

He concurred with FSF research and other studies that regard conventional step-down nonprecision approaches as inferior to precision procedures, adding that dive-and-drive procedures are prone to becoming unstabilized because of the inherent level of difficulty. "It's quite easy to make a mistake when you're doing a step-down or dive-and-drive," Dibley said. "You have to pitch down — which involves level-off, changing configuration and thrust — and that can lead to an unstable approach, which we all know is not a good idea. You can miss one of the steps ... and a number of accidents resulted from that.

"Similarly, if you don't do it correctly ... you'll end up flying level, pitched up and not pitched down toward the runway on a 3-degree slope. Therefore, once you see the runway, you've then got to pitch down, reconfigure the airplane perhaps, and perhaps dive at the runway. It's not a safe, easy situation. ... You're configuring the airplane late, quite often reading checklists right down to the last moment."

He points out several accidents that exemplify such risk factors in his full presentation <halldale.com/wats-2013/world-airline-pilot-proceedings#.UbCcTJXYl5g>. Serious incidents also have involved flight crews recognizing the situation because of a GPWS or TAWS warning, or an intervention dependent on air traffic control (ATC) radar monitoring.

If pilots lack a DME distance–altitude table or approved equivalent device, they can do a simple altitude–distance computation to monitor the correct altitudes over fixes along their constant 3-degree descent path. He referred to the circumstances of the Korean Air 747 CFIT accident in Guam in August 1997 for demonstration purposes.¹

"It's much easier to have a device which gives you a direct DME-to-altitude display," he said. He cited a U.S. National Aeronautics and Space Administration study that found that "most mentally computed descent profiles are not optimum," and he also cited one serious incident in which CFIT was averted by a crewmember's mental computation, yet the computation result actually was in error.

CFIT Continues

Lessons from commercial air transport CFIT accidents and relevant incidents — from those of the 1970s to the May 2010 Afriqiyah Airways crash (see "Fatal Hesitation," p. 12) — underscore the value of the DME distance–altitude table checks during nonprecision and precision approaches alike.

Dibley cited, for example, one case of an aircraft avionics system coupling to an ILS glideslope that was in test mode, resulting in an automated descent below the correct descent angle until a third pilot recognized the 1,000-ft discrepancy from his own mental calculations, and called for a go-around. The flight crew then landed safely. The incident report questioned, however, why the flight crew had not recognized the discrepancy by using the DME distance–altitude table on the approach chart.

Flight crews need to check their height at some stage of an ILS, normally at the outer marker, to check that they have the QNH (barometric setting for the altimeter to show altitude above mean sea level) set correctly, Dibley said. "The advantage of having a table is you can do it at any time," he said. "You might be just having to change ATC frequencies or something as you pass the outer marker." Temperature-related altitude errors also become obvious by this consistent practice.

In another example, a CFIT accident occurred on a nonprecision approach that had been developed partly to achieve noise-mitigation objectives at night, using a 3-degree descent angle that intercepted a steeper 3.7-degree visual approach slope indicator. "So the captain started off and got too low, but the first officer looking at that chart had no way of monitoring the descent profile," Dibley said. Dibley's subsequent simulator reenactment of the accident scenario found that a 3.7-degree constant-angle approach could have been flown easily as an Airbus managed approach (that is, selected flight angle) or by hand-flying, while monitoring with the table in either case.

In April, he reviewed reports for nine of the most recent CFITs that could have been prevented by Enhanced Ground Proximity Warning Systems (EGPWS). These were identified in the database maintained by Don Bateman, Honeywell corporate fellow and chief engineer-technologist for flight safety systems. Dibley found that in five of these CFITs, DME was available while constant-angle-descent approach charts were not.

Some investigations into the influence of nonprecision approach designs have revealed discrepancies in procedure design (Figure 3), he said, bolstering the argument for tables as a situational awareness tool.

"The important thing is that the distance-altitude tables are essential, but they must be clear, and the crew must know exactly what they're meant to be checking," Dibley said.

So long as nonprecision approaches must be conducted to minimums based on barometric altitudes, even flight crews operating the latest transport category airplanes "must at some stage to do a distance-to-altitude check on the glideslope during your approach to confirm the QNH," he said, referring to the A350 FLS as an example. "If the systems are downgraded in some way — be it from the GPS [global positioning system] or the aircraft systems — you're going to go back to raw data. At some stage, the crew may need just altitude-DME information to carry out a constant-angle approach, so tables will be used for the foreseeable future.

"What do we need to do now? Well, educate those who are unaware of constant-angle approach benefits. ... Emphasize that we can implement it immediately on any aircraft at effectively no cost. We must train the crews properly, of course, but there's very little training involved, frankly. If authorities are slow to approve, give them a suitable stimulus. Help produce the simplest, clearest approach profiles and minimize the number of approach options."

Notes

1. In this case, the DME navigational aid (transponder) was sited along the approach course 3.3 nm (6.1 km) from the runway threshold. Therefore, for example, the correct altitude for the airplane at the 5-nm DME fix (9.3 km) for a 3-degree angle of descent (300 ft/nm) and (310-ft DME crossing height) would be: (5+3.3) x 300 + 310 = 2,800 ft.
2. The NTSB's final report said the probable cause was "the crew's decision to descend to 1,800 ft before the aircraft had reached the approach segment where that minimum altitude applied. The crew's decision to descend was a result of inadequacies and lack of clarity in the air traffic control procedures which led to a misunderstanding on the part of the pilots and of the controllers regarding each other's responsibilities during operations in terminal areas under instrument meteorological conditions. Nevertheless, the examination of the plan view of the approach chart should have disclosed to the captain that a minimum altitude of 1,800 ft was not a safe altitude." Among three contributing factors, the report said, two were: "the issuance of the approach clearance when the flight was 44 miles from the airport on an unpublished route without clearly defined minimum altitudes;" and "inadequate depiction of altitude restrictions on the profile view of the approach chart for the VOR/DME approach to Runway 12 at Dulles International Airport."

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