CENIPA Replies

This letter is a response to "Midair Over the Amazon" (ASW, 2/09, p. 11), concerning the collision of the Gol Boeing 737-800 and the ExcelAire Embraer Legacy 600 in Brazilian airspace.

When the International Federation of Air Traffic Controllers' Associations (IFATCA) criticized the final report by the Aeronautical Accident Prevention and Investigation Center (CENIPA) and used the expression "missed opportunity," we did not make any comments, although disagreeing with their standpoint. We understood that they were exercising their right to defend a class or group of people; they were just playing their role, and we will always defend their right to do so.

However, when a respected organization such as the Flight Safety Foundation, echoing the words used by the IFATCA, decides to lend support to this latter organization and criticizes the serious job done by the Brazilian state, it is time for the chief of the CENIPA to reply to the person who wrote the article, and to the Foundation, on account of the aforementioned support.

Unfortunately, the Foundation's article, despite being totally based on the final report made available to the world through the Internet, was not able to make a single positive comment regarding the investigation conducted by the Brazilian state, which had the participation of other international organizations, and preferred to depreciate the two-year-long work done by a team composed of more than 50 people.

Take, for example, the very subtitle that includes the words "controversial Brazilian report": Who classified the final report as controversial? What are the bases for such a classification? Apart from the IFATCA, who considered the report controversial?

To affirm that the U.S. National Transportation Safety Board (NTSB) questioned the findings and conclusions of the final report is, to say the least, inappropriate, and the few points that were not incorporated in the report, on account of differences of investigation methodology, were included in an appendix of the report.

At one point, the article refers to the "probable cause" (which the NTSB, by legislation requirements, is obliged to report), failing to comment (due to lack of information?) that in Brazil the investigators work with contributing factors without establishing precedence between them.

It is worth pointing out that, once more, the influence of the footrest is mentioned as one of the hypotheses considered by the Brazilian investigators, but nothing is said about the fact that such a hypothesis was discarded after a full demonstration in the final report, by means of a detailed ergonometric study, corroborated by the fact that the pilot himself affirmed that he had not utilized it.

When the article refers to the "bad system design," it mentions the NTSB, thus inducing the reader to conclude that such classification had been made by the renowned American investigating organization, and only many lines later does it credit the classification to its real source: the IFATCA. When the article comments on the symbol "=" which is placed between the flight levels, it again induces a reader less familiar with air traffic control to logically conclude that 370 cannot be equal to 360 ("370 = 360"). For the trained eye, however, the interpretation is different: the aircraft is at Flight Level (FL) 370 — neither climbing nor descending — and the new flight level requested is FL 360. This does not mean that the system has a faulty design. Since its creation, it was taught and operated like that for many years without any problems. We know the system is not perfect, and we know

that a perfect system is something everyone is looking for in the world. Can it be improved? Of course, it can. That's why (and, again, this is not commented on in the article) the final report established more than 30 safety recommendations forwarded to the Airspace Control Department.

At another point, the article says that the investigators were not able to learn how the transponder changed to standby (STBY). The final report, however, shows that the pieces of equipment were tested in the laboratories of the manufacturer, in the presence of NTSB representatives, and they functioned faultlessly. They operated normally from the departure until after the aircraft passed over the Brasília VOR, and resumed transmitting after the collision. Therefore, the most probable hypothesis is that the equipment was inadvertently set to STBY. Thus, the investigator and the aviation authority, contrary to what is said in the article written by the IFATCA (reprinted in the FSF article), do not blame A or B for the accident, simply because, in accordance with the prescriptions of the International Civil Aviation Organization — of which Brazil is a group 1 contracting state — it is not the objective of the aeronautical accident investigation to establish blame or liability, but solely to prevent the occurrence of further accidents.

Last, I would like to comment on the ill-intentioned question of the subhead "Misplaced Blame?" It is not the purpose of the investigation to blame or acquit any individual or organization that has played a role in the event; the author, however, tries to mislead the reader by making illogical comparisons. The final report clarifies the findings related to the controllers involved, to the air traffic control and to the flight crew. Thus, it is not wise to compare the preparedness and performance of the controllers to the preparedness and performance of the pilots. There is no doubt that the events related to the moments following the change of the transponder to the STBY mode were exhaustively analyzed in relation to the performance of everyone involved. However, I am not willing to rewrite a report of almost 300 pages or refute all the improprieties of an article that reduced them to five.

In concluding, I think it is proper to praise the author of the article for informing readers that it was based on the CENIPA report, available on the Internet.

As chief of the CENIPA, I expect that the Foundation will treat this reply with the same consideration given to the article in *AeroSafety World*.

Brig. Gen. Jorge Kersul Filho
Chief of the CENIPA
Brasília, Brazil

The editor replies: *The topic of the story was the accident, not the quality of CENIPA's investigation of the accident. The report is indeed controversial because its findings have been questioned by several organizations, including IFATCA and NTSB. Thus, the inclusion of other points of view in the story to present a balanced view of what might have happened is not, in our judgment, a flaw.*

Regarding the footrest issue, the story stated, "Investigators were unable to determine conclusively how the transponder had been switched to the standby mode," continuing to say the "most likely explanation" was that it was an inadvertent result of the use of the radio management unit for other purposes. Only then did the story note that CENIPA identified the footrest as "another possibility," a conclusion the NTSB reached as well, and the NTSB report was quoted, too.

The source of the term "Bad System Design" in the subhead was clearly noted as being IFATCA, not NTSB.

The story's presentation of the radar display symbol "370=360" is exactly what the report stated and was fully explained. No attempt was made to portray this as a formula. It was the ease with which changes in the display might not be identified — given the moderate visual difference between "370 =370" and "370 =360" — when the change is made automatically, that led to the IFATCA's critical comments.

The story states the finding that the transponder likely was inadvertently set to standby and does not state that the equipment was faulty, and neither does IFATCA.

Finally, your statement that "it is not wise to compare the preparedness of the controllers to the preparedness and performance of the pilots" in our opinion is not supported by the factual information included in the report.

AeroSafety World encourages comments from readers, and will assume that letters and e-mails are meant for publication unless otherwise stated. Correspondence is subject to editing for length and clarity.

Write to J.A. Donoghue, director of publications, Flight Safety Foundation, 601 Madison St., Suite 300, Alexandria, VA 22314-1756 USA, or e-mail <donoghue@flightsafety.org>.