

**Aviation Safety Investigation Report
198800221**

Airbus Industries A300

16 June 1988

Readers are advised that the Australian Transport Safety Bureau investigates for the sole purpose of enhancing transport safety. Consequently, Bureau reports are confined to matters of safety significance and may be misleading if used for any other purposes.

Investigations commenced on or before 30 June 2003, including the publication of reports as a result of those investigations, are authorised by the CEO of the Bureau in accordance with Part 2A of the Air Navigation Act 1920.

Investigations commenced after 1 July 2003, including the publication of reports as a result of those investigations, are authorised by the CEO of the Bureau in accordance with the Transport Safety Investigation Act 2003 (TSI Act). Reports released under the TSI Act are not admissible as evidence in any civil or criminal proceedings.

NOTE: All air safety occurrences reported to the ATSB are categorised and recorded. For a detailed explanation on Category definitions please refer to the ATSB website at www.atsb.gov.au.

Occurrence Number: 198800221
Location: Perth WA
Date: 16 June 1988
Highest Injury Level: Nil
Injuries:

Occurrence Type: Incident

Time: 2155

	Fatal	Serious	Minor	None
Crew	0	0	0	0
Ground	0	0	0	-
Passenger	0	0	0	0
Total	0	0	0	0

Aircraft Details: Airbus Industries A300
Registration: PK-GAI
Serial Number: N/K
Operation Type: Regular Public Transport
Damage Level: Nil
Departure Point: Bali Indonesia
Departure Time: N/K
Destination: Perth WA

Approved for Release: 10 February 1989

Circumstances:

The aircraft Captain had received a Garuda Route Clearance Unit presentation on the Perth route prior to departure from Bali and he had made one previous flight into Perth as the First Officer on a DC-10 in May 1988. After an evidently uneventful flight the aircraft was making an approach to Runway 03 at Perth. The cloud base at the time was approximately 800 feet above sea level. Air Traffic Control had used radar vectoring to position the aircraft for the approach and the crew was then instructed to make a pilot intercept of the appropriate radial from the Perth VOR. The aircraft did not accurately follow the required radial and the aircraft diverged up to about one kilometre either side of the published final approach path. The First Officer who was visually monitoring the approach was unable to sight the runway lighting and an overshoot was commenced when the aircraft was about three kilometres from the runway threshold. At about the same time as the Captain commenced his overshoot procedure the Perth Tower controller who had monitored the aircraft's approach from the time it had descended below the cloud base decided that the aircraft was not in a position to make a normal landing. He therefore instructed the aircraft to overshoot. The subsequent approach and landing were without incident. The investigation revealed that the details of the approach published by the Jeppesen Company in the USA contained an error of 5 degrees in the direction of the VOR radial required for the final approach path for the particular runway. These approach details were contained in company documentation available to the crew. Whether this error had any relevance to the incident circumstances was not established. It was noted that there are areas of significant lighting in the vicinity of Perth Airport which could hamper visual acquisition of the runway lighting under conditions of poor visibility. A precision approach aid such as ILS is not available for Runway 03 and runway approach lighting is not installed.

Significant Factors:

The following factors were considered relevant to the development of the incident

1. The crew did not accurately intercept and track on the final approach path.
2. The crew were unable to visually identify the runway before they reached the published minima.