger in their flight.

Time / Day

Date : 202003

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 : Parked
Route In Use : Direct

Person

Reference : 1
Location Of Person.Aircraft : X
Reporter Organization : Air Carrier
Function.Flight Attendant : Flight Attendant In Charge
Function.Flight Attendant : Flight Attendant (On Duty)
ASRS Report Number.Accession Number : 1733955
Human Factors : Time Pressure
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Flight Attendant
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Deviation / Discrepancy - Procedural : Published Material / Policy
Detector.Person : Flight Attendant
When Detected : Aircraft In Service At Gate
Result.General : None Reported / Taken

Assessments

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

Narrative: 1

During aircraft cleaning, the aft galley was being catered. They catered the front next. Upon completing catering, and when the R1 door was closed, I noticed that the warning strap was across the window. I immediately called it out and said "why is that strap across the window"? The door was obviously disarmed as there was no slide deployment. D Flight Attendant was with me. The CSA (Customer Service Associate), who was waiting at the R1 door, then said "you gave the caters a thumbs up when they knocked and the strapped was attached" which I do not recall doing. D Flight Attendant didn't see the warning strap in the armed position when she boarded the plane either. I immediately moved the warning strap to the disarmed position and noticed that the velcro strap on the extension piece was worn out to the point where the extension would not stay attached. It constantly

fell down and hung.

I told the First Officer as she was leaving the flight deck that we had an issue with the R1 warning strap. She indicated that they were about to time out and discounted my comment. I made her look at the strap. She came to the door and said "no, it works, see". I showed her that 4/5 attempts to place the strap on the Velcro didn't work, it would fall down. She said "well you gotta talk to the Captain about it" and then entered the bathroom. I then proceeded to talk to the Captain. He stopped me before I even started and said "if you tell me anything I am obligated to put it in the book, so is this really important?" I said yes, I have an issue with the warning strap. He also indicated that they had a timing issue and couldn't take any delays. I told them that I needed Maintenance.

Maintenance came and fixed the strap. I don't know what happened with the strap being across the window in the armed position. I can only speculate that catering attached it while it was hanging down. If it was in place, they shouldn't have opened the door, the CSA should have also said something as she was waiting by L1, apparently watching, and the entire inbound crew should have checked upon deplaning. I find it odd that all of these checks would have been missed. Furthermore, I didn't appreciate being put in a position where I had to make the call if we were going to take a potential delay and possibly cancel the flight due to a timing out issue. My only job is to bring cabin discrepancies to the captain's attention. This was a poor example of CRM. This morning, I had a conversation with the Captain regarding the events yesterday and reiterated what I have written in this [report], about poor CRM and putting me in an uncomfortable situation. He agreed and said they handled the situation poorly. As we are flying together today on an ETOPS flight to ZZZ, I didn't want to there be any communication issue before we left. Our conversation was pleasant and we cleared the air.

Synopsis

Flight attendant reported a CRM issue developed with the flight deck crew after reporting there was a minor maintenance issue with an aircraft door.

Time / Day

Date : 202002

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.MSL.Single Value : 3000

Environment

Flight Conditions : IMC

Weather Elements / Visibility.Visibility : 9

Light : Night

Ceiling.Single Value : 1700

Aircraft

Reference : X

ATC / Advisory.TRACON : 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

Nav In Use : FMS Or FMC

Flight Phase : Final Approach

Airspace.Class B : ZZZ

Component : 1

Aircraft Component : Navigational Equipment and Processing

Aircraft Reference : X

Problem : Malfunctioning

Component : 2

Aircraft Component : Hydraulic Auxiliary System Ram Air Turbine (RAT)

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)

Experience.Flight Crew.Total : 9000

Experience.Flight Crew.Last 90 Days : 50

Experience.Flight Crew.Type : 300
ASRS Report Number.Accession Number : 1731353
Human Factors : Situational Awareness
Human Factors : Time Pressure
Human Factors : Workload
Human Factors : Confusion

Events

Anomaly.Aircraft Equipment Problem : Critical
Anomaly.Deviation - Altitude : Excursion From Assigned Altitude
Anomaly.Inflight Event / Encounter : CFTT / CFIT
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Detector.Automation : Aircraft Terrain Warning
Detector.Person : Air Traffic Control
When Detected : In-flight
Result.General : Maintenance Action
Result.Flight Crew : Executed Go Around / Missed Approach
Result.Flight Crew : Landed in Emergency Condition
Result.Flight Crew : Requested ATC Assistance / Clarification
Result.Flight Crew : Took Evasive Action
Result.Air Traffic Control : Issued New Clearance

Assessments

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

Narrative: 1

During the flight the ADG, Air Driven Generator, erroneously deployed without faults on the electrical system. The noise and vibration could be felt throughout the aircraft. We followed the QRH and reduced airspeed. I landed without difficulty. The company sent Maintenance to the plane and re-stowed the ADG and signed off the logbook. We continued to destination. Enroute we experienced several electrical malfunctions. First a transitory "AUTO XFER FAIL" caution message appeared. Per QRH no action required. Next both the STAB Trim and Mach Trim caution messages appeared. Per QRH we prepared for a possible out of trim, stabilizer, approach and landing. After about 10 minutes we were able to re-engage both Stab Trim and Mach Trim. The FMS CDU repeatedly displayed "FMS-FMS N1 Disagree" in the scratchpad. While on radar vectors at 3,000 feet MSL a GPWS "Too Low Terrain" warning occurred and then ceased. Since we were on radar vectors and between layers with good visibility no action was taken. We were then cleared for the approach with the autopilot engaged. Flight Mode Annunciator captured both the Localizer and Glide slope. Just before the HSI CDI centered, the CDI began moving very rapidly and erratically. I disengaged the autopilot and corrected toward the CDI. There was no reaction by the CDI since they were moving erratically. I elected to go around. Once again on radar vectors we both made comments to each other about the way the instruments behaved. We requested an RNAV approach. We set the RNAV approach in the FMS and prepared for another approach. This time we were past the FAF and descending, above our MDA, when the flight instruments began the same erratic behavior. I again started another missed approach and at the same time received an altitude warning from the Approach Controller. I asked for an airport with VFR weather to make a visual approach. We did not trust our flight instruments. We diverted to [a suitable airport]. It was this approach where the altitude deviation occurred. Turning inbound I descended a

couple of hundred feet from the 2,100 foot floor. We corrected and landed without further difficulty. On taxi to parking the nose wheel steering failed as I was being marshaled to a stop. The altitude deviation was the result of hurrying to get the plane on the ground. In retrospect, we should have been very deliberate and cautious given the problems we encountered that day; we had plenty of fuel. With the high stress levels we had, CRM would have helped us avoid needless pitfalls.

Synopsis

CRJ-200 Captain reported landing safely after experiencing multiple electrical and autoflight anomalies.

Time / Day

Date : 202002

Local Time Of Day : 1201-1800

Place

Locale Reference.ATC Facility : ZZZ.Tower

State Reference : US

Altitude.MSL.Single Value : 1160

Environment

Weather Elements / Visibility.Visibility : 10

Light : Night

Ceiling.Single Value : 10000

Aircraft

Reference : X

ATC / Advisory.Tower : ZZZ

Aircraft Operator : Corporate

Make Model Name : Citation Excel (C560XL)

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 135

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 : Corporate

Function.Flight Crew : Pilot Not Flying

Function.Flight Crew : First Officer

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Flight Instructor

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Multiengine

Experience.Flight Crew.Total : 25000

Experience.Flight Crew.Last 90 Days : 120

Experience.Flight Crew.Type : 1000

ASRS Report Number.Accession Number : 1726381

Human Factors : Confusion

Human Factors : Distraction

Human Factors : Situational Awareness

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Deviation - Speed : All Types
Anomaly.Deviation - Track / Heading : All Types
Anomaly.Deviation / Discrepancy - Procedural : Clearance
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Detector.Person : Flight Crew
When Detected : In-flight
Result.Air Traffic Control : Issued New Clearance
Result.Air Traffic Control : Provided Assistance

Assessments

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

Narrative: 1

[I was] SIC inbound and on circle to land RWY XX at ZZZ from RNAV GPS RWY XY. While being cleared for the RNAV XY circle to land XX at ZZZ, the PIC flew through the final approach course due to her disarming the approach function in the Universal UNS-1 FMS. We were vectored back on course by ZZZ Approach Control. As we saw the runway and were descending to the initial approach altitude, ZZZ Approach Control cleared us for the visual to XX circle east, report canceling instruments with him or Tower. The PIC was preoccupied with many other extraneous matters and was voicing that. She began her descent to the circling altitude of 1,160 msl while I checked in with the Tower and canceled instruments. I recommended her to level off at the pattern altitude of 2,100 MSL, in order to have a much better view of the runway for the downwind circle. The ceiling and visibility were excellent. She disregarded my advice and continued her descent to the much lower circle altitude. When we arrived at the circle alt I was having difficulty keeping the runway in sight, the PIC had disengaged the A/P and was hand flying. Her heading was [20 degrees off from the] reciprocal of the landing runway and she was allowing the aircraft airspeed to slow down near Vref. I brought this to her attention several times and she would momentarily correct. As her situational awareness deteriorated, she told me to have the Tower call her base leg turn. I was struggling to keep the runway in sight at this low altitude and monitoring our airspeed and heading. She became preoccupied with what a poor impression she was presenting to our passengers, I told her to forget that and fly the aircraft. As a small single engine prop aircraft in the pattern with us was cleared to turn base and land, she became more anxious about ours and the runway location. I saw the aircraft turn base and told her she could begin her turn toward the runway, again her airspeed management became an issue. Her turn rate was becoming insufficient and I was more emphatic in my calls to her on turn rate and airspeed. At this point she became audibly irate with me and rolled out of her turn only to line up with Runway XZ instead of Runway XX. At this point the Tower, noticing the error, cleared her to land on RWY XZ. I asked her if that was her intention, at which she exclaimed RWY XZ was too short for us to land. I told the Tower we declined to land on RWY XZ because it was too short and the Tower told us to "go around". She did not execute our SOP missed approach procedure, I asked her if she was going to "go around", no answer. She simply flew the aircraft down the runway at the circling altitude. The Tower noticed this and asked our intentions. I said we would like to land on Runway XX, the Tower cleared us to turn left and enter the downwind for Runway XX. At this point I looked over in front of her and noticed the REILS and then the PAPI for RWY XX. I announced this to her, she apparently saw the runway and began her turn. I told the Tower we had the runway in sight. The Tower then cleared us to land. Even at this point in the approach sequence the PIC was complaining that she was going to look bad to the passengers. Again, I told her to forget about that and fly the aircraft. In summary I was very apprehensive regarding taking control of the aircraft from

her at that low altitude and her low airspeed at night because of the possible negative and perilous reaction she might have. There was no CRM or situational awareness present and she was not at all responsive to my guidance.

Synopsis

Corporate jet SIC reported that during a circle to land maneuver at night, the PIC lined up with the wrong runway, allowed airspeed to decay, and did not execute an ATC-commanded go-around. The PIC did not respond to the SIC's guidance and CRM was compromised.