# **National Transportation Safety Board** Washington, DC 20594

#### **Brief of Accident**

#### Adopted 05/23/1997

DCA96MA008

File No. 2148 11/12/1995 EAST GRANBY, CT Aircraft Reg No. N566AA Time (Local): 00:55 EST Make/Model: Mcdonnell Douglas / MD-83 Fatal Serious Minor/None Engine Make/Model: P&w / JT8D-219 Crew 0 5 0 Aircraft Damage: Substantial Pass 73 0 0 Number of Engines: 2 Operating Certificate(s): Flag Carrier/Domestic Name of Carrier: AMERICAN AIRLINES INC Type of Flight Operation: Scheduled; Domestic; Passenger Only Reg. Flight Conducted Under: Part 121: Air Carrier Last Depart. Point: CHICAGO, IL Condition of Light: Night/Dark Destination: WINDSOR LOCKS, CT Weather Info Src: Weather Observation Facility Airport Proximity: Off Airport/Airstrip Basic Weather: Instrument Conditions Lowest Ceiling: 2800 Ft. AGL, Overcast Visibility: 3.00 SM Wind Dir/Speed: 170 / 025 Kts Temperature (°C): 16 Precip/Obscuration: Pilot-in-Command Age: 39 Flight Time (Hours)

Certificate(s)/Rating(s)

Airline Transport; Commercial; Flight Engineer; Military; Multi-engine Land; Single-engine Land

Instrument Ratings Airplane

Total All Aircraft: 8000 Last 90 Days: 55 Total Make/Model: 4200 Total Instrument Time: UnK/Nr

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The airplane impacted trees, then an ILS antenna as it landed short of the runway on grass, even terrain during a night VOR approach in strong, gusty wind conditions. At the time of the accident, the indicated altitude (height above airport elevation) that the airplane's QFE altimeter was indicating was about 76 feet too high (based on the altimeter setting received at 0030), resulting in the airplane being 76 feet lower than indicated on the primary altimeters. Because the flightcrew knew that the atmospheric pressure was falling rapidly, they should have requested a current altimeter setting from the approach controller when was not given, as required, upon initial radio contact. Although the flightcrew did not use the most current QNH setting they had available (29.40 inches of Hg.) in the standby altimeter, this error did not affect the accident sequence of events because the flightcrew had the correct, but outdated, OFE setting (29.23 inches Hg.) in the altimeters they were using when the accident occurred. If the first officer had monitored the approach on instruments until reaching minimum descent altitude (MDA) and delayed his search for the airport until after reaching the MDA, he would have been better able to notice and immediately call the captain's attention to the altitude deviation below the MDA.

#### Brief of Accident (Continued)

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Occurrence #1: UNDERSHOOT

Phase of Operation: APPROACH - FAF/OUTER MARKER TO THRESHOLD (IFR)

## **Findings**

- 1. LIGHT CONDITION DARK NIGHT
- 2. WEATHER CONDITION RAIN
- 3. WEATHER CONDITION HIGH WIND
- 4. WEATHER CONDITION GUSTS
- 5. (F) APPROACH/DEPARTURE CONTROL SERVICE INADEQUATE ATC PERSONNEL(DEP/APCH)
- 6. (F) ALTIMETER SETTING NOT OBTAINED FLIGHTCREW
- 7. (C) MINIMUM DESCENT ALTITUDE BELOW FLIGHTCREW

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Occurrence #2: IN FLIGHT COLLISION WITH OBJECT

Phase of Operation: APPROACH - FAF/OUTER MARKER TO THRESHOLD (IFR)

### Findings

- 8. OBJECT TREE(S)
- 9. OBJECT ANTENNA

Findings Legend: (C) = Cause, (F) = Factor

The National Transportation Safety Board determines the probable cause(s) of this accident as follows.

the flightcrew's failure to maintain the required minimum descent altitude until the required visual references identifiable with the runway were in sight. Contributing factors were the failure of the BDL approach controller to furnish the flightcrew with a current altimeter setting, and the flightcrew's failure to ask for a more current setting. (NTSB Report AAR-96/05 adopted 11/13/96)