

# CASE STUDY COMMENT 4

## CAPT. PRADEEP DESHPANDE

The unfortunate end that 'The Trabi' met, apart from being the classic case of 'wrong place at the wrong time', had its origin, like in most accidents, in a series of omissions on the flight deck and elsewhere.

From the time of departure until the incident, the pilots, almost wilfully, manoeuvred themselves through a series of safety nets designed to prevent such an occurrence. The pressure of not being late at the destination is routine and is something that those who operate these sort of 'on-demand' flights learn to handle very early in their lives. Recommended speeds during descent and approach to an aerodrome are not in every aircraft Operations Manual. They allow for a smooth transition to a stable final approach and also provide ATC with the vital seconds they may need to assess the dynamic environment, to facilitate safe and efficient aircraft and vehicle movement. Importantly, controllers get used to the speed at which things move around them and expect these normal speeds to be flown by arriving and departing aircraft so exceptions should be advised and if necessary approved which they were not.

The confusion caused by an unexpected RA should have alerted the pilots for any other out of the ordinary situation in the aerodrome environment. Therefore, when faced with a sudden ILS glide-slope outage, the pilots should have immediately gone around and advised the outage to the ATC. They instead chose to weave through this safety net as well and persisted with the approach. The reaction of the pilot flying to the EGPWS warning blaring over the area speakers was to silence it rather than pay heed to the warning. He thought very little of the fact that the warning was indicative of an unstabilised approach

The intervention by the Captain at this stage was timely but inadequate. His unilateral decision to execute a circling approach to the opposite runway without any performance assessment, and that of the pilot flying to follow it without questioning it, points towards insufficient CRM (Crew Resource Management).

### A RECOMMENDATION

This must be that the Captain, whether pilot flying or pilot not-flying, must retain the responsibility for the safe conduct of the flight. They must continually assess its conduct and mitigate emerging challenges by virtue of their experience, training, skills and authority as PIC (Pilot In Command). Every approach, no matter how routine, must be briefed for its important aspects. An alternative course of action in the



**CAPTAIN  
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served as a combat pilot in the military for 22 years. He was a flying instructor and examiner in the military before joining commercial aviation. Commercially he has flown the Airbus A 310 and is currently flying the B 737 800 NG at Air India. He has approximately 9000 hours from 32 years in aviation.

event of inability to execute the planned approach must be a part of the standard operating procedures. Should another approach that has not been planned have to be executed, a proper assessment of the aircraft performance vis-à-vis the prevailing conditions should be mandatory, even at the cost of delaying the landing. Good CRM calls for crew to be of assistance to each other and, where necessary, to convey their apprehensions. Simply issuing instructions or following them without due consideration for safety and one's abilities is indicative of poor CRM and a recipe for an accident.

The impact of such lapses may not always be borne solely by the parties involved but could cause collateral damage to men and material, as was the case with Brent's ill-fated Trabant 601! □

