

7/1/2026

FOR YOUR INFORMATION

2026-225/5-67

2364083

To: Airport Manager, Chicago O'Hare Int'l, (ORD), IL., FAA (AGL-600)

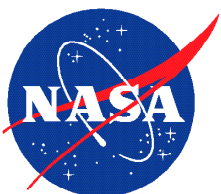
Info: FAA (Director of Air Traffic Operations CSA, AAS-1, AAS-300, AJV-A, AVP-1, AVP-200, AFS-260, AFS-200, ATM ORD Tower, Runway Safety Team), A4A, AAAE, ALPA, AOPA, APA, ASAP, ATSAP, ATSG, CAPA, IATA, ICASS, IFALPA, IPA, NATCA, NBAA, NTSB, RAA, SWAPA, Jeppesen Sanderson Inc.

From: Becky L. Hooey, Director
NASA Aviation Safety Reporting System

Re: ORD Airport Taxiway Signage and Markings

We recently received ASRS reports describing a safety concern that may involve your area of operational responsibility. We do not have sufficient details to assess either the factual accuracy or possible gravity of the report. It is our policy to relay the reported information to the appropriate authority for evaluation and any necessary follow-up. We feel you should be aware of the enclosed deidentified report.

To properly assess the usefulness of our alert message service, we would appreciate it if you would take the time to give us your feedback on the value of the information that we have provided. Please contact Dr. Becky Hooey at (408) 541-2854 or email at becky.l.hooey@nasa.gov.



Aviation Safety Reporting System
P.O. Box 189 | Moffett Field, CA | 94035-0189



ACN 2364083**DATE / TIME**

Date of Occurrence	202605
Local Time Of Day	0601 to 1200

PLACE

Locale	ORD.Airport
State	IL
Altitude - AGL	0

AIRCRAFT / EQUIPMENT X

ATC / Advisory - Ramp	ORD
Make Model Name	Medium Large Transport, Low Wing, 2 Turbojet Eng
Operating Under FAR Part	121

PERSON 1

Function - Flight Crew	Captain
Function - Flight Crew	Pilot Flying
ASRS Report Number	2364083

EVENTS

Anomaly	Deviation / Discrepancy - Procedural - Clearance
Anomaly	Ground Incursion - Taxiway
Detector - Person	Flight Crew
Detector - Person	Ground Personnel
Result - Flight Crew	Became Reoriented
Result - Flight Crew	Requested ATC Assistance / Clarification
Result - Air Traffic Control	Issued New Clearance

NARRATIVE 1

Crew received taxi instructions from ramp control while positioned in the ramp area at ORD. During the initial transmission, the instructions were delivered rapidly and included multiple routing elements. The First Officer, who was relatively junior, missed portions of the readback, and the controller requested the instructions be read back again.

The revised taxi instructions were understood as follow another aircraft, taxi on the east side of the Y, taxi via Taxiway SE, hold short of Taxiway A, and contact Ground Metering.

While complying with the instructions, the crew encountered several aircraft positioned on Taxiway SP immediately ahead. Additionally, Aircraft Y and Aircraft Z were oriented southeast on Taxiway SP, limiting available maneuvering space and requiring the aircraft to continue further south on Taxiway SP.

As the aircraft proceeded, the crew attempted to identify the hold short point for Taxiway A. However, the crew was unable to positively identify the transition point between Taxiway SE/SP and Taxiway A due to limited signage and the absence of a clearly depicted Taxiway SE on available company taxi charts.

Uncertain whether the aircraft had stopped at the correct location, the crew contacted ramp control for clarification. Ramp control advised that the aircraft had proceeded too far and instructed the crew to hold position and contact Ground Metering.

After contacting Ground Metering, the crew was advised they were not expected to be in that location and were instructed to contact Ground Control.

The primary contributing factor was confusion regarding the taxi routing and hold short location in a congested and operationally complex ramp environment. Several factors contributed to the event:

The routing issued differed significantly from normal and familiar procedures commonly used in that area in recent months. Historically, crews typically remained on either side of the Y and contacted Ground Metering prior to taxiing northwestbound on Taxiway SP while monitoring 131.3. The routing issued during this event differed substantially from that normal flow. Taxiway SE was not clearly depicted on available company airport charts available to the crew. Signage and markings in the area did not clearly identify where Taxiway SE or SP transitioned into Taxiway A.

Multiple aircraft positioned in the area created congestion and reduced maneuvering clarity.

Rapid communication cadence and repeated radio exchanges increased cockpit workload during a critical phase of taxi operations.

Despite the confusion, the crew operated conservatively, taxied slowly, sought clarification when uncertain, and attempted to maintain clear and professional communication throughout the event.

To help prevent similar events in the future, the following improvements should be considered:

Improve airport signage and surface markings in the southeast ramp/SP/A taxiway transition area to better identify taxiway boundaries and hold short locations.

Ensure all active taxiways and routing terminology used operationally are accurately depicted on company airport charts and electronic flight deck references.

Promote standardized taxi routing practices whenever possible to reduce confusion caused by frequent procedural changes.

Encourage clear, concise, and measured communication between controllers and flight crews, particularly during periods of high workload and congestion.

Consider additional coordination between ramp control, Ground Metering, and ATC to ensure consistent expectations regarding aircraft positioning and routing in this area.

The crew believes the event resulted primarily from unfamiliar routing, unclear taxiway identification, and a congested operating environment rather than any intentional noncompliance with ATC instructions.

SYNOPSIS

Air carrier Captain taxiing for departure at ORD reported signage and markings in the area did not clearly identify where Taxiway SE or SP transitioned into Taxiway A .